How do young Nepalese people living in the UK make sense of mental health and problems of mental health: a qualitative exploration.

Bandana Upadhya

Submitted for the Degree of

Doctor of Psychology
(Clinical Psychology)

School of Psychology Faculty of Arts and Human Sciences University of Surrey Guildford, Surrey United Kingdom September 2015
Abstract

Background: People from Nepal who have migrated to and settled in the UK are forming a fast growing ethnic minority group. A small number of studies have highlighted concerns about the lack of understanding of mental health problems and awareness of mental health services amongst groups of Nepalese people living in the UK. However there have not been any investigations into how they conceptualise mental health and respond to their mental health needs. Moreover, there have not been any studies on the younger Nepalese population.

Aims: The purpose of this study was to explore the subjective perspectives of young adults from the Nepalese community on mental health.

Method: The study adopted a qualitative research methodology. Five young Nepalese adults (average age of 25.2) were recruited using purposive sampling strategy and interviewed using semi-structured interviews. The interviews were transcribed and analysed using Interpretative Phenomenological Analysis.

Results: One master theme was developed to demonstrate participants’ perception and experience of psychological distress and/or mental health issues: ‘viewing mental health differently’. Three themes were further developed to explain the master theme, which included ‘understanding mental health’, ‘recognising and solving problems: focus on self and others’; and, ‘closeness and escapism: focus on family and the community’.

Conclusions: The findings were discussed in terms of existing literature on other ethnic minority groups and theories on somatisation of mental illness and biculturism. The implications of the findings are also discussed.
Acknowledgements

I would like to pay my sincere gratitude to the course team at the University of Surrey for the toughest and most rewarding three years of my life. After these three years, I am triple in knowledge, skills and resilience.

Mary John, thank you for always inspiring me. You make me proud to be a Surrey Graduate.
Charlotte King, thank you for your patience. You made training that little bit easier with your organizational skills.
Dora Brown, thank you for helping me transform a humble idea into a thesis I can be proud of.
To all my course mates, thank you for making training manageable and fun.
To my family, partner and friends, thank you for supporting me, tolerating me and not giving up on me.
List of contents

Major Research Project (MRP) Empirical paper.......................................................5

MRP Empirical paper appendices...........................................................................46

MRP Proposal........................................................................................................84

MRP Literature Review........................................................................................99

Summary of clinical experience............................................................................133

List of assessments.............................................................................................136
Major Research Project Empirical Paper

How do young Nepalese people living in the UK make sense of mental health and problems of mental health: a qualitative exploration.
Abstract

**Background**: People from Nepal who have migrated to and settled in the UK are forming a fast growing ethnic minority group. A small number of studies have highlighted concerns about the lack of understanding of mental health problems and awareness of mental health services amongst groups of Nepalese people living in the UK. However there have not been any investigations into how they conceptualise mental health and respond to their mental health needs. Moreover, there have not been any studies on the younger Nepalese population.

**Aims**: The purpose of this study was to explore the subjective perspectives of young adults from the Nepalese community on mental health.

**Method**: The study adopted a qualitative research methodology. Five young Nepalese adults (average age of 25.2) were recruited using purposive sampling strategy and interviewed using semi-structured interviews. The interviews were transcribed and analysed using Interpretative Phenomenological Analysis.

**Results**: One master theme was developed to demonstrate participants’ perception and experience of psychological distress and/or mental health issues: ‘viewing mental health differently’. Three themes were further developed to explain the master theme, which included ‘understanding mental health’, ‘recognising and solving problems: focus on self and others’; and, ‘closeness and escapism: focus on family and the community’.

**Conclusions**: The findings were discussed in terms of existing literature on other ethnic minority groups and theories on somatisation of mental illness and biculturism. The implications of the findings are also discussed.
Statement of Journal Choice

The peer-reviewed journal chosen for the MRP Empirical paper is *Journal of Mental Health*. This particular journal is considered ideal for the current study since it focuses on mental health issues amongst a specific population, which fits with the journal’s scope. It is further considered that presumed readers of the journal i.e. mental health professionals and service developers would benefit from an awareness of different ethnic minority groups and their perception of mental health, with the aim of incorporating the lessons into clinical practice and within service development work. Additionally the journal has a relatively high ranking (53/111) and a relatively good impact factor (1.72) which add to the Journal’s appeal. A copy of the guideline for authors (from the journal website) has been appended (Appendix A)
Introduction

Globalisation has meant that the UK is now a largely multicultural nation. Ethnic minority groups trying to settle in the UK can face language barriers, discrimination, cultural conflicts, isolation and cultural bereavement, all of which can have a negative impact on their mental well-being (Bhugra & Jones, 2001; Bhugra, 2001). Difficulties can also arise for service providers and policy makers in the host country who, without sufficient awareness, will be unable to suitably adapt services to make it more accessible and useful to various ethnic minority groups. Mental health services are particularly vulnerable to this. Mental health professionals today have to treat various ethnic minority groups whose understanding and perception of mental illness and diagnoses are likely to be significantly different from their own (Bhugra et al., 2011). Research has shown that people from Black and Ethnic Minority (BME) groups are the least likely group to seek help for mental health problems and have a significant disadvantage when it comes to getting their mental health needs met (Bhui et al., 2003; Bristow et al., 2011). In order to make mental health services more culture-friendly and therefore accessible to ethnic minority groups, more effort needs to be made to understand mental health from the perspective of different cultures.

People from Nepal who have migrated to and settled in the UK are forming a fast growing ethnic minority group. Based on the 2001 census, there were 5,943 people born in Nepal living in the UK. These figures are likely to have risen dramatically since 2004, because in 2004 Gurkha soldiers who retired pre- and post-1997 won the right to settle permanently in the UK, together with their dependents (Adhikari, 2012).

Nepal is a small country situated in South Asia, classified as one of the least developed countries in the world (Adhikari, 2012; Jha, 2007). According to a report by the World Health Organisation (WHO), there were only 18 outpatient mental health facilities available in the
entire country (none of which were for children and adolescents only) (WHO-AIMS report, 2006). Regmi et al (2004) reported that the majority of people living in Nepal conceive mental illness as a person ‘losing self-control’, becoming ‘crazy’, and/or being ‘possessed by spirits’. Regmi et al (2004) further stated that people with mental illness are considered ‘unfit’ and often rejected by their families as well as the wider society. As a result, many are reluctant to come forward for treatment. Due to the limited number of mental health professionals, specialist mental health training, mental health services, as well as widespread stigma and discrimination associated with mental health problems, the country is faced with great challenges in improving access to and quality of mental health care (Devkota, 2011; WHO-AIMS report, 2006). It is possible that people who have migrated to the UK from Nepal also hold these beliefs about mental health and may be reluctant to enquire about mental health services in light of the inadequate services that are available in their home country. Additionally, most people in Nepal are reported to prefer seeking private consultation for psychiatric illnesses, if they are able to afford it (Jha, 2007), which may have an impact on how mental health services are consulted by some of the Nepalese population in the UK.

There are a limited number of studies that have looked at the mental health needs of Nepalese people living in the UK. Two studies were conducted in the Rushmoor region (North East Hampshire) where a growing number of Nepalese people appear to have settled. One of these was an investigation into the factors affecting access to mental health services by individuals from BME groups (not specified) and Nepalese people, compared to the majority White British population of the same area (Amani, 2012). The study was a pilot, and surveys were the main method of data collection. Most of the responses were from individuals aged between 41 and 50. Some of the key findings of this study were that Nepalese respondents were less likely to speak to their GP about any mental health concerns (similar to other BME
respondents). They were also less likely to know about and therefore access local mental health services, compared with the White British respondents. This study does little in informing why the differences exist between the White British and the Nepalese respondents. Moreover, it is unclear which different ethnic groups made up the BME respondents and therefore there is little that can be revealed about why some of the behaviours are shared between the different ethnic minority groups while others are not. There was also an underrepresentation of responses from Nepalese youths, young adults as well as those over the age of 50.

The second investigation was conducted by the Department of Health (DOH; Casey, 2010) and looked at the overall health needs, including mental health, of Nepalese people living in the Rushmoor area. Focus groups consisting of health professionals from local General Practitioner (GP) practices gave rise to three major themes relating to mental health: stigma, somatisation and delay in diagnosis. The ‘stigma’ theme related to healthcare professionals, including GPs, wondering whether mental health was associated with stigma in the community, causing Nepalese people to decide against seeking help. The second theme – somatisation – related to the observation that Nepalese people tended to somatise their mental health concerns since many reported physical health complaints such as dizziness, abdominal pains to their doctors, when the underlying problem was often mental illness (usually depression). The third theme of ‘delay in diagnosis’ referred to concerns by GP practises that there was usually a delay in the diagnosis of mental illness amongst Nepalese individuals, since they were likely to be tolerant of difficulties until it became severe. These findings are based on the viewpoints and observations of people who are not themselves from the Nepalese community, and therefore may not be an accurate depiction of what actually happens for Nepalese people.
The available studies are limited and fail to indicate how Nepalese people experience, conceptualise, identify or manage emotional distress, and which factors might influence these processes. It has been suggested that an individual’s cultural background is likely to influence the way mental health difficulties are experienced, communicated, recognised, tolerated, whether or not they are expressed, and conceptualised (Hwang, Myers, Abe-Kim & Ting, 2008). For example, there are cultural differences in the way psychological distress is physically manifested. Studies have found that somatic or physical manifestation of illness is common in Asian cultures, whereas talking about problems and expressing one’s emotions verbally is more common in Western cultures (Farooq et al., 1995; Chun, Enomoto & Sue, 1996). Somatisation was found to exist amongst Nepalese people as well, according to the DOH report outlined above (Casey, 2010). Nepalese people might also have different perspectives on talking about their problems and may not see it as an appropriate and/or effective means of resolving personal conflict. A qualitative study found that South Asian women spoke about their mental distress in a way that avoided talking about themselves (Fenton & Sadiq-Sangster, 1996). Even within the Nepalese culture, there might be different, culture-specific ways in which people communicate their distress.

A review of the literature has also highlighted a limited focus on mental health issues of younger Nepalese people living in the UK. Casey (2010) reported growing problems of drug misuse amongst young Nepalese males in the North East Hampshire region. She discovered that healthcare professionals trying to engage with these young people often faced challenges in engaging both the young people and their parents. Interestingly, parents seemed to opt for a stricter style of treatment available in Nepal, with beliefs that their children would respond better to “firmness”, since this was also the way they were raised. The report does not offer perspectives from the young people themselves on their problem and/or choice of treatment, which largely seems to be influenced by their parents. It is unknown whether young Nepalese
people have similar beliefs to their parents about these issues or whether they are more influenced by the beliefs of the larger Western culture, and furthermore, how they might manage any differences between the two cultural influences.

Children of immigrant parents are said to be living in-between two cultures. Individuals are known to be bicultured if they speak both their native language and the language of the receiving culture, are friends with individuals from both cultural backgrounds and expose themselves to media belonging to both cultures (Schwatz & Unger, 2010; Mistry & Wu, 2010). Bicultured individuals may experience an obligation on the one hand to follow rules and guidance set out by their parents but on the other hand be drawn to or influenced by the culture of the host country through their peers, the mainstream education system and the media (Benet-Martínez & Haritatos, 2005, Mistry & Wu, 2010). This could be the case for young Nepalese adults who were born here or have lived in both countries, Nepal and UK. They may have inherited the culture of both countries, which could be a source of opportunity or confusion. Some may feel more drawn to the tradition of their home country, while others feel more interested in adapting to the culture of the UK, creating a conflicting situation to manage.

Berry (1997) proposed a framework for understanding how ethnic minority groups negotiate identification between their culture of origin or ethnic culture and the mainstream or dominant culture. He suggests that two key issues come into play during this process: the extent to which ethnic minority groups are motivated or permitted to retain identification with the culture of origin or the ethnic culture and, the extent to which they are motivated or permitted to identify with the majority culture. Individuals can take on one of four possible acculturation positions once they have worked through the two issues. Acculturation refers to the process whereby one cultural group, usually the minority, adopts the values, language and behaviours of another, usually the majority. The first acculturation position, according to
Berry (1992) is called ‘assimilation’ where individuals identify mainly with the dominant culture. The second is called ‘integration’ where there are high levels of identification with both cultures. The third is termed ‘separation’ where identification is mainly to the ethnic culture and the final one is termed ‘marginalisation’, in which the ethnic minority individual does not identify with either culture. There appears to be large group and individual differences in how people acculturate, in the amount of stress experienced and in terms of how well they adjust psychologically and socially (Berry, 2005; Koneru, Weisman de Mamani, Flynn & Betancourt, 2007). Thus, the different acculturations processes might influence how first or second generation young Nepalese people perceive symptoms of psychological distress or mental health problems. Thus, someone who is ‘assimilated’ in the Western or majority culture might be more likely to harbour beliefs that are in line with Western perspectives, compared with someone who is ‘separated’. It would be interesting to investigate whether first and second generation, young Nepalese people draw to any one culture or both (or neither) cultures in their attempts to make sense of their personal distress and when choosing a course of action. It is such curiosity that has given rise to this research. Thus, the aim of this research was to acknowledge subjective perspectives on mental health from people belonging to a Nepalese community in the UK, specifically young adults. The objective was to add to an incipient body of literature relating mental health and ethnic minorities. To help fulfil the aim and objective, the research adopted a qualitative methodology as this type of research is said to be ideal for case-study analysis and in-depth investigations of people’s experience, perceptions and attitudes, as opposed to quantitative research where the purpose is to generalise collected data (Yin, 2003). Furthermore, to help answer the research question: how do Nepalese people living in the UK make sense of mental health problems, the study used interviews to collect data. The interviews used a semi-structured format. Semi-structured interviews were considered to be
appropriate since it uses a flexible approach to data collection and is said to be useful for accessing rich, in-depth accounts of people’s experiences (Smith, Flowers & Larkin, 2009). The method of data analysis was Interpretative Phenomenological Analysis (IPA henceforth). IPA is a method suitable for exploring personal perspectives and lived experiences of people in an in-depth manner. It enables people to make sense of and give meaning to their personal world, as well as to express their experiences within its particular contexts (Smith, Flowers & Larkin, 2009). Moreover, IPA is often recommended for cross-cultural research with ethnic minority groups (Liamputtong, 2010).

**Method**

*Participants.* Following IPA guidelines, this study followed a purposive sampling strategy to recruiting participants. Purposive sampling is where participants are selected on the basis that they will allow the researcher access to particular viewpoints on the phenomena being studied (Smith, Flowers & Larkin, 2009). Thus, participants from a specific group (e.g. people originally from Nepal who have lived in the UK for more than a year) and with specific characteristics (e.g. those with personal experience of emotional or psychological distress or mental health problem) were recruited. A list of the inclusion criteria employed has been appended (Appendix B).

Potential participants were initially contacted via referrals from gate-keepers in the Nepalese community. Names and contact details of 6 willing individuals were made available to the researcher via referrals from identified gate-keepers. Participants were initially contacted via text messages to check for consent and the possibility for a phone conversation (in order to provide more information and initiate the engagement process). Two of the 6 participants did not respond to the text message. Three participants gave verbal consent to participation however did not respond at follow-up. Following numerous attempts to make contact, it was
assumed that they no longer wished to participate. Thus, out of the six potential participants, only one was able to participate in the study.

Due to the difficulties faced in recruiting using the strategy outlined above, other means of recruitment were employed. One of these methods involved requesting help from members of a Nepalese-based youth group. Two individuals were recruited via the youth group and subsequently interviewed. Thereafter, two further individuals were recruited via an opportunistic method, using the researcher’s (also Nepalese) personal contacts from the Nepalese community. Further details and the researcher’s reflections on the process of recruitment have been appended (Appendix D).

Overall, five individuals were invited to participate in the study. Small samples are usually preferred in IPA studies because it enables the researcher to achieve a comprehensive interpretation of each individual case before examining similarities and differences between cases (Smith & Osborn, 2007).

The final sample consisted of four female participants and one male participant with their ages ranging from 19 to 29 (average age of 25.2). The average amount of years participants lived in the UK was 9.1 years. All participants reported their country of origin to be Nepal. All participants identified with having struggled with either an emotional, social, mental health and/or physical health issues. The sample was also considered homogenous as all of the participants were first-generation young Nepalese adults, who moved to the UK with their parents. Participants were given pseudonyms. Relevant demographic information for each participant is outlined in Table 1.
<table>
<thead>
<tr>
<th>Participant pseudonym</th>
<th>Gender</th>
<th>Age</th>
<th>Number of years lived in the UK</th>
<th>Identified problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shreya</td>
<td>Female</td>
<td>29</td>
<td>20</td>
<td>Depressed, Hallucination</td>
</tr>
<tr>
<td>Kalpana</td>
<td>Female</td>
<td>27</td>
<td>6.5</td>
<td>Depressed, Unexplained infection</td>
</tr>
<tr>
<td>Anju</td>
<td>Female</td>
<td>19</td>
<td>3</td>
<td>Heard voices</td>
</tr>
<tr>
<td>Jitendra</td>
<td>Male</td>
<td>25</td>
<td>7</td>
<td>Drug addiction</td>
</tr>
<tr>
<td>Gita</td>
<td>Female</td>
<td>26</td>
<td>9</td>
<td>Stress, Migraine</td>
</tr>
</tbody>
</table>

Table 1: Table showing participant pseudonyms, gender and age
The interview. All participants met with or spoke to the researcher/interviewer at least once prior to the interview. Participants were given relevant documents, including information about the study and a consent form by email or in person, before their interview. Participants were offered explanations about consent and confidentiality and subsequently asked for a signature on the day of the interview. Participants were met either at their home (only in the case of participants known to the researcher), community centre or council offices, depending on what was most suitable for the participant and the researcher.

The interview was semi-structured and informal. The interview consisted of a number of open-ended questions. The interview started with a short introduction to the study, which mentioned that participants would be asked some questions about their experience of living away from Nepal and about the issue that they had/were struggling with. The first interview question asked participants how long they had lived in the UK, followed by a broad question of: ‘what is it like living in the UK?’. Thereafter, participants were asked to tell the interviewer more about their experience of mental health or physical health, or if they had not used those words previously, to describe the problem they had encountered. The purpose of this was to avoid using words participants did not associate with. Participants understood what they were being asked. General questions about mental health and mental health services were also included in the interview to prompt participants to share their viewpoint on these issues even if they did not identify themselves as having problems of mental health. The full interview schedule has been appended (Appendix C).

The interview duration ranged from 45 minutes to 2 hours. All of the interviews were audio-recorded, with permission from the participants. The recordings were transcribed verbatim. Some of the participants used Nepalese words in the interview. The Nepalese words were transcribed in Nepalese (using English letters) however with an English translation next to it.
in brackets. Pseudonyms were used instead of the participants’ real names during the transcription process to ensure participant anonymity. Researcher’s reflections on the interview process have been added to the appendix (Appendix D).

**Ethical considerations.** The study has received favourable ethical approval by the University of Surrey (Appendix E). All participants consented to participate in the study. Participants were informed about data confidentiality. All confidential participant materials, including audio recordings and interview transcripts were stored as password protected computer files and paper copies were securely stored at the University of Surrey.

Since the topic of the interview was sensitive and personal, it was anticipated that participants may become upset during and/or after the interview. For this reason, participants were debriefed after the interview and a plan was put in place to help those who may need additional follow up support. This included permission to contact the researcher and an outline of self-care strategies. Participants were not keen on accessing helplines as this was not a usual form of support for them.

**Analysis.** Interpretative Phenomenology Analysis (IPA; Smith & Osborn, 2003) was used to analyse the interview data. The process recommended in IPA is a case by case analysis followed by a comparison across cases which involves a series of stages (Smith & Osborn, 2003; Smith, Flowers & Larkin, 2009). In line with the recommendation, each transcript was read carefully and repeatedly to enable the researcher to become familiar with the data. Each thorough reading of the transcript produced new insights into the account. Initial notes were made during these readings which involved marking any free associations, initial interpretations or anything of interest. All of the initial notes were made on the right hand side of the transcripts. Thereafter, the initial notes were analysed further to find emergent themes, which were noted as ‘theme titles’ on the left hand margin of the transcripts. The theme titles were words or phrases that most suitably captured what was found in the
material. When similar ideas occurred at various points in the transcript, the same theme title was repeated. This process was carried out for each transcript. Thereafter, all the emergent theme titles were placed on separate post-it notes spread out on a table so each note was visible. Each post-it included reference numbers to enable the researcher to identify which participant the theme belonged to. The post-it notes containing themes from all the participants were arranged and rearranged in various clusters in attempts to find connections between them. The researcher then tried to make sense of the connections within the clusters that developed, from which three main themes emerged. The three major themes were given new titles. They were further compared and analysed to derive a master theme that helped answer the main research question. Lastly, quotations from each transcript were noted under each of the main themes. Though, Jitendra was more difficult to engage in conversation during the interview, and therefore his contribution to the analysis is much less in comparison to the female participants, who gave much longer and detailed interviews.

Credibility of the study was established by following guidelines proposed by Yardley (2000). Details about this have been included in a separate document in the appendix (Appendix F).

Results

Although the participants in this study varied in demographical background, the data yielded certain commonalities. Overall, one master theme was developed: viewing mental health differently.

The overarching master theme of viewing mental health differently refers to all the variability in the interpretations that participants made about their personal difficulty and its impact on them as a person, since this was not the same for all. Furthermore, it refers to the variability in their conceptualisation of mental health. It also refers to the variability in how they recognised and responded to their problem, as well as the way in which they managed the involvement of their family and the wider community. To help explain this master theme,
three themes are fully developed below. These are: ‘Understanding mental health’, ‘Recognising and solving problems: focus on self and others’, and ‘Closeness and escapism: Focus on family and the community’.

**Understanding mental health.**

Participants conceptualised mental health or mental health problems in various ways, depending on their personal experience and understanding.

One participant referred to her experience of depression as a type of physical illness incurred in the brain, causing it to be in pain.

*My brain was hurting, it was physically hurting (Shreya)*

*My brain chemical was all fuzzy and I was really ill (Shreya)*

Shreya, with her experience of having a psychiatrist uncle and private therapeutic intervention, had a largely medical understanding of her difficulties, specifically the recognition that she was struggling because her brain chemicals were not functioning adequately. Understanding her difficulty as a problem of the brain caused her to unwillingly surrender to what she understood as a lifelong illness:

*When I go into depression you would just know it, it’s almost like having a stroke, it’s a neurological thing..... (Shreya)*

When Jitendra talks about his struggle with drug addiction, he draws attention to his brain controlling the addiction by means of being contaminated:

*....quitting drugs is one of the most difficult things that anyone can face it’s in your blood and it’s in your brain (Jitendra)*

There is an implication that viewing the ‘brain’ as the focus of his problem enables Jitendra to withdraw personal responsibility from his behaviours and act in accordance to the decisions of his ‘brain’.
Anju also considers brain function to be a component of ‘dimak ko samasya’ or mental health problems. However for her there is a need to emphasise that mental capacity or brain function is not lost through mental health problems. Due to her experience of witnessing mentally unwell people being abused and treated as though they no longer own a brain, she appears to wish strongly that she is not viewed in the same way and subjected to the same kind of abuse:

....but you know even a crazy person still has a brain but because they hear voices and they get angry at themselves but if people were to listen to them.... if you listen to them you will also then maybe understand where they are coming from,

Some participants related mental health to a fear of madness or an acceptance that they were “crazy” for a period of time. For example, Anju admits that she had become “crazy” after explaining to me, at length, how “dimak ko samasya” (mental health), to her, essentially means becoming crazy.

I had also become paagal (crazy) some time ago (Anju)

To her, being “crazy” means that a person has lost self-control, is vulnerable to verbal and physical abuse by others and is likely to end up homeless. She seems to have developed these ideas following her observation of people in Nepal labelled by others as “crazy”.

In Nepal I have seen many occasions people throwing stones at them and hitting them, now if someone is crazy they say all sorts of things, but other people who are not crazy don’t realise why the person is saying those things, they don’t even realise what the crazy person is going through... (Anju).

Interestingly for her, her personal experience of becoming “crazy” led her to deconstruct the word and reframe her understanding of it. It is possible that she believes she was saved from the all the bad things that might have happened to her, had she experienced the same problems in Nepal instead of the UK. It is also possible she feels that her journey of recovery
has not only given her insight into a condition that was mysterious to her but also the
opportunity to develop new ideas and attitudes regarding mental health or mental illness.

...being crazy does not mean you have done something wrong, they haven’t actually
done anything wrong, but now I know that it’s because they are hearing things. (Anju)

Shreya also refers to a sense of madness, but for her this is the related to others’ impression of
her.

…People have told me that I am mad Uncle and Aunty have told me I am mad, like
you are totally gone (Shreya)

Interestingly, Shreya is describing the kind of response that Kalpana is afraid she will face if
she discloses information about her depression. For Kalpana, there is an intense and
overpowering fear of madness, largely in terms of how she would be perceived by others. Her
fear of being socially identified as “mentally unstable” is so immense that it deterred her from
seeking help despite wanting it.

I wanted to talk to a therapist or something…but I think people judge you and people
will say you are mentally, you must not be mentally stable if you are going to see a
therapist urm maybe that clouded my judgement (Kalpana)

Gita adopted mostly an observational style as she described the way Nepalese people did not
have many words to describe mental health or appeared not to have an equivalent term for it.
Her suggestion was that it was for this reason that people chose to describe someone who
seemed odd or mentally ill as ‘paagal’ (crazy). For Gita, there are wider social implications of
using the word ‘crazy’. For example, she acknowledges that her previous lack of awareness
of mental health issues was a result of her upbringing in the “Nepalese system”, in turn
recognising the system as problematic and a hindrance to appropriate solutions.

…couple of years ago I had no clue about it because I was more or less brought up in
Nepali systems and Nepalese way of dealing with mental health or nepali perception
of mental health which is there is no term or no equivalent uhh its uhhh its basically
like that someone is crazy or mad or not (Gita)

In the above statement, she also highlights black and white thinking around how someone is
either crazy or they are not. She is suggesting that there is no recognition that people might
have different severity of mental health difficulties or that there is hope for recovery, which
makes the idea of going “crazy” incredibly threatening.

Participants also offered theories about what caused their problems. Some participants
perceived mental health as resulting from an accumulation of excessive and uncontrollable
worrying about stressful life events. For example Anju reflects on how she became ‘crazy’
because she could not stop worrying about her problems and was unable to share it with
others. Thus for her it was an accumulation of worries and the feeling of not being able to
stop that led her to have unusual experiences.

I started worrying about all these things again and again and wanted to cry because
of it, we had all those troubles at home and also we don’t have a lot of money which
was getting me more worried… I started hearing all these things, when people are
always thinking and thinking and worrying and worrying looks like they will start
hearing things themselves, like a crazy person (Anju)

Kalpana also refers to an experience of not being able to stop thinking as key to worsening
her problems. She describes making various attempts to remove the thoughts from her mind
as a way of finding relief from her problems:

…I did like ridiculous stupid things just to take my mind off it (Kalpana)

There is a sense in Kalpana’s description that thinking about problems makes them real so
they must be removed from awareness. This seems to stem from her behaviour with her
family where she feels unable to openly express her grief or concerns. In doing so, she
appears to have developed a tendency to suppress her emotions and distract her mind, causing
her to believe she is coping with her problems. To her, not remembering a problem is the same as not having it.

*I would have acted in front of my parents that I was OK... I think actually acting that I am OK helps me personally* (Kalpana)

Participants like Gita and Anju have a way of describing their difficulties that may be specific to their country of origin. Gita explains that “tension” is a term commonly used by Nepalese people to vaguely describe the experience of stress. She describes how noticing “tension” becomes a way of identifying and communicating the experience of an internal struggle. Gita realises that although tension is commonly used and probably easily understood, it is a non-specific terminology that has potential risk of not being greatly useful in elucidating what the actual problem is. Thus, ‘tension’, if misunderstood and unresolved, can lead to someone going ‘paagal’ or ‘crazy’:

*...had that problem (leading to ‘tension’) been addressed then they might have solutions that is not picked up on that’s why they are left to you know to deal with it themselves and it might worsen and actually make them paagal* (Gita)

*...the longer you keep experiencing tension and thinking about all the bad things that are happening, people start to become crazy* (Anju)

There is an implication that tension or worry is an internal turmoil that can spiral out of control until it is manifested as a behavioural change, mental health or physical health problem. It is at this point that it becomes visible for the outside world to observe, comment on and influence.

*I told the uncle that I was being targeted and I will get killed and the army uncle must have thought I had lost my mind* (Anju)

*...the worry or stress or tension keeps adding up and makes somebody have headaches or fever or not able to sleep, not being able to eat...* (Gita)
Furthermore, there is a sense that ‘tension’ is manageable since it can be hidden, resolved or ignored. On the other hand ‘crazy’, for reasons that it cannot always be hidden, ignored or quietly resolved, is viewed as more problematic and less personally manageable. Once you are known to be crazy then your life is thought to be at the disposal of others. There is a lot of uncertainty and fear about what will happen to you once you are mentally unwell.

Many of the participants mention the role of physical health problems, whether it was a way of recognising that a problem existed or a route to seeking help for their distress. In Shreya’s case, she saw worms in her stool that doctors were not able to explain. Only when causality was impossible to decipher and suspicions about the participant hallucinating was raised, the possibility of mental health problems were considered. In the case of Kalpana, when doctors could not find any medical cause for the cold sores on her face, stress was loosely suggested to be the cause, which Kalpana also readily accepted.

...the (doctor) just said it was a bacterial outburst that your body is showing coz your immune system is really weak coz I was not eating properly and I was really stressed out (Kalpana)

Gita mentions experiencing intense migraines and neck pain following periods of chronic stress or strain, which was difficult to ignore:

_I think it comes to a breaking point when you are actually suffering with a really bad fever and you just crash I get this really bad headaches at the back of my head that could be the result of forcing myself to you know not switch off (Gita)_

It is possible that participants are more receptive to, more willing to discuss and seek urgent help for bodily changes compared with psychological or emotional distress. There is a sense that participants assign responsibility for physical health problems to doctors, whereas in matters of mental or psychological well-being, self-responsibility was assumed.
Recognising and solving problems: focus on self and others

The second major theme is about the process of recognising problems and dealing with it, through self-awareness, self-help, and interaction with others.

All of the participants in the research drew attention to how well they know themselves and their sense of self. This seems to be important in the journey they have gone through with their personal difficulties. For example Jitendra invested a lot of energy, focus and time on repairing himself, thus making him very aware of his own strengths and weaknesses. There is a hint in the way he speaks about the birth of his nephew as a life-transforming event in which he himself had a rebirth and created a renewed self-image:

*My nephew was born and in that phase when I saw a little boy and I was really moved you know I don’t know what happened something came from within that OK enough is enough for things to change I have to change... I wanted to be a good example to my nephew coz throughout my life I have been a bad example* (Jitendra)

Shreya seems to view her inner self as fragile and irreversibly damaged. This is a painful realisation for her, evident in the way it moves her to tears:

*...the emotional damage has already been done.... I cannot recover fully you know when you are a certain way all through your life I felt I can never get better* (Shreya)

Shreya further likens her sense of self-fragility to being “weak”, “sensitive” and lacking “emotional intelligence”. For her these are the personal attributes that keeps making her vulnerable to mental health difficulties. She also sees her encounter with mental health difficulties as evidence of personal failure. However as she begins to reveal how people in
Nepal treated her for becoming unwell, it seems that her sense of personal failure may have been imposed on her by the way others have responded to her:

*that wasn’t even the hardest part it was going back to Nepal afterwards and the reaction of other people, people came in like 20 and 30s to see in Nepal to visit me to see me broke it makes some people feel better when other people are not happy it makes them feel better people were like she went to London when she was a child and now she is back really ill what a disappointment what a failure (Shreya)*

The above passage creates an image of people attending a funeral to mourn the end of Shreya’s life. It is possible that it were these reactions that left her feeling that she was damaged.

Shreya actually makes comparisons, rather indirectly, between the way people in Nepal and those in the UK have responded to her mental health difficulties. She acknowledges that in the UK having depression can cause rejection by others, especially as you withdraw from them:

*When you are sad a lot you just don’t want to hang out with people so they kind of moved away from me (Shreya)*

In Nepal however depression draws social attention, albeit negative social attention:

*...people came in like 20 and 30s to see me in Nepal to visit me (Shreya)*

There is a sense that she despises both of these culturally-driven responses, feeling victimised and stigmatised in both, albeit in rather different ways. In Nepal she was made to feel damaged and in the UK she was made to feel unwanted. Feeling tormented by both cultures makes Shreya question where she belongs, leading her to position herself away from both cultures and find comfort in locating herself in a different category altogether, a category that is devoid of cultural identity.
I don’t fit in that (Nepalese) culture, I don’t feel I do, I don’t feel I totally fit in the West either so then now I feel like I fit in with the poets and the artists and the manic depressives likes Robin Williams... (Shreya)

Kalpana and Gita, on the other hand, appear to have a more positive self-image, which becomes a basis of how well they recognise difficulties within themselves and also how they decide to respond to their difficulties. Kalpana refers to a rule she has adopted to preserve a positive sense of self:

I never cry and ask for help to someone else if I can do it on my own or if I am going through something (Kalpana)

This rule is important because it affects her ability to recognise the impact of her depression. She is driven by rules that she should be mentally strong and deal with emotional problems on her own.

Gita also appears to have a need to be self-reliant, which has an impact on how she copes with stress and emotional difficulties. She harbours a self-expectation that she should deal with her problems on her own and not seek support from others. It is possible that her migraines are an outcome of this pattern of responding to stress.

I think I have always dealt with my own worries and problems, always kind of doing it myself and not speaking to people about it (Gita)

Jitendra also displays a need to solve his own problems. He speaks about finding the drug and alcohol services that were available to him as ineffective and useless, leading him to treat his own drug addiction. Moreover he appeared to feel a great sense of personal responsibility towards redeveloping himself.

...the thing is the services are there, everybody knows about it right, but they just don’t use it, only once they are caught by police and then as soon as they have stopped using it and leave the service they go back into drugs again (Jitendra)
“Now I have understood that nothing is easy in life, if it is worth having, you gotta fight for it, no body is going to give it to you” (Jitendra)

Part of being self-reliable seems to involve keeping problems hidden from others. It is possible that these tendencies are a reflection of participants’ cultural beliefs. For example, Kalpana explained that she hid her depression from others in order to shield herself from judgement; she clearly feels that judgement and stigma associated with mental health is a common occurrence within the community and therefore it is natural for her to want to prevent it.

“its just our the way our society is I think like our Nepalese society we have this preconception in our head that getting help just means that you are mentally unstable, that’s why you are getting help” (Kalpana)

Anju assigns her inability to share her grief with others as something belonging to the Nepalese way of things:

Nepali people tend to do that a lot, they don’t tend to tell other people if they are having problems, I mean its awkward to tell, isn’t it? (Anju)

She further describes feeling worried about not being understood, about being subjected to gossip or even mistreated for sharing her vulnerabilities. Thus secrecy about your mental health becomes a strategy to preserve a positive public image and self-identity:

“I get worried about whether others will understand my feelings or not, if they understand fair enough but if they don’t then it just makes things worse, what if they say harsh things to you or they laugh at you? Some people would make fun of you and gossip about you uhh so really what’s the point of telling people your problems” (Anju)

Gita describes her experience of the “judgemental” and “nosey” members of the community influencing her decisions around what she says to whom, where most often she feels she has to lie in order to protect herself and her family from judgement and abuse by others:
I can feel they are thinking about my parents already they are being judgemental like oh having moved out what effect have you had on your parents (Gita)

Closeness and escapism: Focus on family and the community

This theme refers to the conflict and resulting distress that participants experience between the values taught by their parents, related to their ethnic tradition, and those that they have adopted from the majority culture. The conflict in turn appears to contribute to participants’ struggle with mental health. For some it causes them distress while for others it becomes a source of help or motivation towards overcoming their mental health problems.

Shreya described a desire to break free from family ties but being debilitated with a great sense of guilt. She blamed the Nepalese culture for fuelling the feelings of guilt within her:

'It is not socially accepted to dislike your family coz nepali people remind you that your mum has done this for you and that for you so you feel more guilt on top of what you already have…' (Shreya)

Part of the struggle experienced by participants in trying to balance the two cultures comes from their feelings of obligation towards their family. They describe the “sacrifice” their parents have made for them, as if they are somehow indebted to them.

..then the thought of my family came along in my head and I am thinking my parents are there I have to make them proud urm they have done so much for me and I have to have this exam and go back home to my parents and make them proud so as soon as the thought of my parents came I think that’s what helped me a lot I knew what I needed to do (Kalpana)

The implication here is that Kalpana considers it her duty to repay her parents for their sacrifice, in this case through academic achievement. She considers that the ‘depression’ is preventing her from fulfilling her duties, which then drives her to overcome the depression.
Jitendra, on the other hand, seems less affected by parental wishes and pressures to stop taking drugs, though he blames his on the effect of the drugs. Unlike Kalpana, he seems less certain that the motivation to fight against the addiction came from his family.

."But I think I had enough of that life, that’s the main part not having my parents happy was the other part but obviously you don’t care when you are doing drugs. I am not even 100% sure what came from within, but like when my nephew was born that is the time I really got into quitting (Jitendra)

It seems that parents are also the main decision makers in the family which means that decisions relating to mental health are also made by parents, regardless of their children’s age. This has the potential of creating further conflict between participants’ need for self-control and their sense of obligation towards parental choices. Shreya mentions being taken to a mental health hospital in India for treatment without any opportunity to protest or decline the decision. Instead, she quietly harboured feelings of resentment at the fact that decisions were made on her behalf, while at the same time feeling sad at her inability to go against her parents.

"I don’t want to go to Nepal coz when I had one of my bad periods one of my (depressive) bouts I was sent there to India actually for treatment…oh my god if I survived that I can survive anything (Shreya).

Participants further reflect on the pressures of navigating two cultures or belief systems that largely contradict one another. On the one side is the British culture that promotes independence and individualism, and on the other hand is the Nepalese culture which expects dependency and submission to parental choices on education and marriage. In attempts to manage the intercultural conflict, participants appear to conduct their exploration of the mainstream culture in secret. This behaviour seems to be driven by a fear that their parents
would not understand their choices, that it would upset their parents or that they might get punished for deviating away from their traditional values

…I would go out to like rock concerts.. but say its someone’s birthday and I would not tell them the truth and it really hurt me coz I was lying all the time just to be able to socialise (Shreya)

It seems that parents emphasise the importance of maintaining traditional values outside of Nepal. Children are expected to participate in the entire family’s attempt to preserve the belief systems of their home country. When participants wish to behave outside of parental expectations, they are overpowered with fear and guilt, which seemingly contribute to their struggle with mental health problems. For example, Gita describes feeling extremely worried about telling her family of her decision to move out, crippled by the awareness that this was not permitted and could bring shame to her family, causing her immense stress.

I had already had the idea of moving out but then it was difficult for me to you know how do I bring up the topic with what do I say or even to convince them (parents) yea what reasons could I give them to make them convinced and even if they would say yes at the same time they would be concerned about what other people would think what the society would think because we live in such a tightly knit community where everyone knows everyone coz of the army connections (Gita)

She highlights how when she eventually moves out, she is accused of committing the shameful act of escaping family commitment and responsibility:

...you could have saved that money and helped your parents kind of thing... they think that ‘she is trying to run away from family ties and responsibilities (Gita)

It seems that remaining tied to the family and community has important consequences when it comes to managing problems. Family members appear to assume responsibility for sorting out each other’s problems. In Nepal there are extended families that share the responsibility
between each other for the family’s well-being. Living in the UK, many of these families are deprived of that extension and so the smaller family unit now have to look after themselves and each other. We see this in Anju’s case, who described the difficulty her mother faced in not knowing what was “wrong” with her daughter and how to help her:

….we are in a foreign country, an unfamiliar country, she doesn’t know who to ask where to go for help, she used to say who can I ask what is wrong with my daughter

(Anju)

Living in an area that is densely populated with Nepalese people meant that her mother was able to locate a spiritual priest to help “remove the bad omens”, a form of treatment routinely practised in Nepal and thought to be the most effective in getting rid of mental health problems.

….so she asked (my dad) about where she can find those people who deal with spirits and bad omens so my mum went to see him in [name of place] … so my mum went there and had my horoscope checked up (Anju)

Since families have such an important role in finding solutions to problems, it becomes apparent why participants are conflicted by their need to separate from their family and their need to stay close. When parents cannot help, a trusted person from the Nepalese community, a potential extension to the family, could be of help instead. This was the case for Anju who decided to seek help from someone in the community after witnessing violence at home.

…..I got really scared so I went upstairs to my room and there is a balcony outside my room I went there and called this Nepali didi (sister) who had helped me before, she called the police and the police came, another nepali didi came with the police (Anju)

A community of Nepalese people could play the part of being a large, extended family, in terms of the sharing and solving of mental health problems, including signposting to the
relevant service. However this poses a dilemma because help may be offered by community members, but at the expense of potential gossip, disapproval and stigma.

...they talk about one another it’s very negative I find they don’t help so who gives a shit about the community, they don’t help you anyway (Shreya)

Discussion

This qualitative study is one of the first to explore how young Nepalese people living in the UK perceive ‘mental health’ related issues based on their experience. The study showed some variation of perceptions, but most participants associated mental health with madness (or specifically, becoming crazy). This finding fits with the behaviours and perceptions observed amongst Nepalese people living in Nepal (Regmi et al, 2007), presenting a situation where perceptions have migrated alongside people. The finding also correlates with research relating to other ethnic minority groups of the UK. For example, Bradby et al (2007) studied the attitudes amongst South Asian families whose child was being treated by a child and adolescent mental health service and found that mental illness was associated with a fear of gossip about madness, which in turn served as a deterrent for help-seeking beyond close family members.

Some participants in this study seemed to be conditioned to a fear of stigma, gossip and spoiled identity, which are commonly associated with mental illness by ethnic minority groups (Bradby et al., 2007, Time to change report, 2010). Such fears of negative judgement, ridicule and gossip by others resulted in participants suffering in silence, becoming self-reliant and/or ignoring the problem. This could be a culture-based outcome, since culture is said to influence the extent to which an inner and outer self is developed out of relationships with others and the social institution (Markus & Kitayama, 1991). One particular female participant however had a rather non-traditional and predominantly medicalised perception of mental health, linking her symptoms of depression to an illness and brain dysfunction. This
participant has also lived in the UK the longest, so this could be seen as a rather westernized perception. However other qualitative studies have shown that South Asian women of the UK tend to assign their feelings of depression to having an ‘illness’ (Fenton & Sadiq-Sangster, 1996; Burr & Chapman, 2004), so it is more likely to be an expression of depressive symptoms amongst people originally from South Asia. Future studies could also explore the way Nepalese people express specific mental health difficulties in order to find culture-specific commonalities in the way the difficulty is manifested, which could in turn be used to adapt assessments and interventions for specific mental health problems.

How stress and/or psychological distress were expressed emerged as a significant issue in the study. Specifically, when emotions were denied, suppressed and unacknowledged, they evidently transformed into physically noticeable problems, which were met with immediate attention, help-seeking behaviours and/or access to treatment. One way of conceptualizing the observed phenomena may be to think of it as a tendency amongst the Nepalese participants to somatise or physically express their psychological distress. It appears that there may be a higher prevalence of somatisation in Asian countries, compared with Western countries (Farooq et al., 1995). Previous studies have shown that women from South Asian communities of the UK, including Nepalese women, tend to somatise their emotional distress (Casey, 2010; Hussein, Creed & Tomenson, 1997). Another study found that South Asian women felt that having physical symptoms made a visit to the GP more appropriate (Burr & Chapman, 2004). Some of the participants in this study reported fears of rejection and stigma from other people, causing them to deny or suppress emotional reactions to stressful events and avoid openly communicating their distress. As a result, they were more likely to express psychological distress in a somatic form and likely to seek medical help when they believed that their problems had a physical cause and effect. It is possible that by expressing their grief somatically, participants were minimizing or preventing negative social responses, i.e. the
accusation that they are crazy, mentally unstable, or lazy. On the other hand, somatic expression of distress can be more positively received by others, i.e. through empathy and the offer of help (Hwang, Myers, Abe-Kim & Ting, 2008).

The dilemma of navigating between two cultures seems to be prevalent in the case of the first-generation Nepalese individuals who participated in this study, which might be a characteristic of having a bicultural identity or a sign of bicultarism. Bicultarism refers to the identification or internalisation by one person of two cultures – the ethnic culture and the mainstream or majority culture (Umana-Taylor, Yazedjian & Bámaca-Gómez, 2004). Previous investigations into this construct have revealed that bicultarism is often talked about in both positive and negative terms: positive since it evokes feelings of pride and uniqueness, and negative since it creates identity confusion and value clashes (Phinney & Devich-Navarro, 1997; O’Hearn, 1998; Benet-Martinez & Haritos, 2005). In line with this, most participants in this study drew attention to the difficulties around navigating between two, often contradictory, cultural orientations. However, one participant seemed more orientated towards her original culture, and instead of struggling with the identification process, found it difficult to operate in the new culture. Thus, merely existing in the middle of two cultures does not make individuals identify with both. The definition of bicultarism suggests that bicultured individuals are more or less comfortable and skilled in both cultures, which may not be the case for all individuals. The different acculturation categories proposed by Berry (1992, 1997), namely assimilated, integrated, separated and marginalized could be drawn upon to explain these individual differences between participants’ experience of the two cultures.

In the current study we saw that the majority of participants regularly moved or switched between traditional and mainstream value systems and corresponding behaviours. When they were not given permission to follow the mainstream culture, they continued their pursuit in
secret, which became their (guilt-ridden) method of adapting to the two conflicting value systems. Schwatz and Unger (2010) put forward an idea that fits with the above pattern. To them, an individual with a bicultural identity will amalgamate influences, values and practices of their ethnic culture and the majority culture. The outcome is an individual who identifies with both cultures, holds values from both cultures and also behaves in ways that is consistent with both cultures. Most participants in the current study appear to have mixed their Nepalese values of respect and submission to authoritative parents, with western ideas of individualism, personal success, self-determination, emotional independence and wish to solve their own problems. In the case of participants in this study, parents were the most influential factor this process. In support of this finding, a study has found that it is parental or familial ethnic socialization – a process by which parents teach or expose children to the traditions of the family’s ethnic culture – that leads to the retention of ethnic cultural values amongst bicultural children and the emergence of integrated, assimilated or separated acculturation positions in children (Umana-Taylor, Bhanot & Shin, 2006). Thus, parents can actively decide or control how they want their children to acculturate. If parental efforts to socialise children is too intense or if it clashes with the influence of the majority culture, children could experience conflict between the two cultures.

There are various points to be learnt from this study and that can be of use to mental health professionals working with young adults from the Nepalese community. For example, a reason that was attributed to causing mental health problems was an accumulation of worry, which resembles the stress-vulnerability model (Zubin & Spring, 1977) routinely used to explain mental health disorders such as psychosis and bipolar disorder. It emerged that the word ‘tension’ is commonly used by Nepalese people to describe mental distress or emotional discomfort, which increases their vulnerability to mental health problems. Some Nepalese
people might refer to mental health problems as “dimak ko samasya”. Knowledge of these words may serve as a useful communication tool.

Additionally, professionals might benefit from being sensitive to the possibility that young Nepalese people may have developed a bicultural identity, which means they could be influenced on the one hand by a fear of madness inherent in the culture they share with their parents, and on the other hand may have been socialized into more western concepts of mental health problems. Services need to be mindful that though the young person might adapt well to the view point they are offering, it may be in conflict with their family beliefs around mental health and mental health treatment, which could create further stress for the individual. Services should also be careful to not think that an ethnic-matched mental health provider would be preferred by all Nepalese people, since this may vary from one individual to another. As we have seen in the current study, not all Nepalese people value help from other Nepalese people. Additionally, since younger Nepalese people are more likely to want to help themselves through difficulties, they could benefit from having access to educational leaflets and resources (e.g. on self-help programs); future research would need to explore where these resources would be most-suitably placed.

One of the limitations of the study was in its exclusion of young Nepalese people who have come across the mental health services in the UK and as a result have received a mental health diagnosis and/or treatment via mental health services. This might have enriched the nature of the data collected and offered a more varied view of the perceptions Nepalese people have to offer when talking about mental health. However, this could be a direction for further investigation.

On the other hand, strength of the study lies in the fact that the researcher was also Nepalese which meant that participants were free to speak in Nepalese during the interview to explain
concepts in their language. This meant that descriptions and interpretations that were culture-specific were more easily picked up by the researcher, by virtue of sharing cultural background with participants. However, the study is an original study from the perspective of the Nepalese people interviewed and ideas from the researcher have not been imposed on the research.

**Conclusion**

This study has illustrated that Nepalese young adults living in the UK have differing subjective perspectives on mental health, driven by the way that they have conceptualised their experience with psychological distress or mental health problems, the way they recognise and deal with their symptoms on their own and/or within the family, and their experience of living in and outside of Nepal as well as navigating through the complexities of dual cultures. The study does not allow for generalisations to be made, however much of the insights gained through participants’ stories can be taken into consideration by mental health professionals who currently work with Nepalese individuals or would like to gain a better understanding of the way mental health is perceived by different ethnic groups and how that relates to the way they cope with their problems.
References

  United Kingdom, UK: Centre for Nepal Studies


List of MRP Empirical paper appendices

Appendix A: Authors Guide for Journal of Mental Health.................................47
Appendix B: Inclusion criteria.................................................................53
Appendix C: Interview schedule ..............................................................54
Appendix D: Reflection ...........................................................................55
Appendix E: Ethical Approval.................................................................58
Appendix F: Credibility..........................................................................60
Appendix G: Coded Extract....................................................................61
Appendix H: Information to referrers.......................................................71
Appendix I: Participant information sheet ...............................................75
Appendix J: Consent form.......................................................................82
Appendix A: Authors guidelines for the *Journal of Mental Health*

Journal of Mental Health

Instructions for Authors

Aims and Scope

The Journal of Mental Health is an international forum for the latest research in the mental health field. Reaching over 65 countries, the journal reports on the best in evidence-based practice around the world and provides a channel of communication between the many disciplines involved in mental health research and practice.

The journal encourages multi-disciplinary research and welcomes contributions that have involved the users of mental health services.

The international editorial team are committed to seeking out excellent work from a range of sources and theoretical perspectives. The journal not only reflects current good practice but also aims to influence policy by reporting on innovations that challenge traditional ways of working. We are committed to publishing high-quality, thought-provoking work that will have a direct impact on service provision and clinical practice.

The *Journal of Mental Health* features original research papers on important developments in the treatment and care in the field of mental health. Theoretical papers,
reviews and commentaries are also accepted if they contribute substantially to current knowledge.

**Submissions**

All submissions, including book reviews, should be made online at Journal of Mental Health's Manuscript Central site at [http://mc.manuscriptcentral.com/cjmh](http://mc.manuscriptcentral.com/cjmh)

New users should first create an account. Once a user is logged onto the site submissions should be made via the Author Centre. Please note that submissions missing reviewer suggestions are likely to be un-submitted and authors asked to add this information before resubmitting. Authors will be asked to add this information in section 4 of the on-line submission process.

Manuscripts will be dealt with by the Executive Editor. It is essential that authors pay attention to the guidelines to avoid unnecessary delays in the evaluation process.

The names of authors should not be displayed on figures, tables or footnotes to facilitate blind reviewing.

**Word Count**

The total word count for review articles should be no more than 6000 words. Original articles should be no more than a total of 4000 words. We do not include the abstract, tables and references in this word count. However manuscripts are limited to a maximum of 4 tables and 2 figures.

**Book Reviews**

All books for reviewing should be sent directly to Martin Guha, Book Reviews Editor, Information
Manuscript Style

Manuscripts should be typed double-spaced (including references), with margins of at least 2.5cm (1 inch). The cover page (uploaded separately from the main manuscript) should show the full title of the paper, a short title not exceeding 45 characters (to be used as a running title at the head of each page), the full names, the exact word length of the paper and affiliations of authors and the address where the work was carried out. The corresponding author should be identified, giving full postal address, telephone, fax number and email address if available. To expedite blind reviewing, no other pages in the manuscript should identify the authors. All pages should be numbered.

Abstracts: The first page of the main manuscript should also show the title, together with a structured abstract of no more than 200 words, using the following headings: Background, Aims, Method, Results, Conclusions, Declaration of interest. The declaration of interest should acknowledge all financial support and any financial relationship that may pose a conflict of interest. Acknowledgement of individuals should be confined to those who contributed to the article’s intellectual or technical content.

Keywords: Authors will be asked to submit key words with their article, one taken from the pick-list provided to specify subject of study, and at least one other of their own choice.

Text: Follow this order when typing manuscripts: Title, Authors, Affiliations, Abstract, Keywords, Main text, Appendix, References, Figures, Tables. Footnotes should be avoided where possible. The total word count for review articles should be no more than.
6000 words. Original articles should be no more than a total of 4000 words. We do not include the abstract, tables and references in this word count. Language should be in the style of the APA (see Publication Manual of the American Psychological Association, Fifth Edition, 2001).

**Style and References:** Manuscripts should be carefully prepared using the aforementioned Publication Manual of the American Psychological Association, and all references listed must be mentioned in the text. Within the text references should be indicated by the author’s name and year of publication in parentheses, e.g. (Hodgson, 1992) or (Grey & Mathews 2000), or if there are more than two authors (Wykes et al., 1997). Where several references are quoted consecutively, or within a single year, the order should be alphabetical within the text, e.g. (Craig, 1999; Mawson, 1992; Parry & Watts, 1989; Rachman, 1998). If more than one paper from the same author(s) a year are listed, the date should be followed by (a), (b), etc., e.g. (Marks, 1991a).

The reference list should begin on a separate page, in alphabetical order by author (showing the names of all authors), in the following standard forms, capitalisation and punctuation:

a) For journal articles (titles of journals should not be abbreviated):


b) For books:


c) For chapters within multi-authored books:
G.Parry & F. Watts (Eds.), A Handbook of Skills and Methods in Mental Health
Research (pp. 75–89). London: Lawrence Erlbaum.

Illustrations: should not be inserted in the text. All photographs, graphs and diagrams should be referred to as 'Figures' and should be numbered consecutively in the text in Arabic numerals (e.g. Figure 3). The appropriate position of each illustration should be indicated in the text. A list of captions for the figures should be submitted on a separate page, or caption should be entered where prompted on submission, and should make interpretation possible without reference to the text. Captions should include keys to symbols. It would help ensure greater accuracy in the reproduction of figures if the values used to generate them were supplied.

Tables: should be typed on separate pages and their approximate position in the text should be indicated. Units should appear in parentheses in the column heading but not in the body of the table. Words and numerals should be repeated on successive lines; 'ditto' or 'do' should not be used.

Proofs
Page proofs are sent to the designated corresponding author. They must be carefully checked and returned within 48 hours of receipt. Please note that in the proof stage, only typographical errors, printer's errors and errors of scientific fact can be corrected. No substantial author's changes will be made.

Copyright
It is a condition of publication that authors transfer copyright of their articles, including abstracts, to Shadowfax Publishing and Informa Healthcare. Transfer of copyright enables the publishers to ensure full copyright protection and to disseminate the article and journal to the widest possible readership in print and electronic forms.
Appendix B

Inclusion criteria

- Participants must currently be residing in the UK and their country of origin must be in Nepal
- Participants must be aged 18 or over (and be no more than 29 years old)
- Participants must be able to communicate in English (researcher willing to make exceptions if this is difficult to meet)
- Participants must have some personal experience of emotional distress or mental health difficulties (either currently or in the past)
- Participants must be willing to be interviewed and the interview to be audio-recorded
Appendix C

Interview schedule

Would you mind telling me how come you are living in the UK?

What is it like living in the UK?

There is no right or wrong answer to the next question. What does ‘mental health’ mean to you?

You mentioned that you were struggling with your health/mental health/stress/a problem. Would you mind telling me more about this?

Prompts: What did you do about it? How was that?

What do you know about services you have at your disposal for attending to health/mental health?

Do you know about similar services back in Nepal? How were they?
Appendix D: Reflection

This was a research topic that was important to me. It was also extremely challenging to conduct. Firstly, I was overcome with fear of not picking up the truth, or of tainting it in some way, by being too closely attached to it. I worried that my similarities with the participant group (in terms of my age and position as a first generation Nepalese migrant) would give rise to certain assumptions that would hinder the focus of the interview and the interpretations made. At the same I was doing this particular research for reasons that I was a Nepalese woman with some insight into mental health issues (as a trainee) and the opportunity to conduct – with support – an original piece of research. I immediately recognised that I was potentially in a privileged position to be the voice of people in my community as well as help practitioner colleagues to form a better understanding of the perceptions and actions of an ethnic minority group. Unfortunately, I believe the sense of responsibility became overwhelming at times.

What I perhaps did not sufficiently anticipate were the problems I would face in recruiting. I naively believed that other Nepalese people would surely be willing to talk to me, also a Nepalese. What became clear to me when I started the recruitment process was that I posed a great threat to potential participants who did not know me personally and therefore could not be sure about my intentions. The gate-keepers who were helping me find participants would come back saying that the person is worried about what I will do with their story. People apparently feared that as a Nepalese I would broadcast their ‘secret’ or ridicule them in some way. People were especially suspicious of the fact that the interview would be recorded. Another problem was that a lot of the younger men I contacted were hesitant about sitting for an interview. Despite my attempts to reassure them about the process, they seemed to find the idea too threatening. I wonder whether my position as a female researcher contributed to their discomfort. All the young men who were referred to me had previous problems with
drug and/or alcohol addiction. I found it extremely difficult to recruit this particular group who disengaged at various points in the recruitment process. Some disengaged when I told them that they would be interviewed and the interview was going to be recorded (unfortunately they were not always made aware of this process by the referrer). Some relapsed prior to our meeting so were unable to be interviewed. Some others changed their minds and disengaged for reasons that were unknown to me, which was often frustrating. I knew from my own experience and observation, that Nepalese people can be extremely curious about other Nepalese people. In my case, this meant that people would be interested about my profession and position as a researcher to the point where, I became threatening and untrustworthy. My profession was unfamiliar to many people. Many of them assumed that I was a trainee psychiatrist which again seemed to be a troubling possibility for them. Unfortunately by not being able to interview these participants, I have been unable to explore this further and therefore may have missed out on an important insight.

In my attempt to reach out to hard to reach individuals and study reasons that people did not seek external support, I decided against recruiting via NHS-based mental health services. On retrospect I feel that my study has been limited by that decision. Firstly, I feel that in the safety of the NHS I might have been able to find more willing participants. I might also have been able to explore the journey people took from recognising that something was wrong to ending up in the care of a service, as well as make enquiries about their experience of treatment. I consider this to be possible avenue for future research.

As trainee clinical psychologist used to conducting psychological assessments, I had to work hard to ensure I was not adopting a therapeutic style of interviewing, especially since participants were talking about their experience of psychological distress. I ensured this was not the case using the following procedures: getting feedback from peers after an interview practice session, reading about interview skills in relevant qualitative books, through (in-
action) reflection during the interview, listening back to tapes after each interview in order to learn from them, and finally through advice and feedback from my supervisor. It was difficult to completely leave behind my therapeutic influences since after almost 3 years of clinical psychology training I have been tremendously attuned to asking questions in a certain way, e.g. using socratic style questioning. Thus, this might have impacted what participants told me. Furthermore, some of the participants, especially those who were previously known to me, were aware of my therapeutic role alongside my role as a researcher. It is possible that this impacted what they chose to tell me in the interview.

I wonder whether despite my efforts not to impose any of my personal views, assumptions and previous knowledge about the Nepalese culture on the participants, I would not have been able to stop them from viewing me as another Nepalese person with a set of shared beliefs. With the assumptions that I already know, perhaps participants sometimes did not explain certain culture-specific behaviours and attitudes to me. As and when I picked this up during the interview I prompted participants to further elaborate, though I imagine I was not able to do this on every occasion. Therefore, this could possibly have impacted the kind of interpretations I was able to make from the data.
Appendix E: Evidence of ethical approval

Chair’s Action

Proposal Ref: 987-PSY-14

Name of Student/Trainee: BANDANA UPADHYA

Title of Project: How do Nepalese people living in the UK experience help-seeking for mental health difficulties and social issues: a qualitative exploration

Supervisor: Dr Dora Brown

Date of submission: 03 February 2014

Date of confirmation email: 05 March 2014

The above Research Project has been submitted to the FAHS Ethics Committee and has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee with conditions. The conditions stipulated after ethical review have now been addressed and the relevant amended documents submitted as evidence prior to commencement of your study.

The final list of documents reviewed by the Committee is as follows:
Protocol Cover sheet
Summary of the project
Detailed protocol for the project
Participant Information sheet
Consent Form

This documentation should be retained by the student/trainee in case this project is audited by the Faculty Ethics Committee.

Signed: __________________

Professor Bertram Opitz

Chair

Dated:

**Please note:**

*If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.*
Appendix F: An account outlining how credibility was ensured in the study

Credibility of the study was established by following guidelines proposed by Yardley (2000). According to Yardley (2000), there are four characteristics to good quality qualitative research: sensitivity to context, commitment and rigour, transparency and coherence, and impact and importance. Sensitivity to context was achieved by conducting a literature review to build awareness of existing literature on the topic being researched. This included drawing findings from the study to existing studies and theories in the discussion, and by using purposive sampling to recruit participants with special attributes relevant to the phenomenon being studied. Commitment and rigour were ensured through development of interview skills, prolonged and thorough engagement with the topic being studied, interview material (both audio and transcribed data) and during data analysis. Transparency and coherence were ensured through a detailed outline of the data collection and analysis process, by checking credibility of themes between researcher and their supervisor as well as using peer supervision, and lastly through reflections on the potential impact of the researcher’s characteristics and intentions on the interviewees’ responses and the interpretations made (in a separate reflection section, Appendix E). Impact and importance were ensured by the contribution of the research findings to current literature, the Nepalese community and health professionals as well as service providers working with the Nepalese community.
### Appendix G: Coded extract demonstrating the master theme and each of the main themes

<table>
<thead>
<tr>
<th>Master theme</th>
<th>Main themes/Superordinate themes</th>
<th>Cluster of themes from participants (with corresponding theme titles)</th>
<th>Supporting quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Viewing mental health differently</td>
<td>1. Understanding mental health</td>
<td>(An illness of the brain)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crashed brain, Depression equals damaged brain,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Becomes a problem once it’s in your brain,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Depression is like stroke, loss of brain function,</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>contaminated brain)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Shreya: my brain chemical was all fuzzy…..</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Shreya: my brain was hurting.. it was physically hurting</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Anju: but you know even a crazy person still has a brain but because they hear voices and they get angry at themselves</td>
</tr>
</tbody>
</table>
Jitendra: and it was hard because obviously quitting 
drugs is one of the most difficult things that anyone can 
face it’s in your blood and in its in your brain 

(Going crazy)
Sense of self as crazy, fear of crazy, perceived as mad, 
fear of being perceived as crazy, mental health is when 
you are crazy, crazy person, focussing on bad thoughts 
makes you crazy

Shreya: people have told me that I am mad uncle and 
auntys have told me I am mad like you are totally gone

Anju: I had also become crazy some time ago
Anju: even my brothers used to cry because they 
thought I had become a crazy person

Kalpana: as soon as you say mental health they would 
think Oh that person is crazy or this guy is crazy

(Build-up of worry)

Excessive worrying, build-up of worry, building up 
to an explosion, tension, worrying makes you crazy

Anju: when people are always thinking and thinking 
and worrying and worrying looks like they will start 
hearing things themselves, like a crazy person
Gita: I think that kind of gave me lots of urm I don’t know worry coz like I was worrying about so many things I was worrying about my parents what if my aunt or family friends ask about me I don’t know what they will say or how would they feel

(Somatisation)
somatisation of worry, worms in stool, infection,
physical manifestation of pain, emotional suppression, sleep it off, wish to stop feeling

Shreya: I still kept seeing these worms like really thick and then when I went to my dad took me to this hygiene medical place and urm we did thorough tests like blood tests liver tests tests just tests sample of the stool everything and then it came out negative so the professional doctor classed it as urm depression

Kalpana: yea 2,3 months I struggled a lot I did go to the doctors I had to go to A&E urm coz I had cold sores all over my face

Gita: I think it comes to a breaking point when you are actually suffering with a really bad fever…. 
<table>
<thead>
<tr>
<th>2. Recognising and solving problems: focus on self and others</th>
<th>(Focus on self)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fragile sense of self, Damaged self, sense of self as different, sense of self as inadequate, renewed self-perception, self-reliant, rules for self-preservation, protecting self, re-birth of self, attempts to bring back lost self, self-aware</td>
<td></td>
</tr>
<tr>
<td>Shreya: I have always been very sensitive uhh I am a sensitive person</td>
<td></td>
</tr>
<tr>
<td>Shreya: I cannot recover fully you know when you are a certain way all through your life I felt I can never get better</td>
<td></td>
</tr>
<tr>
<td>Gita: : I think uhh again its to do with your own individual character plus your mind set and what you are like uhh because I think uhh when I was in Nepal I wanted to kind of find out why things happen and why cant I do things for example like in terms of pocket money we didn’t have to worry your parents kind of gave you money but I wanted to experience like what is it like to work and earn your own money,</td>
<td></td>
</tr>
<tr>
<td>Jitendra: I don’t know what happened something came from within that OK enough is enough for things to</td>
<td></td>
</tr>
</tbody>
</table>
change I have to change… I wanted to be a good example to my nephew

Kalpana: I didn’t want anyone to know what was going on I didn’t want any strangers to know or judge me or know what was going on so I sort of thought I can deal with it myself I am just taking my time

Kalpana: I never cry and ask for help to someone else if I can do it on my own or if I am going through something

(Focus on others)

Sense of not belonging, desire for acceptance, social rejection, group identity, critical others

Shreya: they were telling me it was my fault for being weak
Shreya: When you are sad a lot you just don’t want to hang out with people so they kind of moved away from me

Anju: I get worried about whether others will understand my feelings or not, if they understand fair enough but if they don’t then it just makes things
worse, what if they say harsh things to you or they laugh at you? Some people would make fun of you and gossip about you uhh so really what's the point of telling people your problems.

Gita: I can feel they are thinking about my parents already they are being judgemental like oh having moved out what effect have you had on your parents?

Kalpana: I don’t know its just the way our society is I think like our Nepalese society we have this preconception in our head that getting help just means that to get help means that you are mentally unstable that’s why you are getting help I think that’s the way we think we don’t think about what it can do to you or help you we would rather think what other people would think about it if they knew that you were going to a therapist so urm I don’t know now when I was growing up in Nepal it wasn’t common I don’t think I knew anyone who went to a therapist and no one would suggest to you as well…

3. Closeness and Escapism: (Conflicting need to protect and to separate from parents) Parents as the decision makers, Pressure from family, Resentment at family, Damaged
relationship, family as the trigger, hiding from parents

Sense of loyalty towards parents, Protecting parents from pain, Obligation towards family, Indebted to parental sacrifice

Kalpana: ….then the thought of my family came along in my head and I am thinking my parents are there I have to make them proud urm they have done so much for me and I have to have this exam and go back home to my parents and make them proud so as soon as the thought of my parents came I think that’s what helped me a lot I knew what I needed to do

Shreya: It is not socially accepted to dislike your family coz nepali people remind you that your mum has done this for you and that for you so you feel more guilt on top of what you already have…

Anju: once I believed the voice and got angry at my mum and dad because they would not believe me when I told them what I had heard, they asked me if I was going mad or what, when my parents did not believe what I was telling them I did not want to live anymore
Gita: In our culture it's very family orientated, you know living together it's not really encouraged to move out even though you are capable to do so or even if you want to at the same time there is huge respect for your parents as well and you don't want to go against your parents you know that kind of thing and there are also other social aspects as well as it's not seen as a really good thing.

Jitendra: my parents were not very happy with it they knew I was up to something but they didn't know I was so down into it I was already deep inside they were just really frustrated coz I was really skin and bones before hehe coz obviously the effect was there.

Shreya: if the mother if the family have had their issues resolved if they urm if the child within them if they are urm aware if they are aware of their own issues and they are well rounded people even in Nepalese families you raise healthy children there is the emotional support whatever but if you are trying to live through your children if you are frustrated with your life and you want to see yourself through your children that’s unconditional love that’s not healthy.
(Helpful community vs Unhelpful community)
Nosey community, helpful community, untrustworthy community

Anju: I got really scared so I went upstairs to my room and there is a balcony outside my room I went there and called this Nepali didi (sister) who had helped me before, she called the police and the police came, another nepali didi came with the police

Kalpana: I am quite open about it with people although it depends who you talk to especially about drugs you know they might its not you don’t want people to talk about it I think it depends who you talk to so I don’t want obviously it’s a small community isn’t it? If someone says something to someone else it goes around and I don’t want end of the day I don’t care what people say I don’t want it to go to my parents I don’t want my parents to know about it

Gita: I had already had the idea of moving out but then it was difficult for me to you know how do I bring up the topic with what do I say or even to convince them (parents) yea what reasons could I give them to make them convinced and even if they would say yes at the
same time they would be concerned about what other people would think what the society would think because we live in such a tightly knit community where everyone knows everyone coz of the army connections

Shreya: community but if you think about it these are the community people yea all around here and they always worry about what other people think but like how are you going to progress coz everyone else is worried about what everyone else is going to think ….they talk about one another it’s very negative I find they don’t help so who gives a shit about the community, they don’t help you anyway
Appendix H: Information to referrers

Exploring how Nepalese people understand mental health and seek help for their problems.

Information for referring agents

Background information

My name is Bandana Upadhya and I am a Trainee Clinical Psychologist doing a Doctorate in Clinical Psychology at the University of Surrey. This is a three year post-graduate degree and I am currently in my second year. As part of the PsychD Clinical Psychology course, I also work part time in mental health services in the NHS, which involves conducting psychological assessments and interventions to service users, under the supervision of a qualified Clinical Psychologist.

A requirement of the Doctorate in Clinical Psychology is to conduct a major research project in a topic that is original and makes a significant contribution to the field. My particular research interest however had taken course even before I began my clinical training. It started when I was volunteering in a service set up to help people with addictions of drugs and alcohol, in Aldershot (Hampshire). During this time, I made a saddening and note-worthy discovery. That young people belonging to the Nepalese community in the Aldershot area sought the service merely to exchange needles and appeared reluctant and even aversive to receiving support (e.g. counselling) for their addiction problems. The service manager was motivated to reach out to these young people and to help them in their challenging endeavour decided to recruit me, also a young Nepalese living in the UK. However, my attempt at initiating conversation and offering support were immediately rejected.

What troubled me even further was the realisation that there were clearly a selection of individuals nominated to carry out the task of taking back fresh set of needles for a hidden
group, thus indicating that the problem remained relatively ‘underground’ and therefore inaccessible.

This observation made me curious and greatly concerned about the attitudes potentially driving the absence of help-seeking amongst a population of Nepalese youths living in the UK? It made me wonder whether the answers could be found by delving into what seeking help means in the Nepalese culture at large, but also what it means if you belong to a minority group and to a migrant population. Moreover, it made me question whether or not the services currently available were in line with their needs, or whether these needs were understood in the first place. Subsequently, I began considering how I could find this out. Being positioned at the University of Surrey therefore provided a platform to try and answer these questions (and perhaps more) in the form of a credible research study. Taking an idea and transforming it into a realistic research question meant performing a literature review, which led my attention to various supporting evidence. I found that Nepalese residents of Aldershot were less likely to speak to their GPs about their mental health concerns and were less likely to be aware of local mental health services, compared to the white British living in the same area. My attention was also drawn to health needs assessment report completed on the Nepalese population of Aldershot, which indicated that Nepalese people were likely to somatise mental disorders, and that Nepalese women were likely to identify themselves as depressed but unlikely to report this. Thus there is clearly a difference in the way that Nepalese people understand, communicate and manage mental health related concerns, which need to be investigated further and more comprehensively. Data that emerge from such investigations, including mine, can then helpfully inform how services are organised and managed to suitably meet the needs of the group in question, so that they are not marginalised.
Thus the broad question I wish to ask through my research is how psychological or emotional difficulties are viewed, recognised and dealt with by Nepalese people living in the UK. To do this, I want to ask people about their unique experiences so that together we can try to answer the question I wish to investigate.

**Recruiting suitable participants**

Due to potential stigma associated with mental health disorders and drug addictions within the Nepalese community (based on previous research findings), I would like to recruit participants in a manner that is sensitive and innocuous, for which I need your help. An information sheet has been prepared for the benefit of interested participant, which includes all the relevant details about the study and what participation may involve. They will also have the opportunity to contact me to ask further questions. I am also happy to meet with them prior to interview to discuss further about the study. They may also request to see the interview topics beforehand. Please note that participants will be asked for consent prior to participation and their identity will remain anonymous throughout.

The study has certain inclusion criteria that must be met. These include:

- Participants must currently be residing in the UK and their country of origin must be in Nepal
- Participants must be aged 18 or over (and be no more than 29 years old)
- Participants must be able to communicate in English (researcher willing to make exceptions if this is difficult to meet)
- Participants must have some personal experience of emotional distress or mental health difficulties (either currently or in the past)
- Participants must be willing to be interviewed and the interview to be audio-recorded

**Relevant additional information**

All travel expenses will be reimbursed.
Please raise the study with anybody who you think may be suitable (after considering the inclusion criteria), and also give them one of the study information sheet that I have attached.

**The next step**

If they are interested in participating please contact me using the contact details provided below. I will ask you more questions about the individual to ensure they meet the criteria and also for their contact details. Therefore please make sure they are happy for me to contact them. Alternatively you can give my contact information to them if they wish to contact me directly. We could even arrange a three-way meeting if this would be desirable or more appropriate.

If you have any further question about the study, or comments about recruiting participants, please do not hesitate to contact me.

Finally, I would like to thank you for the taking the time to read this information, and for agreeing to help me with my research. Your help is very much needed and appreciated.

My contact details and those of my research supervisor are given below.

**Research being conducted by:**

Bandana Upadhya  
Trainee Clinical Psychologist  
University of Surrey, Guildford  
Email address: b.upadhya@surrey.ac.uk or bupadhya5@gmail.com  
Phone number: 07415108482

**Research being supervised by:**

Dr Dora Brown  
Lecturer and Researcher  
University of Surrey, Guildford  
Email address: d.brown@surrey.ac.uk
Appendix I: Participant information sheet

Participant Information Sheet

Exploring how Nepalese people understand mental health and seek help for their problems.

My name is Bandana Upadhya and I am a trainee clinical psychologist doing a Doctorate in Clinical Psychology at the University of Surrey. This is a three year post-graduate degree and I am currently in my second year. As part of the PsychD Clinical Psychology course, I also work part time in mental health services in the NHS, which involves conducting psychological assessments and interventions to service users, under the supervision of a qualified Clinical Psychologist.

Prior to this, I have completed a degree in Psychology, and also gained relevant work experience, both of which are a necessary requisite for the doctorate. Some of the work experience included working as an Assistant Psychologist with young people with learning disabilities and autism, working as a healthcare assistant with older adults suffering from Dementia, and as a support worker with people recovering from addiction to drugs and alcohol. I have also previously completed a Master’s degree in Research Methods at the University of Surrey.

My country of origin is Nepal. My family and I migrated to the UK in 1999 after my father, who was serving for the British Army, was posted here. Having lived in the UK for more than 13 years, I consider myself to have integrated well into the British culture whilst maintaining many of my Eastern norms and values.

As part of the doctorate training, I have to carry out a major research project on a topic that is original and will contribute in some ways to the field of clinical psychology and also the wider community. So I have decided to conduct a research study that is close to my heart,
and which I believe is a necessary step towards investigating the psychological needs of a growing and largely unrepresented migrant population.

**What is my study about?**

Research suggests that Nepalese people living in the UK seek help for problems (such as mental health issues like anxiety, depression, etc) in different ways to British people. Research also shows that there are high rates of drug-related problems among young Nepalese people brought up in the UK, but that they don’t seek help for this here, with the result that many young people end up being sent back to Nepal by their families for treatment there. It’s also not clear why treatment for mental health issues and drug-related problems is not sought in the UK by the British Nepalese community. Nor do we know whether Nepalese people living in the UK experience what British people would call ‘mental health problems’ differently, why help for these kinds of problems is not asked for, how Nepalese people feel about the help on offer in Britain and what kind of help would be most appropriate.

As a Nepalese person who is also training to become a clinical psychologist, I am interested in researching how Nepalese adults who live in the UK view emotional or psychological difficulties they have encountered and how they respond to it as well as how they feel about getting help. I hope to ask a number of questions on topics relating to these issues that will be the basis for a discussion between us.

It is my ambition that an investigation of this nature will allow me to gain some insight into the world of Nepalese people who are in the unique positions of being migrant citizens of a host country which is also their current and (most likely) permanent place of residency. I hope that findings from this research will shed some new understandings around the emotional and/or psychological needs of a population that is under-researched and at the risk
of being marginalised. I also hope that the findings can contribute towards supporting future
decisions around engaging and providing suitable services for this particular group.

**Do I have to take part?**

Taking part in the study is entirely your choice. To help you decide, you may also wish to
seek advice from friends, family, other professionals, community leaders, etc. You can also
contact me for further information or to answer any queries and concerns you may have about
the study. My contact details can be found at the end of this document.

Even if you agree to take part, you can choose not to answer all of the questions in the
interview. You can also withdraw from the research at any time without giving a reason.

**What will I have to do?**

The interviews will take place either at Rushmoor Council Offices, which are near
Farnborough town centre, or at the University of Surrey which is in Guildford. You will be
asked for an hour or more of your time for the interview, where I will ask you some questions
relating to your experience. I can also send you the topics that we will be discussing together
before we meet so that you can think about what you would like to say to me.

Please note that I will be recording the interview instead of writing down your responses,
which will enable me to pay full attention to what you are saying. The recorded material will
only be used to remind me of what you said during the interview and not for any other
purposes. Once the research is completed, the recordings will be destroyed. The consent
form will contain further information about the recording procedure, and I am also happy to
answer any additional questions you may about it.

Where we meet will depend on which of the two options (either Rushmoor Council Offices
or the University of Surrey) is the most convenient for you. Unfortunately, I will not be able
to meet you at your home but if you are unable to make it to the above locations, we may be
able to negotiate a different private venue that suits you better. Please note that your travel expenses will be reimbursed.

**How do I agree to take part?**

You will be given a consent form to read and sign, to say that you have understood what the research is about and what it involves, that you have been given the opportunity to ask any questions, and finally that you agree to participate in the study.

The Consent Form also says that all information about you is kept confidential in accordance with the Data Protection Act 1998.

**What will happen with the information I share?**

Everything that you share with me will remain confidential. Your name and all details about you as well as any other information that may identify you personally (e.g. where you live, names of family members, etc) will be kept anonymous in the study. You will be given a fictional name following the interview, and thereafter only your fictional name will be used when referring to the information you have shared.

Information that you share with me will also be accessed by my research supervisor during the course of the study. My supervisor is someone senior to me, working as a lecturer and researcher at the University of Surrey. She will be helping me carry out my research to the highest standard possible. Once again, only your fictional name will be used during discussions with the supervisor.

All information gathered during this research study will be stored securely in a locked filing cabinet at the University of Surrey, in accordance with the Data Protection Act 1998 and will be destroyed after five years.
**What happens when the research is completed?**

It is likely that this particular research will take over a year to be completed, written up and approved, which might be a long time after you participated.

Most researchers wish to have their research findings published in relevant journals so that others working in the same field can learn more. These are usually academic journals which the public might not have access to. I can send you a copy of the final research study if you would like, plus copies of any articles in which the research is published.

Additionally, due to the topic that is being researched and its relevance for the Nepalese community, I will be aiming to have the findings published in websites and/or magazines aimed at the Nepalese population of the UK or relevant others. Again, if you are interested, I can send you information about this at the time.

Personal details about you will not be published or shared at any point, and special care will be taken to ensure that no-one will be able to identify you personally.

**What are the benefits of taking part in this research?**

Taking part in this research will provide you with an opportunity to talk about your unique experience. By sharing your story, you are contributing not only to the academic and research world, but also actively participating in future movements towards setting up new services or bringing about changes to existing services available to other Nepalese citizens of the UK. Additionally, you are also giving the Nepalese community a valuable opportunity to have a positive and effective voice within the wider society. So your input to this particular research will be extremely helpful and worthwhile.

**Are there any downsides to taking part?**
You may find some of the questions too personal. Alternatively, you may find it difficult to talk about a past experience that was particularly challenging to you, or your family. If you find a question too personal or upsetting in any way, you don’t have to answer it. We can also take a break at any time during the interview or decide not to carry on with it. As mentioned above, you can also request to see the questions beforehand to help you prepare. However, if you would like any support after the interview, I might be able to direct you to some support networks you could get in touch with. Alternatively, if you would like to talk with me about any aspect of the interview or research in general, you can contact me. Although I might not be able to provide any specific psychological support, I can listen and/or try my best to answer queries you may have about the research.

**What if there is a problem?**

If you have any concerns about the way in which you have been treated during the course of the research study, then you can contact my supervisor to discuss further. Her name and contact details have been provided below.

**Has the research been approved by any committee?**

The study has been approved by the Faculty of Arts & Human Sciences at the University of Surrey Ethics Committee.

---

Thank you for taking the time to read this information sheet. I hope that I have satisfactorily answered all of your questions about the research study. However, if you have any remaining questions, please feel free to contact me.
My contact details and those of my supervisor are given below.

**Research being conducted by:**

Bandana Upadhya  
Trainee Clinical Psychologist  
University of Surrey, Guildford  
Email address: b.upadhya@surrey.ac.uk or bupadhya5@gmail.com  
Phone no. 07415108482

**Research being supervised by:**

Dr Dora Brown  
University Lecturer and Researcher  
University of Surrey, Guildford  
Email address: d.brown@surrey.ac.uk
Appendix J: Consent form

Consent form for participating in research

Research title: A study exploring help-seeking for social and mental health related issues amongst young Nepalese living in the UK.

Bandana Upadhya, Trainee Clinical Psychologist, University of Surrey
b.upadhya@surrey.ac.uk

The Department of Psychology at the University of Surrey supports the practice of protection of participants in research.

- I have read and understood the ‘participant information sheet’ page which provides me with information about what the study is about, where and why it is being done and how long it is likely to take
- I understand the nature and the purpose of the interview, and agree to being interviewed
- I understand that my decision to participate in this research is entirely voluntary
- I understand that I am free to withdraw at any point throughout the duration of the interview without giving any reasons and without any penalty.
- I understand that I am not obliged to answer any questions which I do not wish to answer.
- I have been given information by the researcher of what I will be expected to do. I have been told about any possible distress which taking part in the project may cause me and have been offered support should this happen.
- I will tell the researcher immediately if I become upset or worried by any questions that I am asked during the interview, or if I have any concerns afterwards. I have been given the opportunity to ask the researcher questions about the research and have understood the answers to all of the questions I have asked.
• I understand that all personal data is held and processed in the strictest confidence, and in accordance with the Data Protection Act (1998). I have been informed that audio recordings will be destroyed once the study has been completed and that written transcripts will have any information that could identify me will be taken out to ensure my anonymity.

• I am happy for the researcher to write about what I say during the interview and publish this as long as this information remains anonymous. I understand that quotes from the interviews may be used, but these will be made anonymous.

• I have read and understood everything written above and have chosen to consent to participating in this study. I have been given enough time to think about this and agree to comply with the instructions and restrictions of the project.

Name of participant (BLOCK CAPITALS)
Signed
Date

Name of researcher/person taking consent (BLOCK CAPITALS)
Signed
Date
A qualitative exploration of help-seeking behaviour amongst Nepalese youths living in the UK

Introduction

Background and Theoretical Rationale

Role of culture in mental health
Mental illness is a common phenomenon that exists across many cultures and geographies. However, culture is considered to play an important role in the presentation of distress and illness (Suresh and Bhui, 2006). Diagnosis and treatment can in turn be influenced by the differences in linguistics, social situation, and religious practices between the migrant population and the clinician providing care (Bhugra et al, 2011).

Mental health in ethnic minorities
Ethnic minority groups in the UK are grouped under the umbrella term ‘Black and Ethnic Minority (BME)’ groups. Research has shown that BME groups are significantly disadvantaged when it comes to getting their mental health needs met, and are also the least likely group to seek help for mental health problems (Bhui et al, 2003). Additionally, individuals from BME populations, specifically, African-Caribbean and Black African, are more likely to make contact with mental health services through more coercive pathways such as involuntary admissions, compared with White British individuals who are more likely to make contact through GP referrals (Morgan et al, 2004). There is an additional risk that coming into contact through adverse routes negatively affects future engagement with mental health services, i.e. during relapse, resulting in a cycle of negative experiences, disengagement, relapse, etc. It can also impact engagement from others in the family or
wider community (Morgan et al, 2004). Mental health care for ethnic minority groups residing in the UK should therefore take account of the specific needs and traditions of the group in question. This would involve paying attention to how mental illness is viewed and treated by the different cultural groups.

A literature review found some studies that have looked at help-seeking for mental illness amongst ethnic minority groups. One study revealed that for South Asian people living in Harrow (London) mental illness is surrounded by shame, fear and secrecy, leading to misunderstandings about the causes of mental illness and subsequent unwillingness to seek help from health professionals (Time to change report, 2010). The study further found that having a mental illness within this specific community disadvantaged the individual concerned as well as their family, in terms of respect within the community and marital prospects.

Elsewhere, it was found that South Asians living in a small city in Scotland were largely underrepresented as service users of Child and Adolescents Mental Health Service (CAMHS) (Bradby et al, 2007). The reasons for this were identified as the tendency of South Asians to label mental illness as ‘madness’ and fear that it had damaging implications in terms of the family’s identity, thus making parents of children with mental health difficulties unwilling to speak to anyone other than close family members they believed they could ‘trust’. There were also fears of gossiping within the community and the potential hindrance to marital prospects for the children, which served as disincentives for help seeking. Another pattern that was found in the study was that the South Asian families were more likely to attribute their children’s difficulties as ‘naughtiness’ or the product of discrimination, while the mental health professionals viewed them as mental illness.

Other studies looking into attitudes and behaviours related to help seeking amongst BME populations found that General Practitioners (GPs) were not considered an appropriate or
legitimate source of help for mental health problems, that local services run by community leaders (belonging to same ethnic group) were more likely to be consulted when people were feeling low or isolated, and that language barriers often restricted help-seeking (Bristow et al, 2011). It was found in a separate study that changes in ethnic density (number of residents living in a certain neighbourhood divided by the total number of residents) and access to mental health services within some ethnic groups, for example a 10% decrease in ethnic density was related to an increase in the likelihood of people who identified themselves as ‘Indian’ reporting a mental illness (Becares and Das-Munshi, 2013). However, changes in ethnic density did not affect the likelihood of people reporting mental health problems to a doctor within the last month. Thus, increases in self-reported rate of mental illness did not translate to increases in help-seeking behaviour.

In terms of pathways to care, one study highlighted the difference between BME populations and White British by showing how far less African-Caribbean and Black African individuals, compared with White British individuals, were likely to be referred to mental health services through their GP. On the contrary, a greater proportion of those belonging to BME groups would be involved with mental health services through more coercive means, i.e. the criminal justice system (Morgan et al, 2005).

Mental health in the Nepalese population of UK

There are currently a growing number of individuals originally from Nepal temporarily or permanently settling in the UK. It has been identified that this group of individuals, alongside others from Black and Ethnic minority groups, are the least likely (compared to their White counterparts) to seek help for mental health difficulties (Amani, 2012). To date, there have only been two attempts to try and understand the mental health needs and attitudes towards help seeking of Nepalese people living in the UK (Casey, 2010 and Amani, 2012)
Briefly, one of these papers showed that Nepalese citizens of an area being studied (known to be highly populated with Nepalese migrants) were less likely to report knowing someone with a mental illness, less likely to speak to their GP and more likely to speak to community leaders and religious figures about mental health concerns, less likely to know about local mental health services and access them (Amani, 2012). The second study reported that GP’s found it difficult to diagnose mental health difficulties in the Nepalese community, which they suggested was related to the somatisation of mental illness.

Beyond the fact that there is a lack of studies done with this population, what is lacking from the studies that have been conducted is an exploration of how Nepalese people understand mental illness and what help seeking means to them, in the context of their cultural, societal and psychological viewpoints.

**Conclusion**

What has been clear from the literature review is that we know ethnic minority groups are unlikely to seek ‘traditional’ routes to seek help for mental health problems, i.e. speak to their GP, however they do not make sufficient enquiries into the role that culture plays in how mental health is perceived, as well as how being a migrant and/or an ethnic minority might impact the risk of mental illness and the decisions that are made about help seeking.

Therefore, there is a need for more studies to look at the behaviour of Nepalese people living in the UK within the contexts outlined above, and more studies are also needed on the younger generations who are largely underrepresented in the few studies that have been carried out.

**Research Question**

What are the experiences of help-seeking amongst young Nepalese people living in the UK?

**Method**
This section will describe details about the research perspective, sample size and selection, research design and procedures.

Research perspective

The research question proposed above will be approached from a qualitative perspective, because the researcher is interested in exploring the perceptions and lived experience of young Nepalese people seeking help and since qualitative research is an approach to study life experiences and their given meanings. Qualitative methodology has also been recommended for cross-cultural research, in which social and cultural contextual information is sought from ethnic minority groups (Liamputtong, 2010).

This study will utilise an interpretative phenomenological perspective to data collection and data analysis. An interpretative phenomenological approach is used in research when the subject under investigation involves personal accounts of a particular phenomenon, rather than be concerned with creating an objective viewpoint of that phenomenon (Smith & Osborn, 2008).

Participants

The study aims to recruit 6-8 participants, using purposeful sampling. It is considered that a small sample size is better than a larger one in qualitative studies that are interested in an in-depth and rich account of individual cases (Smith and Osborn, 2008).

Purposive sampling methodology means that the researcher will apply some inclusion criteria requirements when recruiting participants, which are listed as follows:

*Include*

- Young people who identify their country of origin as Nepal

- Young Nepalese people who have had some experience of seeking help for mental health problems and/or social needs
- Young Nepalese people aged above 18 and below 30 – the rationale for selecting this particular age category is to include those who have achieved independence and who have the capacity to seek help on their own account

- Young people who identify themselves as first generation Nepalese i.e. who have moved to the UK from Nepal or second generation Nepalese i.e. who were born in the UK

- Those currently living in the United Kingdom

Potential participants - once ethical approval is granted - will be accessed via multiple means i.e. established youth groups, community leaders or community representatives (youths or older), word of mouth, social events (organised by and for young Nepalese people). Due to the potential fears of stigma and shame associated with mental health problems that exists amongst Nepalese people both in Nepal and outside, it is considered/anticipated that there may be some difficulties in recruiting individuals to participate in the proposed research. We do not know whether these issues i.e. of stigma and shame exist amongst the younger groups since they have not previously been investigated. However, it is hoped that by seeking potential participants from multiple avenues will make the endeavour easier and more successful.

Measures/Interviews/Stimuli/Apparatus

The primary research approach that will be taken in this study is semi-structured interviews, where participants will be asked open-ended questions in an informal and conversational manner. Open-ended questions have been selected to enable participants to share their experiences and discuss their viewpoints in as much detail as they wish, unlike closed questions where they might feel restricted to fully express themselves.
Conducting interviews using a semi-structured style is recommended in IPA since it enables the interviewer to engage with the participant in a flexible way and modify their initial questions to fit with what the participants reveal, and also explore other interesting areas that may unexpectedly arise (Smith and Osborn, 2008).

Thus, an interview schedule with a set of questions will be used to guide the interviews. Since all interviews will be face-to-face, there will be opportunities to observe non-verbal communication that may add to the richness of the data collected. The interview schedule prepared for the purpose of this study contains nine questions. Each interview is anticipated to last 60 minutes, however the allocated time is only a guide and it is participants’ responses that will guide the length of the interview.

All interviews will be tape recorded, with permission from participants, since this provides an accurate account of the interview, and also means it can be replayed numerous times to help with the analytic process. The recorded interview material will then be transcribed for data analysis.

**Procedure**

1. Apply for ethical review to gain permission to conduct research

2. Refine interview schedule

3. Recruit participants by developing links in the Nepalese community (e.g. youth groups, community leaders), attending Nepalese events/meetings*, via social media (look for virtual youth groups on Facebook) and relevant websites.

4. Provide detailed information about study to individuals showing interest; distribute a questionnaire to gather basic information about potential participants (in order to apply inclusion and exclusion criteria)
5. Apply inclusion criteria in selecting suitable participants (See above)

6. Gain consent from suitable participants to participate in the research and gain permission to audio tape interviews (N.B. information will be provided about the purpose of audiotaping as well as how the information will be used and stored) (see above).

7. Arrange time and location for interviewing participants. Participants will either be interviewed in their homes, if appropriate, or in council or community buildings so there are less chances of being disturbed (permission will be sought for this).

8. On the day of interview, participants will be reminded of their right to withdraw from the research at any time without any repercussions

9. Conduct interviews (using the interview schedule as a guide)

10. Audiotape interviews

11. Transcribe interviews

12. Analyse data

13. Write report

*Being of a Nepalese ethnicity myself, I anticipate that I will not have many difficulties integrating into Nepalese-led events and groups

**Ethical considerations**

It is considered that since the research is focussed on collecting data from participants with some form of experience of seeking help for issues personal to them, emotions are likely to be evoked during the course of interview. These emotions may vary in valence and intensity,
depending on the participants’ individual experience. Thus, in an attempt to protect the participants from any psychological harm (since physical harm is unlikely), the researcher will monitor the participants’ psychological state on an on-going basis, and be sensitive to their needs (e.g. offering the option of regular breaks). Participants will also be given contact details of the researcher should they need to speak to the researcher after the interview. An ethical dilemma that may potentially arise here is one where the interviewer experiences a conflict in roles: on the one hand, researcher gathering information and on the other hand, a clinical training to apply specific therapeutic skills (i.e. compassion and validation) that may be helpful to a distressed individual. If such a dilemma occurs during interview, it is important that the interviewer maintains their position as a researching interviewer without interfering participant’s process of story-telling and meaning-making. Nonetheless, applying good listening skills of a clinician may be helpful in encouraging the interviewee to open up. Another ethical issue that may arise is the sharing of personal information by participants and how this is treated by the researcher. Privacy and confidentiality will be maintained throughout the process of data collection and write-up by ensuring any identifiable information is removed from the tape and final report e.g. names will be replaced with codes. Once interviews are transcribed, all data will be stored in password protected folders in an external hard drive that only the researcher will have access to. Participants’ human right of free choice will be respected by ensuring informed consent is gained prior to interviews, and that participants are informed of their right to withdraw from the research at any point. Permission to conduct the research will be sought from the University of Surrey’s ethics committee prior to gaining consent from selected participants to partake in the study. Since participants will not be recruited via the NHS and are non-vulnerable, NHS ethics will not be consulted.
**Name of Ethics Committee:** University of Surrey Ethics Committee

**Proposed Data Analysis**

Data will be analysed using Interpretative Phenomenology Analysis (IPA). Data analysis in IPA consists of a dual interpretation process: the participant begins making sense of a phenomenon by explaining and interpreting their unique experience, and during the analysis the researcher explains and interprets their understanding of the participants’ account (Smith, Flowers and Larkin, 2009).

Smith and his colleagues have suggested a systematic procedure to data analysis in IPA, which is the procedure that will be adopted in this study (Smith, Flowers and Larkin, 2009). The suggested structure, briefly, entails reading and re-reading of the transcripts, followed by an initial phase of making notes on particular points of interest. Then, the initial notes are used to develop emergent themes. The next stage involves looking to see how the emergent themes are connected. Thus at the end of the process, the researcher will have constructed emergent themes and subordinate themes.

**Service User and Carer Consultation / Involvement**

Service user and carer consultation group at the University of Surrey will be consulted for advice on developing the final interview schedule and the participant information sheet.

Advice will also be sought in case there are difficulties recruiting participants.

**Feasibility Issues**

Some potential obstacles and a possible solution to completing this study are listed below:

- Difficulties recruiting participants
  
  Solution: Widen out the geographic area to search for more participants and review the inclusion/exclusion criteria so that second generation Nepalese also included

- Participants dropping out
Solution: Begin recruiting for participants and collecting data sufficiently early to ensure there is time to recruit further participants, should the need arise

**Dissemination strategy**

It is anticipated that the findings of this study will provide insights – for the first time – into the help-seeking attitudes and experience of Nepalese youths living in the UK. It is hoped that this can be informative to services catering to the Nepalese population of a particular area, as well as future studies with this population group. The aim is to submit the study for publication in various psychology journals, as well as publications targeted to Nepalese people living in the UK.

**Study Timeline**

Please see Gantt chart (Figure 1; below) for a proposed timeline for the study.
Figure: Gantt chart to show proposed timeline for study
References:

- Amani, S. (2012) Exploring the factors affecting access to mental health services for
  the Nepali community in Rushmoor, North East Hampshire. Reach Out Project.
  Accessed at
  http://www.rcn.org.uk/__data/assets/pdf_file/0008/507545/Sarah_Amani_Mary_Sea
cle_Award_Report_-_Reach_Out_Project.pdf

  and expected discrimination from health services among ethnic minority people in
  England. Health & Place, http://dx.doi.org/10.1016/j.healthplace.2013.03.005

- Bhugra, D., Gupta, S., Bhui., K., et al (2011) WPA guidance on mental health and
  mental health care in migrants. World Psychiatry, 10, 2-10

  variations in pathways to and use of mental health services in the UK: Systematic

  British Asian families and the use of child and adolescent mental health services: A
  qualitative study of a hard to reach group. Social Science & Medicine, 65, 2413–2424.

  (2011) Help Seeking and Access to Primary Care for People from “Hard-to-Reach”
groups with common mental health problems. Hindawi Publishing Corporation, 

  Accessed at 

  31: 348-350

- Liamputtong, P. (2010). *Performing qualitative cross-cultural research*. UK: 
  Cambridge University Press.

- Morgan, C., Mallett, R., Hutchinson, G., Bagalkote, H., Morgan, K., Fearon, P., 
  Dazzan, P., Boydell, J., McKenzie, K., Harrison, G., Murray, R., Jones, P., Craig, T., 
  & Leff, J. (2005). Pathways to care and ethnicity. 2: Source of referral and help-
  seeking. *British Journal of Psychiatry* 186, 290-296


Help-seeking attitudes and behaviours amongst the Nepalese and other South Asian population of the UK. A literature review.

Abstract
There is a growing population of Nepalese people in the UK, and research has shown that they are a group unlikely to seek help for mental health problems, like other black and ethnic minority groups of the UK. A literature review has thus been carried out to evaluate existing research on help-seeking attitudes and behaviour among ethnic minority groups living in the UK, such as the Nepalese, South Asians, and other Black and Ethnic Minority populations. Seven studies were selected for the final review following the application of several inclusion and exclusion criteria. The studies provided many revelations: that help seeking for ethnic minority groups did not follow a traditional route, that ethnic minority groups had very different understandings of mental illness, self-initiated help-seeking was largely uncommon, and help was often not sought due to fears of shame and stigma. The review is concluded with directions for future research.

Introduction
Within the diverse society of the UK, mental health care for ethnic minority groups must be considered in the context of their culture and ethnicity. For this to successfully take place, the policy makers and the care providers must have a good idea of how mental illness and its treatments are viewed by the different ethnic minority groups. People from Nepal or the Nepalese people are one such ethnic minority group, and also the group of particular interest to this literature review.
Nepal is a small country situated in South Asia, sandwiched between India and China (Adhikari, 2012). Nepal is principally a rural country, and has been classified as one of the least developed countries in the world (Jha, 2007). As far as the mental health status of Nepal goes, in 2005 there were only 18 outpatient mental health facilities available in the country (none of which were for children and adolescents only) (WHO-AIMS report, 2006). Regmi et al (2007) report that most people in Nepal understand mental illness as someone who has become ‘crazy’, has lost ‘self-control’ or is ‘possessed by spirits’. According to Devkota (2011) people suffering from mental illness are also considered ‘unfit’ and therefore rejected by both families and the wider society, and many therefore are reluctant to come forward for treatment. Furthermore, the majority of people treated in outpatient mental health services have a diagnosis of schizophrenia (21%) and neurotic disorders (51%) (WHO-AIMS report, 2006). As such, the country’s health care system has been criticised for neglecting the importance of psychological care and consequently depriving people of their basic mental health rights (Devkota, 2011). On a more positive note, Devkota (2011) also considers that mental health awareness is increasing in Nepal and the number of people seeking treatment for mental health concerns has increased. However the main challenges that remain are in access to mental health care, which are driven by a major lack of mental health care professionals, specialist mental health training, and mental health services, as well as widespread stigma and discrimination associated with mental illness. It is possible that people who have migrated to the UK from Nepal may also hold these beliefs about mental health and may be reluctant to enquire about mental health services in light of the inadequate services that are available in their home country. Additionally, most people in Nepal are reported to prefer seeking private consultation for psychiatric illness, if they are able to afford it (Jha, 2007), which may have an impact on how mental health services are consulted by some of the Nepalese population in the UK. If these are some of the ways in which help for
mental health is sought in Nepal, it becomes important to understand how this would translate to how help is sought by those who have settled in the UK.

The first data-base that attempted to capture the number of Nepalese people living in the UK was the 2001 census, but they could only be identified by their place of birth (however not every Nepali would have been born in Nepal), or by selecting the category of ‘any other ethnic group’. As a result, the exact number of Nepalese people currently living in the UK is unclear. Nonetheless, according to the 2001 census, there were 5,943 people born in Nepal and living in the UK. An independent survey carried out in 2008 showed that the figures had gone up to 72,173 (Adhikari, 2011). This considerable increase is likely to be the result of the recent changes in immigration laws directly affecting the Nepalese population. The number of Nepalese people migrating to the UK began to rapidly rise between 2004 and 2009, when Gurkha soldiers that had retired pre- and post-1997 won the right to settle permanently in the UK, together with their dependents. Yet another group that add considerably to the growing Nepalese migrant population are students who have come to the UK to study, though they are less likely to settle permanently in the UK (Adhikari, 2011).

The fact that Nepalese people in the UK are migrants from Nepal is an important issue to consider, because migration can be a stressful process, and this fact in itself is considered to be a risk factor for the development of mental illness (Bhugra & Jones, 2001). Migration is perceived to involve three characteristic stages. The first stage involves the physical and psychological preparation that goes into migrating. The second stage involves the physical movement or transition from one place to another. The third stage encompasses learning about the new roles and adjusting in the new community (Bhugra & Jones, 2001). Bhugra et al (2011) proposed that the latter stages of the migration process, whereby people have arrived at the host nation and are making attempts to fit in to the social and cultural frameworks governing the new society, can substantially increase the likelihood of migrants
developing a mental disorder. The increased risk is thought to arise from the problems of acculturation, social isolation, language barriers, unemployment and the potential discrepancies between expectations and actual attainment of goals, which can result in the new country. Although this may be relevant to some extent to the Nepalese community who have settled here in the UK, they must also be looked at with unique set of lenses, since many of them would have been here in the UK serving for the British Army prior to settling permanently in the country. It is not clear whether this type of migration would decrease or increase an individual’s risk for mental illness.

A majority of the Nepalese community, like other migrants who have settled in the UK, are likely to have become ethnic minorities in the new town or city, which can become a hindrance when it comes to seeking help and receiving appropriate care for mental health problems (Bhugra et al, 2011). Some reasons for this may be the cultural bias, discrimination and external stigma that can exist in the host country towards ethnic minorities. Another reason may be that many of the services that are available may not be known and/or suitable to the migrants (Bhugra et al, 2011).

This literature review will thus examine the current literature on help-seeking for mental illness by the Nepalese community, and also by other Black and Ethnic Minority (BME) populations of the UK, with special attention given to the South Asian population. The latter communities have also been included in the literature review because it is anticipated that very little evidence is likely to be currently available on the mental health of the Nepalese community due to their status as recent migrants. Additionally, it is considered that there would be some similarities between Nepalese people and other South Asians, due to Nepal also being a South Asian country. The implications of widening this particular criterion will be discussed later on in the review.

Method
The review aimed to include all papers that described help-seeking behaviours and/or attitudes related to mental health or mental illness by people belonging to the Black and Minority Ethnic (BME) population living in the UK. Help-seeking included perceptions or attitudes as well as behaviours or actions connected with seeking help. However, only papers that included a study of help-seeking in reference to mental disorders (rather than health in general) were included in the review.

The three main search strategies applied for the purpose of this review were electronic database searches, hand-selected citations from relevant papers, and web-based searches (Google Scholar and Google).

The following electronic databases were sought in search of relevant literature: Science Direct, Web of Science and PsychINFO. The following search strategy was applied, with minor adaptations depending on the database used: Help-seeking AND (Mental Health* OR Mental illness OR Mental Disorder) AND (Black and Ethnic Minority) or (Ethnic Minorit*) or (Nepal*) or (South Asian). These terms were searched in various combinations to incorporate help seeking, mental health and each of the interested population group. The search within each database was refined to include only papers that have been published in the last 10 years.

Studies were excluded if they were conducted on non-UK populations, such as ethnic minority populations from the USA. The reason for this is that the mental health care system in the UK is different to the USA, and the BME population of the USA may have had very different experiences to that of those in the UK. Furthermore, any studies that were not written in English were excluded. In terms of the South Asian and BME population, studies were further screened and hand-picked to include only those that investigated help-seeking and access to mental health services.
Many papers were also excluded based on their title and abstract, for example if they were from a biomedical journal. Some full papers were also excluded as they were deemed irrelevant. In some cases, access was denied to full articles (unless a charge was made), and therefore these were also excluded. Age group was not explicitly defined when selecting populations.

Some papers were hand/manually searched from lists of citations/bibliographies from selected review papers and community-based pilot studies, to account for papers not obtained by the search criteria used. One article was requested directly from the author following personal correspondence. This paper was especially relevant due to its particular focus on the Nepalese population in Rushmoor Borough Council.

Google and Google Scholar were used to further identify papers not captured by searches of the electronic databases. Web-based resources such as websites designed for and by the Nepalese community living in the UK were also sought using this approach.

The stages of searches implemented to identify relevant papers are illustrated in Figure 1 (Appendix 2).

Results

The applied search strategies yielded seven studies in total. An overview of the main findings and other characteristics of each study are outlined in Table 1 (Appendix).

The studies have been divided into subsections according to the population studied, regardless of whether they looked at help-seeking specifically or general attitude to mental illness and/or mental health services. The motivation behind this formatting was merely to distinguish papers according to the population studied, and in doing so enable the reader to navigate more easily through the review. With the Nepalese community, more flexible rules were followed in terms of inclusion, as studies were limited. On the other hand, studies studying the BME population were plentiful, but did not necessarily target help-seeking
specifically, and therefore more stringent inclusion criteria was applied when selecting studies to include in the review.

The review will begin by looking at the studies that relate to the mental health status and help seeking for mental health problems of the Nepalese community, followed by the South Asian community, and then the wider BME population of the UK.

Mental health and the Nepalese community of the UK

There were two studies that looked at mental health related issues within the Nepalese community. One of these was a ‘Reach out’ project conducted by mental health professionals working in an Early Intervention in Psychosis team (Amani, 2012). One of the aims of the project was to investigate the factors influencing access to mental health services for the growing Nepalese community in the Rushmoor Borough region (North East Hampshire). The group carried out a pilot survey to explore mental health awareness amongst the Nepalese community and other members of the wider Rushmoor community. The survey was translated into the Nepalese language to make it more accessible for the Nepalese participants, who were specifically recruited from community events, the GP surgery, and those passing by Aldershot town centre. The majority of responses came from individuals aged between 41 and 50 years (29%).

The main findings of the study are listed in Table 1. However, in thinking about the themes that emerged from the study, it seems that in comparison to White British citizens of the area, Nepalese citizens are less likely to report knowing someone with mental illness, less likely to speak to their GP about mental health concerns (same as other BME respondents), and less likely to access mental health services, or even know about any of the available services. Interestingly, a large majority of the Nepalese and other BME respondents claimed they speak to Buddhist priests and community leaders about mental health concerns, rather than their GP. However, we are not able to tell whether this is a reflection of how mental health
concerns are addressed in the Nepalese culture generally, or whether it is related to a lack of awareness of the role of a GP. Yet the fact that the Nepalese community show similar patterns of behaviour to the BME community, suggests that a culturally informed choice may have been made, though it is hard to implicate this without further exploration.

Although the study findings are useful in highlighting some important differences between the ethnic citizens, what we are not able to ascertain from the data are the reasons why these differences exist, and the implications of this. For example, could it be that less Nepalese people report knowing someone with mental illness because there are fewer of them suffering from mental illness in the community, or could it be that they are less willing to admit having a mental health problem due to high levels of stigma and/or low awareness of mental health within their community.

Seemingly, the survey results provided sufficient support for the subsequent work that the ‘Reach Out’ project team carried out with the Nepalese community, such as training selected community members in mental health issues and promoting greater mental health awareness amongst the Nepalese community, though a further study is needed to assess the usefulness of training community members in this instance. However, the survey findings manage to leave us with more questions than provide any meaningful insights into the attitudes and perceptions of mental health issues amongst the Nepalese population of Rushmoor. For example, we do not know whether some of the ways in which the Nepalese community members dealt with their mental health problems (e.g. speak to a community leader) reflects how mental health issues are operationalized in their home country (Nepal) or whether they are attempting to find new ways of dealing with problems within a society where they are not only migrants but also ethnic minorities.

There are additional methodological deficiencies in this study that further limits the usefulness of its findings, for example the lack of statistical testing makes it extremely
difficult for readers to discern the meaningfulness of the data collected in this case. The fact that in some instances the Nepalese and the BME respondents were treated as one group whilst in others they were kept separate is problematic, especially as the author does not explain why this was done. Additionally, we are not informed of which ethnic groups make up the BME population. The survey had a small response rate which limits the power of the data, and also the lack of responses from a younger population means there is an underrepresentation of the Nepalese youths.

The second study conducted on the mental health of the Nepalese community was also conducted with the Nepalese population in Rushmoor (Casey, 2010). Both studies report a rapidly growing Nepalese community in Rushmoor (North East Hampshire) and the necessity to investigate the specific needs of the community (Amani, 2012, Casey, 2010). Since Rushmoor has a military base in Aldershot, it has attracted an influx of ex-Gurkha soldiers either migrating from Nepal or settling down after retirement from the British Army. Thus Aldershot, despite being a small town, has a highly concentrated Nepalese population who have built a community there. This fact becomes an attractive feature for other Nepalese migrants who may wish to settle in previously established communities. Despite this rapid growth of the Nepalese community in Rushmoor, it was recognised that very little was known about their specific health needs, which led the NHS Hampshire to carry out a health needs assessment on the Nepalese population of the region (Casey, 2010).

Casey (2010) adopted a varied range of methods for data collection in order to conduct the health needs assessments, which were rather non-traditional. Casey (2010) argues that it was difficult to quantify the health needs of the community as accurate data from health records are largely missing and this is because Nepalese people were often recorded as belonging within wider ethnic categories, which also included people from other countries. Thus, much
of the data was collected using interview and focus groups with various members of the Nepalese community, as well as health professionals and other service providers.

The assessment report (Casey, 2010) covered many areas of health needs and determinants of health, including the mental health status of the Nepalese community, which is the part most relevant for this literature review. The main mental health concerns identified by the health professionals were difficulties in diagnosis, and low levels of reporting of mental health problems. On the other hand, the focus groups consisting of community members identified that depression was common amongst older Nepalese women. Nonetheless, the key themes that emerged from the focus group discussions were: ‘stigma’, ‘difficulty in diagnosis’ and ‘somatisation’. There were reflections, especially amongst doctors in GP practices, that mental illness may have a stigmatizing role within the Nepalese community, or that the Nepalese people have very different beliefs around mental health and mental illness. It was also reflected that some Nepalese people visiting their GP tended to somatise their mental health problems, i.e. present with physical symptoms (e.g. dizziness, headache) when the underlying problem related to mental health. There were also concerns that mental illness was not being diagnosed until much later into the illness, and that many difficulties were being silently endured until the problem became very severe. No further thought is given to whether this reflects a cultural phenomenon, and would certainly need to be considered in future studies. Many health professionals were also under the impression that the ‘Gurkhas’ held very ‘positive mental attitude’ and came across very ‘self-reliant’. Caution must be taken when interpreting this particular finding, since these were the opinions of the health care professionals, and may not reflect exactly how mental health is conceptualised by Nepalese people. It could be that the GPs and other health professionals were making justifications for the difficulties and the significant delays they experienced in diagnosing mental illness in the Nepalese community, and clearly what they report does not seem fitting
with what the Nepalese people are themselves saying about depression being common amongst the older female population of their community. It could possibly be that many Nepalese people are going to community leaders and religious figures at times of distress (Amani, 2012), and that GPs are consulted only when the illness reaches a severe stage at which medical treatment is deemed necessary. It is also possible that Nepalese people of this community are more in tuned with physical symptoms of illness, rather than any mental health problems. Perhaps this also reflects how mental health care is addressed and its treatment conducted in their home country of Nepal (Jha, 2007). Perhaps distress is not considered something that warrants help seeking from a doctor or other health professionals. Further exploration of these ideas is desperately needed before we are able to better understand the mental health needs and help seeking behaviours of the Nepalese people living in the UK.

Mental health and the South Asian community of the UK

It made sense, due to a shortage in studies relating to mental health and help seeking within the Nepalese community in the UK, and Nepal’s geographical location in South Asia, to look more widely at research carried out with people of South Asian origin living in the UK, including Indians, Pakistanis, and Bangladeshis.

One such study explored the attitudes of the South Asian community in Harrow (North West London) towards mental health problems generally. The study was a qualitative, pilot study conducted in 2010, commissioned by ‘Time to change’, an organisation that aims to challenge stigma and discrimination associated with mental illness (www.time-to-change.org.uk). The overarching aim of this particular project was to gather insights into the South Asian population of Harrow from which to then develop a campaign to tackle mental health stigma and discrimination within the community. The study employed two methods of
data collection using two groups of participants from the Harrow community; these have been detailed in Table 1.

Consultations with service users and carers (Group 1; Stage 1 of data collection) revealed that ‘extended family members’ were perceived to be a source of discrimination and have a negative impact on those with mental health problems. As a result, participants in stage two of data collection were made up of middle-aged individuals who identified themselves as extended family members of someone with a mental health problem. Focus groups and face-to-face interviews were used to explore attitudes and behaviours of extended family members towards mental illness. This component of the research revealed six main findings, which have been listed in Table 1.

Overall, what can be learnt from this study is that for South Asian people living in the UK, mental illness is surrounded by shame, fear and secrecy. Family members kept mental illness a secret as there was a risk that family reputation would get jeopardised. The study revealed that there was widespread misunderstanding over the causes of mental illness, for example causes were generally attributed to ‘black magic’, ‘genetic’, ‘the will of God’ or even ‘bad parenting’. The authors feel that these may explain why many people from the community are reluctant to seek help; if a cause for mental illness is considered to be the ‘will of God’, treatment options become very limited. The study also revealed that people with mental illness have very little value in the community, and that having mental illness can significantly ruin an individual’s and other family members marriage prospect, especially as arranged marriages are common and mental illness is conceived as incurable and heritable. Issues of help-seeking were not given great precedent within this study, as its aim was primarily in detecting discrimination and stigma that exists in the community (and subsequently to tackle them). However, we could speculate that within the South Asian community, due to the large risks associated with developing mental health problems, people
are reluctant to recognise any problems until its later stages. Perhaps, since mental illness is seen as a genetic disorder or the result of ‘evil spirits’, help is sought elsewhere?

In thinking about the methodology adopted in this study, we do not know how any of the participants were recruited, and therefore cannot comment whether or not a fair system was applied. Extended family members are, even prior to recruitment, assumed to be a source of ‘gossip’ and ‘stigma’, but we do not know whether the participants were made aware of this at any point in the study, which can raise some ethical concerns. Middle-aged individuals were specifically recruited to provide data in stage two of the study, since it emerged from stage one that middle-aged South Asians were the ‘gate-keeper’ to family decisions and influenced the attitudes held by the rest of the family. This is a limiting factor in the study, because it would have been useful for example to see how younger South Asians are influenced by the division between Eastern and Western cultures, when it comes to their understanding of mental illness and help-seeking.

A second study qualitatively explored the attitudes and experiences of South Asian families towards a Child and Adolescent Mental Health Service (CAHMS) in a city in Scotland (Bradby et al., 2007). The authors of the study were motivated to explore how and why a highly concentrated South Asian (SA) population in the Scottish city are underrepresented as service-users of CAHMS (i.e. why help was not being sought despite the experience of mental health problems). Additionally, for SA families who have children with mental health problems, their experience of seeking help were also explored.

The study was divided into two phases. The first involved a focus group with community members, and the second phase involved interviews with existing and potential service users, as well as CAHMS health professionals; further details on participant recruitment are provided in Table 1. The focus groups were presented with vignettes that described problems typically seen in CAHMS referrals, and were asked what advice they would give to the
children’s parents, and whether health care services would be appropriate and/or helpful to the child. Semi-structured interviews with families were based on questions about the problem (as defined by the family) and their experience of the problem as well as services they had used (including CAHMS, where appropriate).

With regards to the results, one theme that was prominent among both the focus group and interviewed participants was their understanding and labelling of mental illness as ‘madness’. Focus group participants identified all people of South Asian origin as unwilling to speak to anyone other than close and trusted family and friends about mental health problems. Interestingly, individuals from the focus groups identified ‘psychiatry’ itself as ‘shameful’, and one lady expressed that stigma from seeking help from services should be avoided even if had harmful consequences (e.g. death) for the child. In terms of the families with children with mental health problems, there was fear that the entire family’s identity was at risk of damage. Gossiping around mental illness and its associated stigma and shame for the entire family, as well as potential damage for the child’s marital prospect, was found to be some of the major disincentives for seeking help to mental health professionals. Another issue that emerged from this study was how the families were more likely to attribute their children’s mental health problems to ‘naughtiness’ and a product of discrimination rather than an ‘illness’, which differed from the mental health professionals account of the same problems. Additionally, majority of the parents in the study, despite being British-born, appeared to have been unaware of mental health services until their children’s problems started.

One of the strengths of this study is in the wide range of participants that were interviewed in order to gain an insight of the SA population’s attitude towards CAHMS: SA community members, families with children with mental health problems who refused to use services, as well as those who had direct experience of CAHMS. Interviewing mental health professionals also enabled comparisons to be made between the families and professionals.
understanding of the problem. An additional strength of the study is in the fact that the 
interviewer could speak the same language as the participants. This may have made the 
participants feel more understood (especially when communicating cultural norms) and with 
language no longer a barrier in communication, participants may have felt able to speak more 
freely about their personal experiences.

On the other hand a weakness of the study was that we do not get much insight into the 
perspective of the children and adolescents themselves, though understandably this seems to 
be related to the reluctance of family members to give separate interviews. Additionally, 
richer data could have emerged had the researchers formed a focus group of SA adolescents 
from the community, for example. What is also missing is a matched comparison group from 
the majority culture living in the same region, which would have enabled us to see if 
concerns relating to stigma surrounding children and adolescent mental health problems exist 
in majority cultures as well.

**Help seeking in BME population**

A qualitative study investigated the experience of seeking help for distress and accessing 
primary care mental health services from the perspective of ‘hard-to-reach’ individuals, 
which included those from the BME population (Bristow *et al.*, 2011). GPs can currently refer 
their patients to primary care services in the NHS to receive brief psychosocial interventions. 
It has been reported elsewhere that many individuals are not receiving appropriate care 
despite experiencing mental health difficulties, either because help is not available, or help is 
not pursued or is simply avoided (Dowrick, Dask and Edwards, 2009). One group of people 
who are thought to have insufficient access to primary mental health services are those from 
the BME communities (Bristow *et al.*, 2011).

The study (Bristow *et al.*, 2011) recruited various individuals from BME communities: 
Chinese, Somalian, Irish and South Asian (Table 1). Semi-structured interviews were used to
gather data. The interviews consisted of story-telling; a method designed to explore various topics relating to help seeking for mental health difficulties, i.e. participants experience of seeking help from GP or community services, issues preventing access, experience of services, etc. Data was analysed using a thematic framework, and specific questions were used to guide the authors through the process. Four themes resulted from the analysis. In terms of the themes specifically relating to the BME group, those of ‘help seeking’ and ‘barriers to seeking help’ were found to be the most significant. It was found that many participants did not regard the GP as an appropriate or legitimate source of help for mental health problems, and only consulted them for physical health problems. Many of the older participants across the BME group reported using their local community services (such as those run by their own ethnic groups) at times of feeling low in mood or isolated. Some of the barriers to help-seeking described by the BME group included fears of getting stigmatised by the community, though only a Somalian individual was quoted as identifying this as a problem, thus it is unclear whether these worries were relevant to the other BME group members as well. Another barrier was having difficulties communicating in English. The issue of being misunderstood despite having a translator present was raised by some of the participants who spoke little or no English; in fact translation services were used in this study also, however the authors have not reflected on the impact of this beyond suggesting it would provide accurate data and give participants a ‘voice’. For example, would the non-English speaking BME participants say they have been misunderstood in this instance also? Nonetheless, language or more broadly communication issues have been depicted by the authors as some of the more practical issues that individuals in the BME community could experience, creating hindrance to help-seeking. Furthermore, as far as attitudes towards GP services (as a gateway for primary care mental health services) are concerned, the researchers
found that for all their ‘hard-to-reach’ respondents, including those from the BME group, there was an undesirable gap between the expectations held and the services offered.

One major drawback of the methodology applied within this particular study is the fact that the researchers have included a diverse group of people within their criteria of ‘hard-to-reach’. For example, alongside BME participants, other participants also included women with eating disorder (which in itself encompasses many sub-groups), homeless individuals, and asylum seekers. By doing this, the researchers firstly risk having participants that may belong to more than one group, but if this does happen to be the case, there is the danger of simplifying matters that deserve greater, in depth exploration. In fact, the act of putting together different cultural groups into a BME group can also be problematic since their viewpoint is being treated purely from the perspective of their position as an ethnic minority rather than attempting to identify what features of their culture may make seeking help for distress particularly challenging.

Another methodological flaw with this paper is in the method used to recruit BME participants for the study. It seems that key people within local communities were asked for help, rather than adopting a fairer, randomised procedure. However, this may also reflect the position of the individuals as ‘hard-to-reach’.

A different study (Becares & Das-Munshi, 2013) looking at help seeking behaviour of ethnic minority groups hypothesised that in neighbourhood areas with a low ethnic minority density, there would be an increase in access to mental health services by ethnic minority groups. Mental Health data (e.g. rates of depression and anxiety) were collected in the study using a nationally represented survey called the ‘Ethnic Minority Psychiatric Rates in the Community (EMPIRIC) and a diagnostic tool known as the ‘Clinical Interview Schedule-Revised’ (CIS-R). Furthermore, the presence of psychotic symptoms was assessed using the ‘Psychosis Screening Questionnaire’. The EMPIRIC was further used to measure ethnicity and also
access to mental health services, for example a variable of the EMPIRIC asks respondents to state whether they had seen a doctor in the past month. Ethnic density was calculated by the number of residents of an ethnic group in a neighbourhood divided by the total number residents. Regression analysis was conducted on the data to explore the association between lowering ethnic density and mental health measures (e.g. common mental health disorders), service use, and satisfaction with service use. In terms of the findings, the authors report a link between a 10% decrease in ethnic density with an increase in the likelihood of reporting a mental health disorder, for all ethnic minority group. However these patterns were only statistically significant for the link between decreased Indian ethnic density and increased odds of reporting psychotic symptomatology, and decreased Bangladeshi and Irish ethnic density and increased odds of reporting common mental illness. The study does not provide any insights beyond this, leaving the readers wondering what factors may have contributed to why some ethnic minority groups seem to be significantly affected in their likelihood to report mental illness by even small changes in ethnic density, while others do not.

Furthermore, the study found that across most of the ethnic minority groups, a 10% decrease in ethnic density was not associated with an increase in the likelihood of people reporting the problem to a doctor in the last month. These findings were not statistically significant however they reveal something very important, such that in this instance help seeking behaviour did not mirror self-reported rate of mental illness, since the prevalence of mental illness did increase with a decrease in ethnic density. Though the current study cannot shed light on why this mismatch may have occurred, it seems likely that there is an unmet need when it comes to mental health issues in ethnic minority groups. The authors have speculated (based on previous literature) that other non-traditional or culture-specific pathways to care are likely to be sought by some of these groups or that some groups are likely to experience more coercive pathways to care i.e. compulsory admission to hospital.
In thinking about the methodology applied in this study, given the large number of individuals from whom data was collected, it would be fair to say that regression analysis was an appropriate measure to use, and the use of nationally representative data gives prevents selection bias, although this also means that the researchers have a lack of control in terms of applying any inclusion and/or exclusion criteria. Furthermore, a limitation from using regression analysis is that it does not allow one to discern whether a third or fourth factor may have manipulated the link between any two variables studied (e.g. ethnic density and odds of reporting psychotic symptomatology). Another methodological limitation of the study is in the fact that the researchers extrapolated results from two separate populations (using two separate surveys, both of which were conducted at different time frames, and were then corroborated to the 2001 census) to derive a single, unified conclusion. This demands that the findings are interpreted with caution.

A different study investigated help-seeking and pathways to mental health care and their relationship with ethnicity (Morgan et al, 2005). The study was based on previous knowledge that compared with White patients, African-Caribbean and Black African patients in the UK are more likely to come into contact with mental health services through more negative routes, such as the criminal justice system or compulsory admission, rather than through GP referrals. Data was collected from White British, other White, African-Caribbean and Black African who presented with first episode psychosis, and had come in contact with mental health services within two years of presentation. Data relating to pathways to care were collected from the Personal and Psychiatric History Schedule (provided by World Health Organisation) and information regarding who initiated help-seeking and the referral pathway to mental health services was sought from patients, family, friends and professionals (via case notes). Additional socio-demographic information was also collected in order to control potential confounding factors such as gender, education level, employment status, etc.
The study found remarkable differences between ethnic groups in terms of their pathways to mental health care, such that only 26% of African-Caribbean and 21% of Black African patients were referred by their GPs in South-East London regions compared with 40% of the White British patients. On the other hand, criminal justice agencies were involved in the cases of 35% of African-Caribbean and over 40% of Black African patients, compared with 20% of White British. All of these differences were found to be statistically significant. Additionally, they found that in cases where criminal justice agencies were involved, family and friends of patients were significantly more likely to be the ones seeking help to police for the African-Caribbean and Black African patients compared with the White British patients. In terms of help-seeking by the patients themselves, African-Caribbean and Black African patients were less likely to seek help themselves, compared with White British. Further logistic regression analyses revealed that many variables including ethnicity, male gender, living alone, self-initiated help-seeking, family involvement were associated with an increase and decrease in the odds of accessing psychiatric care through GP referrals, thus suggesting that multiple factors are involved in the process. However in using a process like this, we cannot say which one factor has a greater effect, and whether other factors, not considered in this study, may have also had an influence in determining why ethnic minority groups do not favour this particular pathway to care. Perhaps interviewing some of the patients may have been useful in eliciting some of the reasons for this. With regards to accessing mental health services through the criminal justice system, there was a strong link between ethnicity (being African-Caribbean and Black African) and criminal justice agency referral, with a lack of family involvement being the most influential determinant of accessing care via this route, thus suggesting family and friends involvement may prevent criminal justice intervention for this group of patients. Again, interviewing some of the
family members may have shed some light on the nature and frequency of family involvement that may be necessary.

This study carries much strength in its large sample size of 462 patients, giving it statistical power, though one should note that there were far more data from White British patients compared with the ethnic minority groups. A second strength of the study lies in the fact that the authors have gone beyond merely establishing a link between ethnicity and route of referral to mental health services, by attempting to understand what factors may be determining any differences between the ethnic groups. The use of logistic analyses also meant that potential confounding factors can be taken into consideration. The study however has not considered what role culturally determined constructions of mental illness may have played in shaping how mental health services are viewed and how help is sought.

Discussion

Summary of Review and the position of help-seeking in the Nepalese community

This review aimed to evaluate the available evidence on the role of help seeking for mental health problems in the Nepalese community, but also extended the search to South Asian and other black and ethnic minority populations of the UK, in the last 10 years. Of the studies reviewed herein, only some of them looked directly at factors that influence help seeking amongst ethnic minority groups, though all have highlighted something important about what can encourage or deter ethnic minority groups from seeking help for mental health problems. What is clear from the studies evaluated is that ethnic minority groups are unlikely to speak to their GPs about their mental health concerns, however we are not sure where these beliefs come from, and whether, for the Nepalese people especially, this is a reflection of the society in their home country. The studies reviewed have indicated that ethnic minority groups, especially the Nepalese and other South Asians (e.g. Indians), are discouraged from help seeking for mental health problems due to fears of perceived shame and community (or
family) gossip. As such, help seeking is seemingly avoided as a way to protect families’ reputation in the community, marriage prospects, and prevent experiences of being socially isolated. It was also realised that ethnic minority groups are likely to adopt different pathways to receiving mental health care (e.g. speaking to community leaders and religious figures) or rather fall into more negative pathways to accessing mental health services (e.g. through criminal justice systems), both of which seem to influence future help seeking decisions.

Mental health problems were in some cases interpreted differently by some ethnic minority groups, for example, many apparently somatised their symptoms or potentially ignored ‘distress’. However, it should be noted that these understandings were derived largely from the perspectives held by healthcare professionals, rather than the ethnic group themselves. It was also found that help seeking for mental health is not influenced by ethnic density (Becares & Das-Munshi, 2013).

There were however many methodological errors within the studies (see results section) which reduce the reliability or credibility of the findings, where appropriate. For example, of the two studies conducted on the Nepalese population of the UK, one major shortcoming was that both looked specifically at those living in Aldershot town. Though Aldershot is home to a large Nepalese community, we are not sure how those living in other areas of the UK deal with mental health concerns. Nonetheless, it is clear that more studies need to be carried out on how Nepalese people living in the UK view help seeking when it comes to mental illness, in order to further understand why there is a lack of awareness of mental health services for example (Amani, 2012) and why there is a delay in the diagnosis of mental illness for this group (Casey, 2010).

Additionally, there were inconsistencies in how participants’ ethnic identity was recorded, with different studies adopting different systems for doing this. As identified earlier, using census data may not always be reliable, as many ethnic minority groups are often grouped
into the same category. Some of the studies have relied on self-reported ethnicity, which may make it more reliable but what has not been considered in any of the studies is that ethnic identity that is self-assigned is likely to change from generation to generation. A first generation immigrant is likely to maintain the ethnic identity and health beliefs that was present in their culture of origin, whereas second-generation migrants are more likely to adopt the values of the new culture, one in which they were born and brought up (Suresh & Bhui, 2006). This can lead to changes in how an ethnic individual or group identifies him/herself, which will not easily be captured by pre-determined ethnic categories.

*Are cultural differences in help-seeking sufficiently considered?*

Mental illness is a common phenomenon that exists across many cultures and geographies. Nevertheless, how mental illness is understood and what is done about it differs significantly across different communities. Thus, culture is considered to play an important role in the presentation of distress and illness, which can subsequently impact the diagnosis and treatment received. Diagnosis and treatment can be further influenced by the differences in linguistics, social situation, and religious practices between the migrant population and the clinician providing care (Bhugra et al, 2011). It cannot be taken for granted that people of different cultural backgrounds may hold differing attitudes and behave very differently when it comes to seeking help for mental health problems, let alone how they may perceive mental health in the first place. The studies reviewed do not make sufficient enquiry into the specific role that culture can play in determining the decision to seek help and where to seek help.

However, even before this, efforts have to be made to understand, from the perspective of the ethnic minorities, how mental illness is viewed. This could alter how we study help seeking, and how services are adapted in the future. For example, categorising different ethnic groups into one group risks treating them through single, western perspective, which can be largely misleading and limiting.
Is mental illness a social construction?

Culture is said to influence how distress is understood and explained. It seems that in Nepal, for example, distress only becomes a problem when the behaviour appears out of control, somatic symptoms are noticeable and the person loses all awareness. Even then, the individual is not considered to have a mental health problem or a mental illness, instead he/she is labelled ‘mad’ and rejected from society. Help is still not sought because the individual has lost his/her family, and also an insight into their problem. We recognise that there is currently a shortage of studies to establish whether this pattern exists among the Nepalese migrants in the UK.

Are all age groups sufficiently considered?

Most of the studies on the attitudes and behaviour of ethnic minority groups, including Nepalese people, on help seeking for mental health problems studied the middle aged adult population. The younger and the older age groups are more or less ignored. Perhaps it is the case that the younger and the older aged individuals are less influential in certain ethnic groups when it comes to important family decisions, including those affecting mental health issues.

Future Directions

Help-seeking is a form of coping, similar to praying or consuming alcohol to relieve emotional pain, and is closely related to culture (Suresh & Bhui, 2006). As such, any assessment of help-seeking behaviour for mental health problems needs to be assessed in the context of what is culturally driven, before we analyse the opportunities available and apply strategies to improve access to primary care in clinical psychology settings. Therefore, future studies could explore mental illness as a social construction and how it may impact how help is sought by the Nepalese community. On the other hand, studies exploring the lived experience of Nepalese people living in the UK on why and how help is sought may be
beneficial in informing the way mental health services are operated in towns and cities with a highly concentrated Nepalese community.
References:


Appendix 1

Table 1: Summary of study characteristics and findings

<table>
<thead>
<tr>
<th>Study</th>
<th>Ethnic groups studied</th>
<th>Participants</th>
<th>Method and Analysis</th>
<th>Main Findings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amani, 2012</td>
<td>Nepalese (35%), Black and Ethnic Minority (not-specified) (14%), White British (51%)</td>
<td>Ranged from 11-70, majority=41-50</td>
<td>Survey Percentages</td>
<td>Knowing someone with a mental illness:- White British (WB): 89% Nepalese (N): 26% Previously accessed mental health services:- WB: 46% N: 15% 63% of Nepalese had not heard of any mental health services Themes: Stigma; Somatisation; Delay in Diagnosis</td>
</tr>
<tr>
<td>Casey, 2010</td>
<td>Nepalese Community Members, Health Professionals</td>
<td>Focus Groups and Interviews Thematic Analysis</td>
<td>Themes: ‘Shame, fear and secrecy surrounds mental illness’; ‘Causes of mental health problems are often’</td>
<td></td>
</tr>
<tr>
<td>Bradby et al, 2007</td>
<td>South Asians</td>
<td>Individuals with mental illness and carers; Group 2: Extended family members</td>
<td>Themes:-</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Adults with children from the community (n=35), Families of service users (n=7); Health care professionals (n=7);</td>
<td></td>
<td>Stigma of mental illness and fear of gossiping served as barriers to help seeking; Families of service users made efforts to minimise gossiping, and perceived mental illness as curable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Group 1: Individuals with mental illness and carers; Group 2: Extended family members</td>
<td></td>
<td>misunderstand’; ‘The family can be both caring and isolating’; Social pressure to conform’; ‘Marriage prospect can be ruined’</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pakistani South Asians (n=13): 55-74 years</td>
<td></td>
<td></td>
<td>Themes relating to access to</td>
<td></td>
</tr>
<tr>
<td>Bristow et al, 2011</td>
<td>Chinese (5), Somalian (3), Irish (4), South Asian individuals (5)</td>
<td>Families of potential service users (n=5)</td>
<td>path = families of potential service users</td>
<td>BME</td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------------------------------------</td>
<td>---------------------------------</td>
<td>--------------------------------</td>
<td>------</td>
</tr>
<tr>
<td>Becares and Das-Munshi, 2013</td>
<td>White, British, Black, Caribbean, Indian, Pakistani, Bangladeshi, Irish</td>
<td>Survey respondents: EMPIRIC, n=7798, Citizenship CS, n=9691 and further n=4390</td>
<td>nationally representative surveys: EMPIRIC, EMPIRIC, Citizenship CS, n=9691 and further n=4390</td>
<td>primary care: Conceptualising distress; seeking help; barriers to help-seeking; navigating and negotiating services</td>
</tr>
<tr>
<td>Morgan et al, 2005</td>
<td>White British (WB), African-Caribbean (AC) and Black African (BA) patients within 2 years of presentation;</td>
<td>Psychotic Screening Questionnaire used to assess psychosis Regression Analyses Socio-demographic information taken via interviews of patients, and case notes, using Medical Research Council Socio-demographic Schedule.</td>
<td>South East London: WB 40% AC 26% BA 21% Nottingham: WB 42% AC 21% Referral via criminal justice system South East London: WB 20% AC 35% BA 40% Nottingham = similar data but not statistically significant</td>
<td></td>
</tr>
</tbody>
</table>
Clinical data collected using Schedule for Clinical Assessment in Neuropsychiatry, ICD-10 diagnostic criteria, Personal and Psychiatry History Schedule

Univariate analysis (chi squared and odds ratio) and Multivariate analysis (logistic regression)
Stage 1: Initial searches (various databases)
Total papers: $110 + 10 + 40$

Stages 2 and 3: Screening titles and abstracts to check for inclusion and exclusion criteria
Total Papers: 12

Stage 4: Full texts read
3 papers excluded
Total Papers: 6

Papers identified by other means, inclusion and exclusion criteria met and full text read:
1 paper through Google, Google Scholar
1 paper through personal correspondence
2 papers through searching citations for relevant papers

Total Papers included: 7

Figure 1: Flow chart to demonstrate stages of identifying papers
Summary of clinical experience

Year 1 – Adult Mental Health

In my first year, I was on placement in a Community Mental Health Team for working adults for 1 and a half days a week, and in an Early Intervention in Psychosis (EIIP) team for one day a week. Over the year, I gained experience of carrying out psychological assessments with individuals and families (jointly with supervisors, with colleagues and on my own), developing cognitive behavioural formulations, and Cognitive Behavioural Therapy for anxiety (social and generalized), depression, low self-esteem, and psychosis, narrative therapy for psychosis, learning about family work carrying out memory and cognitive assessments, co-facilitating a CBT Skills group, and presenting to the team on assessment and treatment of internet addiction. SRRP

Year 2

For the first six months I was at a Child and Adolescent Mental Health Service (CAMHS) for three days a week. The experience gained on this placement included: psychological and team assessment of children, their families and adolescents; conducting a developmental history; screening for autism and ADHD; working with teachers and carers; psychoeducation sessions with parents on autism and sleep; carrying out psychological treatments with children for anxiety (mainly social) using adaptations from CBT and Narrative therapy; CBT for Depression and self-harm; CBT for social anxiety and CBT for Obsessional Compulsive Disorder adolescent clients; carrying out various cognitive assessments appropriate for children; participating in a mother and infant supervision group (10 weeks); presentation to team on using mindfulness approaches with children and young people; and carrying out play therapy based on an attachment model with a five year old client.
For the second half of the year (six months) I was on placement in a community mental health team for Older Adults, with combined memory clinic service and challenging behavior service, for three days a week. Experience gained on this placement included: assessment and treatment based on CBT model (for anxiety and depression mainly; adapted for people with memory difficulties); carrying out risk assessments; developing an individualised and integrative formulation with a couple (one of the couples was presenting with hallucinations characteristic of parkinsonian dementia); conducting comprehensive neuropsychological assessments (to assess for presence and type of memory impairment); post-diagnostic counselling; challenging behaviour assessment with clients in residential care home; formulation session with groups of care home staff; developing care plan with care home staff; delivering challenging behaviour training to care home staff; and supervising assistant psychologists.

Year 3

For the first six months of my third year, I was on a specialist placement in an EIIP team for three days a week. The experience gained on this placement included: joint assessment with psychiatric nurses and psychiatrist of individuals referred to the EIIP team to establish presence of psychosis; formulating with clients and team members (e.g. in team meetings); consulting to the team; carrying out individual psychological assessment with clients; carrying out carers assessment; engaging in family work with psychologist colleague; CBT with clients with bipolar disorder, psychosis; depression and anxiety (social); staff training on anxiety; presentation to the team on similarities and differences between psychosis and OCD; and designing plus delivering (with supervisor) a one-day psychoeducation group session for clients with a bipolar diagnosis.
For my final six months of my third and final year, I was on placement in a adults community learning disability team for up to four days a week. On this placement, the experience I gained included: psychological assessments for difficulties such as post-traumatic stress disorder, generalized anxiety and anger problems; use of outcome measure appropriate for people with learning disabilities (for psychological difficulties); carrying out risk assessment, observation of clients thought to be challenging in residential setting and day care services; working with carers and families (assessment and consultation); delivering CBT for anxiety adapted for individuals with LD; developing and implementing behaviour support plan for clients thought to be challenging to others (based on the positive behaviour support model); carrying out cognitive assessment (to contribute to care plan and/or to establish diagnosis of learning disabilities); contributing towards best interest meetings for clients; and presenting to the MDT team on a draft service model (transforming care for people with learning disabilities and/or autism who have mental health difficulties and/or behaviour that challenges).
### Table of Assessments – Year I, II and III

**Year I Assessments**

<table>
<thead>
<tr>
<th>PROGRAMME COMPONENT</th>
<th>TITLE OF ASSIGNMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fundamentals of Theory and Practice in Clinical Psychology (FTPCP)</td>
<td>Short report of WAIS-III data and practice administration</td>
</tr>
<tr>
<td>Research –SRRP</td>
<td>A service-related research project evaluating the effectiveness of an Obsessive Compulsive Disorder (OCD) group therapy programme for individuals diagnosed with OCD in a Community Mental Health Recovery Service (CMHRS).</td>
</tr>
<tr>
<td>Practice case report</td>
<td>Cognitive behavioural assessment of a young woman presenting with difficulties of low self-esteem</td>
</tr>
<tr>
<td>Problem Based Learning – Reflective Account</td>
<td>Relationship to change</td>
</tr>
<tr>
<td>Research – Literature Review</td>
<td>Help-seeking attitudes and behaviours amongst the Nepalese and other South Asian population of the UK. A literature review.</td>
</tr>
<tr>
<td>Adult – case report</td>
<td>A case report of on-going relapse prevention work on a client with previous episodes of psychosis, based on the principles of cognitive behavioural therapy</td>
</tr>
<tr>
<td>Adult – case report</td>
<td>Cognitive behaviour therapy with a lady in her early 30s aimed at facilitating her recovery from a first-episode psychosis.</td>
</tr>
<tr>
<td>Research – Major Research Project Proposal</td>
<td>A qualitative exploration of help-seeking behaviour amongst Nepalese youths living in the UK</td>
</tr>
<tr>
<td>PROGRAMME COMPONENT</td>
<td>TITLE OF ASSESSMENT</td>
</tr>
<tr>
<td>---------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Research</td>
<td>Research Methods and Statistics test</td>
</tr>
<tr>
<td>Professional Issues Essay</td>
<td>The diagnostic category of Developmental Trauma Disorder was not included in the DSM-V. Critically review the implications of such a decision for clinical psychologists, service users and carers across the life span. Discuss alternative understandings of such distress.</td>
</tr>
<tr>
<td>Problem Based Learning – Reflective Account</td>
<td>Reflective account on a problem-based learning titled ‘The Stride family’</td>
</tr>
<tr>
<td>Child and Family Case Report</td>
<td>Play therapy with a young boy with behavioural and emotional regulation difficulties</td>
</tr>
<tr>
<td>Personal and Professional Learning Discussion Groups – Process Account</td>
<td>Personal and Professional Learning Discussion Groups (PPLDG) Process Account</td>
</tr>
<tr>
<td>Older People - Oral Presentation of Clinical Activity</td>
<td>Oral case presentation on formulation session with care home staff</td>
</tr>
<tr>
<td>PROGRAMME COMPONENT</td>
<td>ASSESSMENT TITLE</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------</td>
</tr>
<tr>
<td>Research – MRP Portfolio</td>
<td>How do young Nepalese people living in the UK make sense of mental health and problems of mental health: a qualitative exploration</td>
</tr>
<tr>
<td>Personal and Professional Learning – Final Reflective Account</td>
<td>On becoming a clinical psychologist: A retrospective, developmental, reflective account of the experience of training</td>
</tr>
<tr>
<td>People with Learning Disabilities – Case Report</td>
<td>Neuropsychological assessment of a young man in his twenties</td>
</tr>
</tbody>
</table>