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Exploring Perceptual Changes and Stigma Relating to Mental Health and Wellbeing within the South Asian Community

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ABSTRACT

Within the South Asian community, there is a negative perception towards mental health and psychological wellbeing (Amri and Bemak, 2012). This can have an impact on the older generation due to cultural beliefs; however the younger generation are more accepting in today's Western society. Therefore, this study aims to explore the South Asian community's perception on mental health and wellbeing, specifically mental illnesses; to understand why these stigmas exist, to discover whether these negative perceptions have transitioned to the younger generation of the South Asian community. Six females from South Asian origins were recruited using purposive sampling, between the ages of 18 – 24. Six semi-structured interviews were conducted to obtain data, which were transcribed for the interpretative phenomenological analysis (Smith and Osborn, 2003). Three superordinate themes were developed, firstly the theme 'Judgement': *Shame, Hindering Marriage Prospects and Hidden Secrets.* Secondly, 'Religion': *Blame and Power of the Imaam.* Thirdly, Generational Differences: *Acceptance, Dismissive and Western v Eastern*. The findings indicated that stigma towards mental illness still exist within the South Asian community. Moreover, the findings demonstrated that there is judgement from the community and within the family. Therefore, the negative views from the older generation are slowly being implemented upon the younger generation.

KEY WORDS:	SOUTH ASIAN COMMUNITY	MENTAL HEALTH	RELIGION	GENERATIONAL DIFFERENCES	STIGMA

Introduction

The relationship between the South Asian community in terms of their culture and psychological well-being has been studied extensively (Gunasinghe, 2015; Islam et al., 2014). Culture refers to a set of beliefs, morals, values and behavioural agreements that are shared by the South Asian community and these sets can influence their behaviour and their interpretations of the meanings of other people's behaviour (Spencer-Oatey, 2008). Whereas, psychological well-being is the ideology of overall life satisfaction, being content with life and expressing happy emotions internally and externally (Taylor, 2015). However, Dodge et al (2012) argues that psychological well-being is a broad concept; therefore it is challenging and complex to obtain a precise definition as it is perceived differently.

Mental Health and Psychological Well-being

Mental health and psychological well-being are deemed to be synonymous, although different in terminology; they are often associated together, as psychological well-being can be perceived as positive mental health (Wnuk and Marcinkowski, 2012).

Psychological well-being is known as the combination of both functioning effectively and being in an affective state of hedonism. The eudaimonic perspective explains well-being as a state in which an individual is fully functioning in its optimal effectiveness (Deci and Ryan, 2008).

Whereas, mental health is an individual's mental functioning performing successfully, therefore having the ability to adjust and adapt to changes and manage with hardships and difficulties (Johal and Pooja, 2016). However, mental illnesses occurs when conditions distresses cognition, behaviour and emotions such as depression, anxiety and schizophrenia (Manderscheid et al., 2010).

The prevalence of mental illnesses within South Asian people have shown that 22.9% of Pakistani and Bangladeshis are at risk of poor mental health compared to the 14.6% of White people in 2012 (The Equality and Human Right Commision, 2015). This is evident as a survey of 740 people consisting of South Asian people, Africans and Caribbeans had indicated that 49% had depression in which 61% were Indians and 55% were Pakistani or Bangladeshis (Rehman and Owen, 2013). This is further supported by the 2014 Adult Psychiatric Morbidity Survey, as 17.9% of South Asians had a mental illness compared to 17.3% White British people, mostly attributed to women (23.6%) (McManus et al., 2016).

Conversely, it has been argued that statistics on the number of South Asians with mental illnesses are inconsistent due to small sample sizes, therefore making it difficult to obtain reliable conclusions (Dogra et al., 2012); as Pakistanis are mostly accounted as a majority for South Asians; therefore statistics may disregard Indians and Bangladeshis (Kapadia et al., 2016). However, South Asians, particularly Bangladeshis are less likely to interact with their general practitioner about their issues, therefore be disadvantaged to obtain appropriate healthcare (Memon et al., 2016).

Mental Illness Stigma within the South Asian Culture

Within the South Asian culture, lies a social stigma towards mental health by a set of cultural norms and values (Markus and Kitayama, 2010), rejecting vulnerability and

emotions that exhibit weakness (Kramer et al., 2002), thus creating a barrier to retrieving psychological help (Islam et al., 2014). Stigma occurs when an individual is associated with a negative situation or characteristic, therefore disqualified from social acceptance (Thara and Srinivasan, 2000; Goffman, 1963). Goffman (1963) stated that individuals with mental illnesses are frequently linked to negative characteristics such as disloyal, dishonest and unstable for no reason, other than the label of mental illness that has been attached to them in society (Crisp et al., 2000).

Mental illness is perceived as a taboo subject as it can disrupt one's izzat (honour) in the South Asian community; therefore labels are avoided to prevent negative consequences (Kishore et al., 2011). The South Asian community tends to be collective, thus one's social status and image is seen imperative to uphold; hence mental illness is likely to be hidden and repressed from the community. Research has indicated that cultures from Bangladesh and Pakistan perceived mental health problem as shameful and loss of face (Amri and Bemak, 2012); as the association between mental illness and the feeling of shame can act as a deterrent to treatment, to avoid being social excluded (Corrigan and Kosyluk, 2014). This is demonstrated by Shiek and Furnham (2000), as they used 287 adults from three different cultural groups (Western European, British Asian and Pakistanis) to complete two questionnaires; the Orientations to Seeking Professional Help (Fischer and Turner, 1970) and the Mental Distress Explanatory Model Questionnaire (Eisenbruch, 1990). The results indicated that within the South Asian community, culture is not a significant variable for positive attitude to seeking mental health services.

However, South Asian cultures are deemed collectivistic as it promotes interdependence and social cohesion within the family system (Chadda and Deb, 2013). The close family bond demonstrates emotional and practical support towards the individual with mental health problems. Hence, no requirement of health services is needed (Chaudhry, 2016). Though, Brar (2012) argues that culture, family honour and religion usually dominates one's decision making, thus seeking help for one's mental health can be rejected by the family due to the stigma.

Within the South Asian culture, marriage is highly valued (Brar, 2012). Hence, admitting to a mental illness can be jeopardising to an individual's marriage prospect especially women, which could maintain internalised stigma (Moses, 2014). Tabassum et al (2000) examined attitudes towards mental health issues among Pakistani families and found that none of the participants would consider a spouse with a mental illness. This is further reinforced by Van-Brakel and Miranda-Galarza (2014) as it has been exhibited that families would examine the potential bride or groom and their families for any unwanted characteristics, such as mental illness. Thus, this inhibits women from pursuing help from therapists to avoid the negative consequences which then causes distress to their own wellbeing (Ciftci et al., 2012).

Religion and Spiritual beliefs

Many South Asians use religion and superstitions to explain mental illness, or a way to place blame on the individual with mental illness (Brar, 2012); such as spiritual claims e.g. lack of faith, bad karma and the evil eye. In terms of religious belief, a person with mental illness is perceived as "crazy", or has lost their faith in God (Amri and Bemak, 2012). As Lauber and Rossler (2007) obtained Sikh, Hindu and Muslim participants and found that they believe mental illnesses were caused by God, black

magic and evil eye (nazar) which is jealousy from another person or spirits. Also, treatments involve religious holy men (imaam) portrayed as Islamic healers to such mental health illness such as depression (Hussain and Cochrane, 2004) and Hindus and Muslims would seek advice from a religious advisor (Suhail, 2005; Cinnirella and Loewenthal, 1999). Thus, the negative perspective on mental health and psychological wellbeing could be due to how the South Asian community perceive religion as a cause, and how it plays an important role in their everyday life.

However, Padela et al (2012) claims that Imams can positively shape South Asian's attitudes towards mental illness. A study conducted by Abu-Ras et al (2008) in which they interviewed 102 worshippers, 22 mosque members and 22 imams and found that they had a vital role in encouraging positive psychological wellbeing to those affected after the 9/11 attacks. This is further supported by Ali et al (2005) which indicated that each week, 95% of the 62 imams reported spending substantial time providing counselling to their devotees. Thus, religion may not entirely be the reason as to why there is a stigma towards mental health, but it could depend on how those within the South Asian community interpret their religion in terms of mental health. Religion is a way of coping with mental illness (Dein and Bhui, 2013).

However, these factors can take the blame away from the individual that is experiencing the mental health problem and inserting all the blame on superstitions. Thus, portraying the individual as someone who is helpless and unable to recover which reduces their empowerment, which is detrimental for their well-being and recovery (Roe et al., 2014)

Generational differences

Parents are vital influencers in affecting children's preconceptions at a young age (Priest et al., 2014). It has been exhibited that second generation South Asian women were more likely to hold on to their ethnic culture, that was imposed by their first generation older family members (Inman, 2006). This was demonstrated in Abe-kim et al (2007) that first and second generation immigrants are unlikely to use mental health services, whereas third generation raised in western culture would use mental health services. This was further supported by Knifton (2012) who found that first generation members of Pakistani and Indian participants, were more committed to their traditional beliefs and stigma towards mental illness was evident within the older generation as they associated it with shame and madness (Tabassum et al., 2000).

Moreover, the culture clash between the older parental generation and second generation South Asian youths were recognised as risk factors for mental illness such as stress, depression, identity loss and anxiety; as past experiences of the older generation were inflicted upon the younger generation (Islam, 2012). Nevertheless, the older generation struggled with challenging matters when migrating into a new country with a new culture. These challenges included language barriers, finding employment, dealing with discrimination and gaining access to health care (Roberts et al., 2015). In conjunction with this, they are also trying to live up to the model minority myth; which could induce distress to their psychological wellbeing (Inman et al., 2015).

Additionally, Loya et al (2010) indicated that South Asian college students expressed personal stigmas towards psychological counselling and less positive attitudes

towards counselling than Caucasian students. Therefore, this raises questions whether the older generation's negative perception towards mental health in general, have been transitioned to the younger generation i.e. their children, students. But, these samples have used American South Asian students, but not many researches has been done in England to understand whether British Asians choose to fully adopt values of their traditional South Asian culture or choose to integrate it.

Research Aims and Questions

This research aims to comprehend whether the South Asian community have a negative stigma towards mental health. To understand why these negative perception exist within the older generation. But most importantly to understand whether these negative perceptions from the older generation have been transitioned to the younger generation. This research project will hopefully have some sort of response these research questions and gain rich in-depth data.

Methodology

Design

The design of the study was qualitative as this research encompasses an explanatory and naturalistic attitude to the world (Denzin and Lincoln, 2005). Qualitative studies enable individuals to express themselves without conforming and categorising their response to specific terms imposed by others such as the researcher or past researchers (Sofaer, 1999).

Semi-structured interviews were utilised as the focus was on psychological well-being, which can be subjective, therefore every participant had different opinions and perspectives. Semi-structured interviews allowed the participants to be personal and the interviewer used questions to produce in-depth stories and first person accounts (DiCicco-Bloom and Crabtree 2006).

In addition, the interviews used prompts to allow rapport between the interviewer and interviewee to be established, allowing participants to be comfortable to not feel reluctant to withhold information which allowed a conversation flow to occur (Lavin and Maynard, 2001). Subsequently, this aided the data because there was a level of trust, leading the respondent to uncover new dynamic in the narrative of information retrieval (Blohm, 2007) to which the interviewer was not initially aware of.

The interview schedule had up to eight questions with prompts (APPX 2), due to the flexibility, semi-structured interviews required open-ended questions. This was used as a guide for the interviewer but it was encouraged to allow the participants to lead the conversation (Pietkiewicz and Smith, 2014). Flexibility between the interviewer and interviewee was accessible as interviewees were able to elaborate on a particular issue and ask questions if they did not understand the question (Gubrium and Holstein, 2002). Therefore, a structured layout would have been inappropriate as it limits the richness and depth of the responses (Dornyei, 2007).

Participants

Six women from South Asian backgrounds took part in the study (*M*age = 21.50 years, *SD* = 2.07) and they were recruited through purposive sampling. The research involved specifically selecting students from a South Asian background as they had some experience or were knowledgeable of the phenomena (Cresswell and Plano Clark, 2011). Moreover, this sampling method drawn participants who were willing to articulate and express their thoughts, opinions and experiences about how psychological distress/ diagnoses in mental health is perceived in the South Asian community (Bernard, 2002).

The participation pool was utilised to obtain South Asian students aging from eighteen to twenty-four years old. Six participants participated in the interviews as it exhibited a more defined group because the research is primarily focused on the South Asian community perspective (Smith and Osborn, 2003). The invitation letter (APPX 3) was available to the participants beforehand and once they had been recruited, they were given an information sheet (APPX 4). The information sheet was provided to ensure participants were fully aware of the research project in terms of its aims, objectives and why they were important to the research project.

Recruiting six participants allowed the researcher to have adequate engagement with each participant which allowed a rich, detailed and in-depth analysis consisting of potential similarity and difference. Furthermore, if the sample size had too many participants, it would be difficult to produce sufficient analysis due to the immense amount of data (Smith and Osborn, 2003).

Table 1: Participant Information

Pseudonym	Age	Ethnicity
Anisah	21	Bangladeshi
Jasmin	21	Bangladeshi
Laila	18	Indian
Maria	22	Pakistani
Nafisa	24	Pakistani
Sana	23	Pakistani

Data collection methods

Interviews lasted between 40 to 52 minutes (Mminutes = 44 minutes 59 seconds, SD = 4.48) and were collected using a Dictaphone to record each interviews. Before conducting the semi-structured interviews, consent forms (APPX 5) were given to ensure participants were aware of the research. As the research was qualitative, it was vital to make sure that every response was recorded because the importance lays within the interviewee's responses especially their tone of voice i.e. the way they say it. Therefore, it was essential to obtain a full account of the interviews. Moreover, it would have distracted the interviewees if the researcher was writing out the response during the interviews (Bryman, 2012). Furthermore, the researcher would have not been able to give the interviewee their full attention; therefore, not noticing any inconsistences in the interviewee's answers and missing out interesting points (Bryman, 2012). Afterwards, a debrief form (APPX 6) was given, to ensure anonymity of the data.

Data analysis

Once the interviews were conducted, it was then transcribed and prepared to be analysed using Interpretative Phenomenological analysis (IPA). According to Knight et al (2003), IPA emphasises the individuals' personal, subjective perception and relies on the importance of the interpretation given by the participants, due to IPA's theoretical foundations, which lie in symbolic interactionism plus phenomenology (Smith and Osborn, 2003). In other words, participants can explain and apprehend their reality in a form of their own biographical stories that makes sense to them (Brocki and Wearden, 2006). These interpretations relied on the participants' capabilities to express and articulate their beliefs and experiences sufficiently and adequately (Baillie et al., 2000). Therefore, this allowed the

researcher to explore the responses given by the participants and apprehend their opinions on the South Asian community's perspectives of mental health.

In the process of analysing the transcripts, the researcher was mainly interested in learning about the participants' psychological world, i.e. beliefs and paradigms made patent or suggested by the individual's talk (Smith, 2007).

Smith and Osborn (2003) describe the process of analysing a transcript using IPA. Firstly, the transcript was read numerous times as each reading may exhibit new insights and there may be commentary on the language that is used by the participants. In addition, there may be similarities and differences in the transcript, therefore potential contradictions or elaboration exhibited. The left margin was utilised to annotate any line that is seen as interesting or significant about the participants' responses.

Secondly, the analyst re-read the transcript from the beginning, where emerging theme titles were written on the right margin. The aim of the themes was to capture essential qualities of the interview (Biggerstaff and Thompson, 2008). This is usually where psychological terms and concepts may be used in IPA (Willig, 2001) but at the same time, themes from different section may have a theoretical connection with one another or even from a different transcript. Within the transcript, there may have been a theme or a section that did not have any connection with other transcripts that have been read and analysed (Smith et al., 1995); therefore, it was vital to revisit earlier transcripts to ensure nothing has been misunderstood or even missed out (Biggerstaff and Thompson, 2008).

Thirdly, this stage involved the researcher to put the themes into concepts and/or clusters. Thus, this identified super-ordinate categories that advocated a hierarchical relationship between themes (Biggerstaff and Thompson, 2008).

Lastly, the analyst produced a table consisted of essential focal themes, ordered logically. These vital themes were produced from the range of clusters that were identified in the third stage therefore; these clusters of themes best capture the participants' responses most strongly and significantly. In this stage, the role of the analyst was to match up participants' quotes along with the annotations to each of the superordinate theme that were formed along with the line number of the quote (Smith and Osborn, 2003). The evidence that supports the theme can be a range of quotes unveiling emotions and thoughts about the participants' experience and knowledge of the phenomenon being explored (Biggerstaff and Thompson, 2008).

Justification for a chosen methodology

The research project was to explore the perceptual changes of psychological wellbeing within the South Asian community in terms of the stigma around mental health. The use of semi structured interviews allowed the interviewees to explore new and/or existing attitudes, experiences and have the benefit of revealing arguments and matter of contention that has not been foreseen by the researcher or even from past literature. Thus, this aided the interviewer/ researcher to produce richer in-depth data (Bryman, 2012). Moreover, this gained a diverse collection of information in terms of the outlooks, considerations and meanings created by the participants, regarding stigma towards psychological distress and the perceptual changes within the South Asian community (Biggerstaff and Thompson, 2008).

Although, mental health studies involving qualitative methods were once regarded as unscientific (Hopper, 2008); this viewpoint began to change, due to the recognition that more insight and awareness is obtained using qualitative methods (Berwick, 2000) e.g. qualitative research can enable to categorise social and cultural factors that affect the perspective of mental health and mental health in general, either positively or negatively (Bryman, 2012). Thus, this aids to classify obstacles and difficulties within the South Asian community; which is essential for change to occur, in terms of the perception towards psychological distress/ diagnoses in mental health conditions (Trivedi et al., 2008).

Furthermore, IPA allows the researcher to focus on the participants' understandings, experience, views and perception of the phenomena (Ried et al., 2005) and provides more in-depth insight than thematic analysis which will help provide answers within the healthcare research. As the views from the South Asian community are difficult to reach and understand why these stigma may exist (Biggerstaff and Thompson, 2008).

Ethical consideration

Before conducting the interview, approval for the Application for Ethics Approval (APPX 1) was obtained from the supervisor. Once it has been accepted, participants were recruited through the participation pool. The recruited participants were given an information sheet (APPX 4) and a consent form (APPX 5). The consent form consisted of terms of what they were agreeing to, that is if they wanted to take part. Their data were not be fully confidential, as quotes obtained from their data were used in the analysis. However, only the researcher had access to these data, which were all in a password-protected computer. In addition, their identity remained anonymous, as participants were given the chance to make up their own pseudonym. The interviews were held in a room in Birley campus during working hours (Mon – Fri), as it was a safe environment and had a calm atmosphere. If, during the interview, the participant felt uncomfortable or distress; it was the researcher's responsibility to follow the Manchester Metropolitan protocol. The protocol required the researcher to stop the interview and check on their wellbeing, if they were good to continue, the interview would resume. If not, the researcher would have escorted them out of the room to a safe environment. The debrief form and information sheet had contact details of MMU counselling, The Samaritans and Nightline hotlines will be provided to the participants. As all of the six interviews went well as planned, the participants were given a debrief form (APPX 6) which had their own anonymous code. This enabled the researcher to identify the participant if they chose to withdraw from the study. However, they had the right to withdraw ten days after their interview had been conducted.

Analysis

The findings suggest that there is a negative stigma towards mental health, which has attributed to the themes obtained. Also, there were clear differences between the older generation and younger generation.

Theme 1: Judgement – "everyone likes to hear the bad things about people... it's almost like a self-gratification" (Nafisa)

A predominant phenomenon within the transcripts was that participants were imposed to keep mental health problems hidden to avoid shame and the judgement from the community.

1.1: Shame – "...not to tell our problems to others because people gossip." (Jasmin)

Within all the participants' transcripts, there were statements surrounding that mental illnesses were to remain within the family. Otherwise if it was known to the community, their family would face scrutiny; as Jasmin stated her mother was "…worried about what other people think of our family". Furthermore, Nafisa is diagnosed with depression and OCD, however her dad chooses to ignore this, as she says "…my dad has a reputation to uphold" even though she later explains that her dad had depression but found it hard to express his issues, as Nafisa claims "…he thought it made him less of a man." It has been suggested by Amri and Bemak (2012) that the stigma is not only attached to the individual with the mental illness, but it is also attached to the family itself; this discourages South Asians to seek help as it brings shame and makes one deem "weak" within the family. This theoretical process seems relevant to the participants' accounts (Sana, Nafisa, Maria, Anisah and Jasmin) in that judgement by the community and judgement within oneself were repeated. For instance, Sana explains the reason why she would not seek help "…I wouldn't really talk to anyone about it …I don't want to be seen weak" and Maria explaining why she would avoid talking about her issues "…to avoid an argument, more repercussions…" This suggests that younger members are adopting the attitudes that are being verbalised by the older members in the family, whereas Maria does not want to deal with the negative consequences, such as judgement from the community and her family. According to Chaudhry (2016), label avoidance is common within the South Asian community along with repressing stigmatising features in order to uphold a perfect image to the public. Thus, knowing the full extent of the repercussions of being labelled mentally ill such as "…being banished" (Sana), and being judged on can refrain one from seeking help (Corrigan and Kosyluk, 2014)

1:2: Hindering marriage prospects - "They're worried that we won't be able to look after their sad excuse of a son." (Laila)

The majority of the participants' data indicated that mental illness would hinder their marriage prospects, as Jasmin describes what they [community] would think "…her potential in-laws would think she's incompetent …won't be able to look after her husband or kids.". This is further demonstrated by Laila, whose sister has depression but is in the process of finding a husband, however her grandparents are keeping it

hidden because of the negative perception it comes with "…assume that my sister is lazy, she can't take care of herself…". It has been considered that those with mental illness are often perceived as lazy, unreliable and incompetent of marriage and raising children (Kishore et al, 2011). As Tabussum et al (2000), findings supported this claim, that those who have mental illness are prejudiced, and will not be considered as marriage material and prospective wife and mother.

This has been demonstrated within Anisah's transcript, as her mum suffered depression, but had left her husband, in which led to her mum [Anisah's grandma] facing detrimental repercussions from the community. "…cos of her [Anisah's mum] mental state, my grandma… faced a lot of backlash …like verbal abuse…" Therefore, this implies that within the south Asian community, there is the displacement of blame towards the mother, where there are often negative perceptions regarding 'bad genes' and 'damaged goods', as suggested by Moses (2014). This is further demonstrated by Laila as she points out that her people will assume that her "…family are all depressed", "…upbringing was messed up", the blame is mainly towards the mother within the family unit.

1:3: Hidden secrets – "… he was really close to committing suicide… no-one else knows" (Maria).

A recurrent theme throughout the participants was that there were some hidden secrets regarding mental illness and counselling sessions, for instance, Anisah has started to go to therapy but her dad is not aware, as she stated "…my dad doesn't know that ...I don't want him to think I'm crazy" . However, it was the above quote which really amplified the effect of negative judgement, which inhibits the disclosure of their mental illness, and the detrimental effect this can have towards their well-being (Brar, 2012).

This was due to negative judgement by Maria's father towards her brother. "You're such a fucking mental case! ...I hope you get locked up!" This reveals that judgements do not only exist within the public sphere, but is also predominant within the private sphere. This goes against Chadda and Deb (2013) concept of collectivism of the family structure, as they claim that it is a positive resource to recovery. Also, this goes against Chaudhry (2016) notion that due to the close-knit family dynamic within South Asian family, they can rely on each other for emotional support. Yet, the findings have suggested against this ideology, due to the concealment to avoid the stigmatising community; isolation was experienced by Maria's brother which led to a negative outcome (Moses, 2014).

Theme 2: Religion – "…she's relying on these religious preachers a lot to fix my family and our mental states" (Jasmin)

Within the transcripts, it is evident that people rely on religion to provide explanations and these can have negative effects.

2:1: Blame - "…she thought someone had cursed me" (Jasmin)

It is apparent that religion does have an immense impact, as demonstrated from the above quotations. Sana argues that within the South Asian community, individuals

manipulate religion to validate their own beliefs: "…we've got this habit of cherry-picking what we like to back up our point…even our religion says use science. The interview did not mention the word religion, however it has been expressed in a number of ways that mental illness were caused by superstitious beliefs such as "black magic" (Jasmin, Sana) plus "evil eye" (Maria) in their parents' perspective, the older generation. Consequently, inputting blame upon superstitions. This is demonstrated by Maria as she explains that her brother has adopted that mind-set: "…blame it on the evil eye … he's very externally locus of control …very damaging and I can see that". It has been suggested in the literature that the blame is removed from the individual with the mental illness, to perceive them as a victim of others' spiteful intentions, thus judgement is removed by empathy (Chaudhry, 2016; Ciftci et al., 2012) as demonstrated in Sana's data as she claims "…eliminating that excuse, what will they blame their years of struggle on? Themselves? Never?". This notion implies that those suffering from mental illnesses and blaming the causes on superstitions are seen as helpless and unable to recover, that they have no responsibility; this is known as benevolence stigma as Roe et al (2014) states that they need a benevolent authority to help them recover and is seen as a decision maker, which goes along to the next theme.

2:2: Power of the Imaam – "…religion overrides every other type of treatment." (Nafisa)

It is apparent that imaams are a preferred method for advice as exhibited in Nafisa's transcript: "…people will go to scholars, imaams (.) …rather than … a doctor." This relates to Padela et al (2012) findings in terms of religion being the central resource for healing; as most of the participants (Sana, Nafisa, Maria, Anisah) explained that these religious preachers are sought after, as Islam promotes peace and mental illness is seen as "…disturbing the peace or is an imbalance …going against that" (Nafisa). Therefore Nafisa explains that with these pre-existing negative views, it is likely that the imaams are going to result to prayers as a treatment: "…just pray, read this surah …you should feel better" as it "…agree with them [community]". People will follow the imaam's advice, even though these imaams have a lack of knowledge and expertise within this area (Ciftci et al., 2012).

Nevertheless, imaams can have a positive impact on the community in changing people's negative perception and raising awareness; as Anisah demonstrated that this happened to her father as: "…he discusses stuff with the imaan on stuff that he never used to do". The imaam (religious preacher) is seen as an authority figure as Anisah states her father: "…respects the imaam …wouldn't question the imaam." This is due to the: "…authoritative power the imaan has" (Sana) within the South Asian community. These examples highlights the authoritative power the imaams possess; through counselling and promoting mental health, the imaam can play a beneficial role in changing perceptions, and could possibly challenge the stigma within the South Asian community (Abu-Ras et al., 2008). However, there should be a balance between using religion as a coping strategy as well receiving medical advice from doctors.

Theme 3: Generational Differences – "They [older generation] kind of have a backward mentality." (Anisah)

3:1: Dismissive – "…anyone older …see it like it doesn't exist." (Nafisa)

Mental illness was viewed as non-existent, which was expressed by the participants in the study and it was dismissed through number of ways. Anisah reported that she tried talking to her father about her depression and how it has been affecting her, but her father dismissed this by telling her : "…to be grateful …you have no reason to be feeling like that." Whereas, Laila's grandparents would dismiss her sister's low moods with moodiness, therefore implying that she needs: "…to fix herself up and (.)…needs to sort her attitude." These methods the older generation are utilising to dismiss their children's mental illnesses and expressing that it is the individual with the mental illness that needs to change. Furthermore, Maria states that she doesn't communicate with her mum about her problems, as her mum may use Maria's faults being the cause of her depression: "You started smoking ...You did this…" This further inhibits the South Asian's youths to seek help, to express themselves as their own family members are reluctant to talk about it, or place the blame on the individual with the mental illness (Knifton, 2012).

3:2: Acceptance – "…most girls her ages …understands what she's going through…" (Laila)

When the older generation reportedly dismissed the needs of the participants, acceptance was gained from the younger generation. For instance Anisah explained how she found it difficult deciding whether to seek help as she states that the older generation prevented her, whereas the younger generation were: "…helping me and encouraged me to seek help." This example highlights how the younger generation are aware of mental illnesses and rather than being dismissive. This finding is similar to Gunasinghe (2015) which identified that younger generation are separating themselves from the traditional, "…close-minded" (Anisah) and the view that mental health is "not … an illness" (Maria). Jasmin explains that mental health is taken more seriously within the younger generation, due to greater awareness as she explains "…we're constantly educated about mental health …in films, schools…" she further list many more ways that mental health is promoted. Even though Priest et al (2014) states that parents can influence their children, the power of media, institutions and influencers can change individual's perception, therefore negative stigma is inhibited from transitioning to the younger generation (Chaudhry, 2016)

3:3: Western V Eastern – "…they've gone through so much but they're ok." (Laila)

Comparisons were often made by the older generation in terms of their upbringing to the younger generations as revealed by Laila, "…they've had less resources, knowledge and money than us…" However these comparisons could result to invalidating the younger members in how they feel as Laila began doubting herself: "I question myself and sister …do we have the right to feel this way?" Jasmine added that it validated her psychological distress: "…compare their life to ours … made me feel like shit… no reason to feel this way." These quotes establish that older family members often use comparisons to indicate that their situations in an Eastern culture had much more problems and stressors, therefore implying that

the younger generations have no reason to feel psychologically distressed. These comparisons can be detrimental to the wellbeing of the younger generation, as emotions were made invalid therefore, they would not seek help (Islam et al., 2014; Loya et al, 2010) as demonstrated by Anisah, "…I stay quiet. I become resilient like my parents."

Nevertheless, Nafisa claims that her dad migrating to England allowed him to become more aware of his depression: "…if he stayed in Pakistan …he wouldn't have spoken about it …he would have bottled it up" and that he has taken anti-depressants due to being part of the western society which introduced a new culture to him: "…he was part of an educated… society… more understanding.." Therefore, this demonstrates living within the Eastern society can prevent from one seeking help and acknowledging the issue within the psychology well-being (Abe-kim et al., 2007).

Discussion

Three superordinate themes were established and these were 'Judgement', 'Religion' and 'Generational Differences' which consisted of sub-themes. From this research and pre-existing research, it is clear that negative stigma stemmed from the South Asian culture is predominate within the community in relation to mental health and psychological wellbeing. The notion of rejecting emotions that exhibit weakness were heavily exhibited by the older generation (Kramer et al., 2002) which can easily be implemented; as some participants stated that they would not seek help or express their problems. Therefore this complies with previous literature (Islam, 2012; Loya et al, 2010) as they validated the idea that the older generations' views could possibly be adopted by the younger generation. Yet, these researches were conducted with Canadians and Americans, it still relates to the current findings. The authoritative power the imaam possess within in the South Asian community were highlighted as they can change one's perception, offer support and most importantly raise awareness of mental health (Padela et al., 2012). Furthermore, judgement from the community was evidently shown, however there is a lack of research that implies the risk of judgment the individual face by the family itself within the private sphere.

Limitations

There were six participants using female South Asian students. However, it is important to acknowledge that each participant's accounts had a unique viewpoint. This allowed the researcher to give full appreciation to the female participants as the interviews were up-to 52 minutes long. IPAs are often small; this enables a detailed analysis which can be time-consuming. Therefore, six was a respectable amount to allow in-depth analysis to explain a firm phenomenon, to explore similarities and differences between participants who were Pakistanis, Bangladeshis and Indians from different age ranges (Pietkiewicz and Smith, 2012). In addition, there were no male participants within this research but females are more likely to express their opinions and acknowledge the mental health stigma (McCaghy et al., 2016).

Implications

. Further research could explore whether South Asian males have similar findings to the females in this study, investigating whether they have a negative perception towards mental health and how they were implemented. Furthermore, research on the older generation of the South Asian community would be interesting to explore whether they acknowledge the negative views towards mental illnesses and how this can be detrimental to the younger generation of today's society.

Furthermore, this research can contribute to people's understanding. Institutions, mental health organisations and the South Asian community can use these findings to acknowledge that the stigma towards mental health can be detrimental; it can prevent one from seeking help. Therefore, there needs to be more awareness especially using Imaams to preach one's well-being is important and mental health awareness is essential.

Reflexive Analysis

As a South Asian student myself, it was hard not to impose my views in this research and towards the participants during the interviews. During the interview, the participants' responses validated my reasons to choose this dissertation topic. Especially, Maria's interview as it posed further interest and questions within this topic. Initially, I expected the older generation to have some negative perception but I did not realise the extent of how their views can actually dismiss their children's' well-being. Even though transcribing the interviews was challenging and time-consuming, it made me appreciate the interviews as IPA allowed more insight from the transcripts.

References

Abe-Kim, J., Takeuchi, D.T., Hong, S., Zane, N., Sue, S., Spencer, M.S., Appel, H., Nicdao, E. and Alegría, M. (2007) 'Use of mental Health–Related services among immigrant and US-born Asian Americans: Results from the national Latino and Asian American study.' *American Journal of Public Health*, 97(1) pp. 91-98.

Abu-Ras, W., Gheith, A. and Cournos, F. (2008) 'The imam's role in mental health promotion: A study at 22 mosques in New York City's Muslim Community.' *Journal of Muslim Mental Health*, 3(2) pp. 155-176.

Ali, O. M., Milstein, G. and Marzuk, P. M. (2005) 'The Imam's role in meeting the counselling needs of Muslim communities in the United States.' *Psychiatric Services*, 56(2) pp. 202–205.

Amri, S. and Bemak, F. (2012) 'Mental Health Help-Seeking Behaviors of Muslim Immigrants in the United States: Overcoming Social Stigma and Cultural Mistrust.' *Journal of Muslim Mental Health*, 7(1) pp. 43-63.

Baillie, C., Smith, J. A., Hewison, J. and Mason, G. (2000) 'Ultrasound screening for chromosomal abnormality: Women's reactions to false positive results.' *British Journal of Health Psychology*, 5(1) pp. 377 – 394.

Bernard, H.R. (2002) *Research methods in anthropology: Qualitative and quantitative approaches.* 3rd ed., Walnut Creek, CA: Alta Mira Press.

Biggerstaff, D. L. and Thompson, A. R. (2008) 'Interpretative Phenomenological Analysis (IPA): A Qualitative Methodology of Choice in Healthcare Research.' *Qualitative Research in Psychology*, 5(1) pp. 173-183.

Blohm, M. (2007) 'The influence of interviewers' contact behaviour on the contact and cooperation rate in face-to-face household surveys.' *International Journal of Public Opinion Research*, 19(1) pp. 97-111.

Brar, Mandip. (2012) *An Exploration of the Experiences of Never Married British South Asian Females in the U.K.* Unpublished doctoral dissertation. University of East London.

Brocki, J.M. and Wearden, A.J. (2006) 'A critical evaluation of the use of interpretative phenomenological analysis (IPA) in health psychology.' *Psychology and Health*, 21(1) pp. 87-108.

Bryman, A. (2012) *Social research methods*. 4th ed., New York: Oxford University Press.

Chadda, R. K. and Deb, K. S. (2013) 'Indian family systems, collectivistic society and psychotherapy.' *Indian Journal of Psychiatry,* 55, January, pp. 299-309.

Chaudhry, T. (2016) *The Stigma of Mental Illness in South Asian Cultures.* Honors Thesis. Wellesley College.

Ciftci, A., Jones, N. and Corrigan, P. W. (2012) 'Mental Health Stigma in the Muslim Community.' *Journal of Muslim Mental Health,* 7(1) pp. 17-32.

Cinnirella, M. and Loewenthal, K. M. (1999) 'Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study.' *British Journal of Medical Psychology*, 72(4) pp. 505-524.

Corrigan, P. W. and Kosyluk, A. K. (2014) 'Mental illness stigma: types, constructs, and vehicles for change.' *In* Corrigan, P. (ed.) *The stigma of disease and disability: Understanding causes and overcoming injustices.* Washington, D.C: American Psychological Association, pp. 35-56.

Cresswell, J. W. and Plano Clark, V. L. (2011) *Designing and conducting mixed method research*. 2nd ed., Thousand Oaks, CA: SAGE Publications.

Crisp, A. H., Gelder, M. G., Rix, S., Meltzer, H. I. and Rowlands, O. J. (2000) 'Stigmatisation of people with mental illnesses.' *The British Journal of Psychiatry*, 177(1) pp. 4-7.

Deci, E.L. and Ryan, R.M. (2006) 'Hedonia, eudaimonia, and well-being: An introduction.' *Journal of Happiness Studies*, 9(1) pp. 1–11.

Dein, S. and Bhui, K. S. (2013) 'At the crossroads of anthropology and epidemiology: Current research in cultural psychiatry in the UK.' *Transcultural Psychiatry*, 50(6) pp. 769-791.

Denzin, N and Lincoln, Y. (2005) *The Sage Handbook of Qualitative Research.* Thousand Oaks, CA: SAGE Publications.

DiCicco-Bloom, B. and Crabtree, B. F. (2006) 'The qualitative research interview.' *Medical Education*, 40(4) pp. 314-321.

Dodge, R., Daly, A., Huyton, J. and Sander, L. (2012) 'The challenge of defining wellbeing.' *International Journal of Wellbeing*, 2(3) pp. 222-235.

Dogra, N., Singh, S. P. and Svirydzenka, N. (2012) 'Mental health problems in children and young people from minority ethnic groups: the need for targeted research.' *The British Journal of Psychiatry*, 200(4) pp. 265-267.

Dörnyei, Z. (2007) *Research Methods in Applied Linguistics: Quantitative, Qualitative and Mixed Methodologies.* Oxford: Oxford University Press

Eisenbruch, M. (1990) 'Classification of natural and supernatural causes of mental distress.' *The Journal of Nervous and Mental Disease*, 178(11) pp. 712–719.

Equality and Human Rights Commission. (2015) *Is Britain Fairer? The state of equality and human rights 2015.* [Online] [Accessed on 3rd April 2017] https://www.equalityhumanrights.com/sites/default/files/is-britain-fairer-findings-factsheet-ethnicity.pdf

Fischer, E.H. and Turner, J.I. (1970) 'Orientations to seeking professional help: Development and research utility of an attitude scale.' *Journal of Consulting and Clinical Psychology*, 35(1) pp. 79–90.

Goffman, E. (1963) *Stigma; notes on the management of spoiled identity*. Englewood Cliffs, N.J: Prentice-Hall.

Gubrium, J. F. and Holstein, J. A. (2002) 'From the individual interview to the interview society.' *In* Gubrium, J.F. and Holstein, J.A. (Eds.) *Handbook of interview research: Context and method.* Thousand Oaks, CA: SAGE Publications, pp. 3-32.

Gunasinghe, C. (2015) *Understanding How Izzat Impacts the Lived Experiences of Young Muslim Pakistani Women in the UK: A Phenomenological Approach.* Ph.D. University of East London Professional Doctorate in Counselling Psychology.

Hopper, K. (2008) 'Qualitative and quantitative research: Two cultures.' *Psychiatric Services*, 59(7) pp. 711.

Hussain, F. and Cochrane, R. (2004) 'Depression in south Asian women living in the UK: A review of the literature with implications for service provision.' *Transcultural Psychiatry*, 41(2) pp. 253–270.

Inman, A. G. (2006) 'South Asian women: identities and conflicts.' *Cultural Diversity and Ethnic Minority Psychology*, 12(2) pp. 306-319.

Inman, A.G., Tummala-Narra, P., Kaduvettoor-Davidson, A., Alvarez, A.N. and Yeh, C.J. (2015) 'Perceptions of race-based discrimination among First-Generation Asian Indians in the United States.' *The Counselling Psychologist*, 43(2) pp. 217–247.

Islam, F. (2012) *Health equity for South Asian communities: Health services and healthy policy report.* Council of Agencies Serving South Asians (CASSA). [Online] [9th April 2017)

Islam, F., Khanlou, N. and Tamim, H. (2014) 'South Asian populations in Canada: migration and mental health.' *BMC Psychiatry*, 14(154) pp. 1-13.

Islam, F., Khanlou, N. and Tamim, H. (2014) 'South Asian populations in Canada: migration and mental health.' *BMC Psychiatry*, 14(154) pp. 1-13.

Johal, S. K. and Pooja. (2016) 'Relationship between Mental Health and Psychological Wellbeing of Prospective Female Teachers.' *IOSR Journal of Research and Method in Education (IOSR-JRME)*, 6(1) pp.1-6.

Kapadia, D., Brooks, H. L., Nazroo, J. and Tranmer, M. (2015) 'Pakistani Women's Use of Mental Health Services and the Role of Social Networks: A Systematic Review of Quantitative and Qualitative Research.' *Health and Social Care in the Community*, September pp. 1-14.

Kishore, J., Gupta, A., Jiloha, R. C. and Bantman, P. (2011) 'Myths, beliefs and perceptions about mental disorders and health-seeking behaviour in Delhi, India.' *Indian Journal of Psychiatry*, 53(4) pp. 324-329.

Knifton, L. (2012) 'Understanding and addressing the stigma of mental illness with ethnic minority communities.' *Health Sociology Review*, 21(3) pp. 287-298.

Knight, M., Wykes, T. and Hayward, P. (2003) 'People Don't Understand: An Investigation of Stigma in Schizophrenia using Interpretative Phenomenological Analysis (IPA).' *Journal of Mental Health*, 12(3) pp. 209-222.

Kramer, E. J., Kwong, K., Lee, E. and Chung, H. (2002) 'Cultural factors influencing the mental health of Asian Americans.' *Western Journal of Medicine*, 176(4) pp. 227–231.

Lauber, C. and Rössler, W. (2007) 'Stigma towards people with mental illness in developing countries in Asia.' *International Review of Psychiatry*, 19(2) pp. 157–178.

Lavin, D. and Maynard, D. W. (2001) 'Standardization vs. Rapport: Respondent laughter and interviewer reaction during telephone surveys.' *American Sociological Review*, 66(3) pp. 453.

Loya, F., Reddy, R. and Hinshaw, S. P. (2010) 'Mental illness stigma as a mediator of differences in Caucasian and South Asian college students' attitudes toward psychological counselling.' *Journal of Counselling Psychology,* 57(4) pp. 484-490.

Manderscheid, R. W., Ryff, C. D., Freeman, E. J., McKnight-Eily, L. R., Dhingra, S. and Strine, T. W. (2010) 'Evolving Definitions of Mental Illness and Wellness.' *Preventing Chronic Disease*, 7(1) pp. 1-6.

Markus, H. R. and Kitayama, S. (2010) 'Cultures and selves: A cycle of mutual constitution.' *Perspectives on Psychological Science*, 5(4) pp. 420-430.

McCaghy, C. H., Capron, T. A., Jamieson, J. D and Carey, S. H. (2016) *Deviant Behaviour: Crime, Conflict and Interest Groups.* 8th ed., New York: Routledge.

McManus, S., Bebbington, P., Jenkins, R. and Brugha, T. (eds.) (2016) *Mental health and wellbeing in England: Adult Psychiatric Morbidity Survey 2014*. Leeds: NHS Digital.

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T. and de Visser, R. (2016) 'Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: a qualitative study in Southeast England.' *BMJ Open*, 6(11) pp. 1-9.

Moses, T. (2014) 'Stigma and family.' *In* Corrigan, P. (ed.) *The stigma of disease and disability: Understanding causes and overcoming injustices.* Washington, D.C: American Psychological Association, pp. 247 – 286.

Padela, A.I., Killawi, A., Forman, J., DeMonner, S. and Heisler, M. (2012) 'American Muslim perceptions of healing: Key agents in healing, and their roles.' *Qualitative Health Research*, 22(6) pp. 846–858.

Pietkiewicz, I. and Smith, J. A. (2014) 'A practical guide to using Interpretative Phenomenological Analysis in qualitative research psychology.' *Czasopismo Psychologiczne – Psychological Journal,* 20(1) pp. 7-14.

Priest, N., Walton, J., White, F., Kowal, E., Baker, A. and Paradies, Y. (2014) 'Understanding the complexities of ethnic-racial socialization processes for both minority and majority groups: A 30-year systematic review.' *International Journal of Intercultural Relations,* 43(2014) pp. 139-155.

Rehman, H. and Owen, D. (2013) *Mental Health Surveys of Ethnic Minorities: Research Report.* Unknown place of publication: Ethnos Research and Consultancy.

[Online] [Accessed on 4th April 2017] http://www.time-to-change.org.uk/sites/default/files/TTC_Final%20Report_ETHNOS_summary_1.pdf

Reid, K., Flowers, P. and Larkin, M. (2005) 'Exploring the lived experience.' *The Psychologist*, 18(1) pp. 20–23.

Roberts, L., Mann, S. and Montgomery, S. (2015) 'Depression, a hidden mental health disparity in an Asian Indian immigrant community.' *International Journal of Environmental Research and Public Health*, 13(1) p. 27.

Roe, D., Lysaker, P. H. and Yanos, P. T. (2014) 'Overcoming Stigma.' *In* Corrigan, P. (ed.) *The stigma of disease and disability: Understanding causes and overcoming injustices.* Washington, D.C: American Psychological Association, pp. 269-282.

Sheikh, S. and Furnham, A. (2000) 'A cross-cultural study of mental health beliefs and attitudes towards seeking professional help.' *Social Psychiatry and Psychiatric Epidemiology*, 35(7) pp. 326–334.

Smith, J. A. (2007) 'Hermeneutics, human sciences and health: linking theory and practice.' *International Journal of Qualitative Studies on Health and Well-being,* 2(1) pp. 3-11.

Smith, J. A., Harré, R. and Van Langenhove, L. (1995) 'Idiography and the case study.' *In* Smith, J. A., Harré, R. and Van Langenhove, L. (Eds.) *Rethinking Psychology*. London: SAGE Publications, pp. 59-69.

Smith, J. and Osborn, M. (2003) 'Interpretive phenomenological analysis.' *In*. Smith, J.A. (Ed.) *Qualitative psychology: A practical guide to research methods*. London: SAGE Publications, pp. 51-80.

Sofaer, S. (1999) 'Qualitative methods: What are they and why use them?' *Health Services Research,* 34(5) pp. 1101-1118.

Spencer-Oatey, H. (2008) *Culturally speaking: Culture, communication and politeness theory*. 2nd ed., New York: Continuum International Publishing Group.

Suhail, K. (2005) 'A study investigating mental health literacy in Pakistan.' *Journal of Mental Health*, 14(2) pp. 167-181.

Tabassum, R., Macaskill, A. and Ahmad, I. (2000) 'Attitudes towards mental health in an urban Pakistani community in the United Kingdom.' *International Journal of Social Psychiatry*, 46(3) pp.170-181.

Tabassum, R., Macaskill, A. and Ahmad, I. (2000) 'Attitudes towards mental health in an urban Pakistani community in the United Kingdom.' *International Journal of Social Psychiatry*, 46(3) pp.170-181.

Taylor, T. (2015) 'The markers of wellbeing: A basis for a theory-neutral approach.' *International Journal of Wellbeing*, 5(2) pp. 75-90.

Thara, R. and Srinivasan, T. N. (2002) 'How stigmatizing is schizophrenia in India?' *International Journal of Social Psychiatry*, 46(2) pp. 135-141.

Trivedi, J., Sareen, H. and Dhyani, M. (2008) 'Rapid urbanization - its impact on mental health: A south Asian perspective.' *Indian Journal of Psychiatry*, 50(3) pp. 161-165.

Van-Brakel, W. H. and Miranda-Galarza, M. B. (2014) 'Infectious diseases: a case study of leprosy-related stigma.' *In* Corrigan, P. (ed.) *The stigma of disease and disability: Understanding causes and overcoming injustices.* Washington, D.C: American Psychological Association, pp. 139-164.

Willig, C. (2001) *Introducing Qualitative Research in Psychology*. Buckingham: Open University Press.

Wnuk, M. and Marcinkowski, J. (2012) 'Do Existential Variables Mediate Between Religious-Spiritual Facets of Functionality and Psychological Wellbeing.' *Journal of Religion and Health*, 53(1) pp. 56-67