An Insight into the perspective of UK Men of South Asian origin on having a Psychiatric Diagnosis and the Wider Implications

A Thesis submitted in partial fulfilment for the degree of
Doctorate in Clinical Psychology

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For the one I lost and for whom this would mean so much.

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Abstract

Mental health services are required to provide culturally appropriate levels of care and encourage the development of multi-cultural services. There is a body of research that suggests people from ethnic minorities groups in the UK are under-represented in mental health services. People of South Asian origin do not access psychiatric services as readily as the indigenous population, yet they still experience mental health problems. There is a body of research exploring reasons why there is an under-representation of South Asian women within mental health services. South Asian men are also under-represented in their use of mental health services and there is a dearth of literature examining this phenomenon.

The aims of the present study were to gain insight into how the experiences of second/third generation South Asian men perceive their culture within a mental health context, to explore their perspective of having a psychiatric diagnosis and the possible implications caused.

In depth interviews were conducted with six UK men of South Asian origin. A qualitative methodology of grounded theory was used to analyse the men's accounts. A core category termed 'Reconstructing a sense of identity' was identified and a process model was developed to describe the factors influencing the core category. Five main categories were identified which highlighted the participants' experience of being a South Asian man and having a psychiatric diagnosis.

Participants highlighted the importance of culture as an identifying factor of their identity. In addition, receiving a psychiatric diagnosis suggested that they could identify an identity of having an illness. The influence of services, professionals, family and friends either enabled the participants to integrate their identities or have separate identities each having implications. The accounts from participants emphasise that professionals should work from the client's cultural frame of reference, experience and needs.

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CHAPTER ONE- INTRODUCTION

1.0   Introduction

1.1   *Overview of Chapter*

This chapter outlines the literature informing and providing a context for the research question addressed in this study. It begins with reviewing government literature on services to Ethnic minorities and the prevalence of mental illness. This follows with a discussion on the factors that could play a part in accessing mental health services such as the concept of mental health, support strategies within communities and expression of mental illness. Literature on Asian women is consulted with a view to understand their experiences and in addition men's health literature is examined. Finally, a rationale for the present study and the use of methodology adopted within it is also discussed.

1.2   *Use of Terminology*

The choice of terminology regularly provokes discussion and can lead to confusion surrounding certain terms used in the field of health and race. The problem of cross-cultural research is that it can assume that there is a shared understanding of mental health, which suggests a shared meaning across the languages used to define relevant concepts (Kleinman, 1987). This is further accentuated by the unspecified definition of the term 'culture', which, in psychological research, appears to have become associated with immigrant communities only (Hussain & Cochrane, 2002). Another problem is the term 'ethnicity', specifically the adjective 'Asian'. Bhopal, Phillimore & Kohli (1997) suggest the term implies Asians are a homogenous group therefore blurring the diversity of regional and religious differences.

The researcher does not imply that this is a homogenous group and acknowledges the wide variations in language, religion, cultural and historical experiences that exist in

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this grouping. Within this chapter and study, the terms Asian/South Asian refers to people who identify with, or whose countries of origin are in the Indian sub-continent (i.e., India, Pakistan, Bangladesh and Sri Lanka). The term 'indigenous' or 'Caucasian' refers to the white, British population whose culture and heritage developed within the UK. These terms are used by the Confederation of Indian Organisations (Mind, 2000) and used in this chapter as a means of clarifying the terminology.

1.3 *Government Policies*

A number of key health policy documents highlight issues relating to minority ethnic groups, such as fair access to services. The recently published 'National Service Framework for Mental Health' (1999) sets out guidelines on implementing standards across the National Health Service. The policy document sets out the pathways to higher quality mental healthcare in the UK and also sets performance indicators. One of these performance indicators is the availability of evidence to demonstrate adequate assessment and access to services by Asian groups. The NSF notes that assessment procedures are inadequate for Asian communities and that minority ethnic groups (including refugees) suffer from social exclusion that compounds their mental health problems.

1.4 *Prevalence of Mental Health Illness among different Ethnic Groups*

Sashidharan (1993, pp 129) postulated that 'The relative prevalence of mental health illness among different ethnic groups in Britain is both controversial and complex field of inquiry'. There have been few community-based studies of ethnic differences in the prevalence of mental illness. Existing research suggests that, as with physical health, there are important and possibly large differences in mental health across ethnic groups. The literature in this area has provided two key findings, one being the high levels of schizophrenia and other forms of psychosis found among the African-Caribbean population and the apparently low rates of mental illness generally among

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South Asian people (Birchwood, Cochrane, MacMillian, Copestake, Kucharska *et al.* 1992; Bhugra, Leff, Mallett, Der, Corridan *et al.* 1997). This review will concentrate mainly on South Asian people and their mental health. A wide range of mental health problems exists within the Asian community, such as depression, anxiety, eating disorders and various psychotic disorders (Littlewood & Lipsedge 1982; Fernando 1990). However, these conditions may be experienced and manifested differently in the Asian Community than in the indigenous population.

In order to understand Asian experiences, beliefs and attitudes, migration and settlement of Asian communities will be discussed as well as their understanding of mental health. In addition to this, the stresses identified by Asians and the role of traditional faith healers in treatment will be explored.

1.5   *Migration and settlement of Asian communities*

Webb-Johnson (1991) suggested that research indicated that historical and local experiences have a significant influence on the mental well being of the Asian community. In order to understand the mental health issues in the Asian community it is important to appreciate the experience of migration and settlement, including what the prior expectations of this country were and to what extent they were met.

It has been suggested that Black and minority ethnic communities form approximately 6% of the population, that is, 3,000,000 people in England and Wales (Bhugra and Bahl, 1999) However this figure may not be accurate as there may be illegal immigrants not accounted for, and therefore perhaps we are dealing with a much larger population.

A majority of people from the West Indies and the Indo-Pakistan sub-continent came during the 1950s and 1960s to satisfy the need for unskilled labour. When the first immigrants arrived from Asia, it was mainly for financial reasons of providing for themselves and for their families in Asia. The majority were of peasant origin but some were professionals. They were encouraged to send for their friends and

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relatives, and women came to join their husbands. It became clear that men would need to stay longer as their earnings were not sufficient to enable them to return home. Eventually as more families arrived, communities began to form, and the value of traditional culture and identity became a prominent issue. It is suggested that Asian minorities struggle to find their role and identity in a society that they consciously chose to be their new homeland (Furnham & Bochner, 1986).

When immigrants first arrived they had to contend with concerns about feelings of intrusion from the indigenous population (Bochner, 1982) and concerns about the pressure being placed on the social security, schools, NHS and other societal institutions (Furnham & Bochner, 1986). It was also widely believed that immigrants would take jobs away from locals; this resulted in tension and sometimes verbal and physical conflict between the two societies. Many immigrants experienced this conflict and a majority of people reinforced their self-identity (Mohan, 1988) at home, in the community and with their offspring.

Extreme examples of the consequences of this conflict can be found in a study by Handy, Chithiramohan, Ballard and Silveira (1991), which compared Asian and Caucasians in adolescent self-poisonings. They found that cultural conflicts were of paramount importance in precipitating self-harm behaviour amongst Asian adolescents, and high parental expectations were also influential.

However, other studies have shown how extended family networks also support a family member suffering from mental ill health. Studies have found the extensiveness and "tenacity" of involvement of Asian families during the care of their mentally ill members. This was congruent with previous studies (Lin 1988, Lin et al 1991, Tran 1972) which observed strong family orientation and multi-generational responsibility in Asian cultures compared to the emphasis on individualism (and all the generations "on their own") in the West. This pattern of extensive family involvement in the help seeking behaviour of family members has frequently been documented in Asian cultures.

Thus research findings indicate that even though it can be the extensive involvement of the family that may be the cause or catalyst in young Asian people suffering from mental health problems, they can also be supportive and helpful in overcoming mental health difficulties. However Lin et al's study was with people who had long-term mental health problems and age was not specified. It could be hypothesised that perhaps families are more supportive depending upon the mental health problem being experienced. Alternatively there may be more support available for the older person with mental health needs.

Studies have shown that mental health problems affect all ages in Asian culture, however the literature indicates that some are more vulnerable at certain ages such as 15-24 age group. This age group are forming their own identity outside the home, having aspirations, wanting to experiment, and be like the majority (the indigenous community) (Beliappa, 1991). It could be that it is at this time that families impose more restrictions and traditional values because they are aware that this is the most impressionable age group. This is one of the stresses identified by Asians throughout the country (Fenton and Sadiq, 1990; Beliappa, 1991).

1.6   _Understanding of Mental Health within Asian Culture_

Western cultures make a clear distinction between mind and body and provide separate services for each. Eastern cultures take a more holistic approach and view the mind and body as one, each being on a continuum of the other, thus affecting the persona as a whole (Fernando, 1990). This has implications for the treatment considered appropriate by those with mental health problems (Beliappa, 1991). For example the diagnosis of depression is often based on 'selective identification of Western symptoms in non-Western patients... leading to mis-identification... when classifying non-Western people' (Nikelly, 1992, pp19). He recommended that a 'cultural' axis in the Diagnostic and Statistical manual for Mental Health Disorders Version III (1987) should be included to allow for the culturally diverse definition of symptoms to emerge, upon which a meaningful diagnosis could then be made.

It has been suggested that the relationship between the individual and their community also influences the recognition and treatment of depression. Within Asian communities, defining depression as an illness depends on not only the severity of the condition but also the visibility and resultant effects on social obligations of that culture. In comparison Western societies emphasizes the importance of independence and autonomy whereas in Eastern societies it is emphasised that duty to the community is greater than duty to oneself (Donovan, 1986). Therefore the aim of addressing personal problems in the Western societies may be to instigate change in the individual's situation as well as those around them. However in Eastern societies, the status quo of the situation is what needs to be maintained and the individual needs to learn to adjust (Wheeler and Izzard, 1997). Therefore, whether the illness is treated or ignored may be dependent upon this community versus individual-needs factors. It appears from literature that culture exerts an influence over the perceptions of mental illness and over the expression of distress, which is 'located' within the relevant cultural framework. Hence, Hussain and Cochrane (2003) postulate that this may serve to explain differences in beliefs around the definition and presentation of symptoms of mental illness within different communities.

Wilson and McCarthy (1994) explored the causes of low utilisation of mental health services with Asian communities. They interviewed Asian attendees of general practices and found that there were equivalent rates of true non-psychotic morbidity in the indigenous and Asian sample. They found no difference in the way their symptoms were reported. However they found that Asians who had a psychiatric illness were more likely to report physical complaints and GPs were less likely to identify a psychiatric disorder. Similar studies have been conducted with other minority groups looking at the detection of psychiatric morbidity and similar results have been found (Lloyd and St Louis, 1999; Jacob et al, 1996, Li et al, 1994).

1.7   *Stresses identified by Asians*

Beliappa's (1991) study randomly selected 98 Asians living in one of the London boroughs and found that their major concerns were regarding employment, marriage,

children, finance and health. These concerns varied for people of different ages and gender groups. She found that only 13% of her sample regarded the family as a viable source of support and only for concerns relating to health and childcare. The family was not seen as a source of support for marital and employment problems. She found that the men were more likely to link their experiences with racial discrimination and feelings of powerlessness, whilst women were most affected by cultural differences and the resulting feelings of isolation. Beliappa found that men in her sample were more likely to externalise their feelings of distress by arguing with their families whilst women tended to internalise their feelings through crying and praying. She also noted that women used more emotional terminology when describing their concerns in comparison to the men in her sample.

This study challenged assertions made by previous studies. One study concluded that Asians suffer less psychological morbidity than the indigenous population and tend to manifest greater 'psychological robustness' (Cochrane & Stopes-Roe 1977). Another study concluded that the low rate of reported mental illness is attributed to fear of stigmatisation and a 'somatisation' of mental distress. It found that individuals (in the sample) did not 'somatise' emotional problems, although they did recognise that emotional problems affected physical health. One of the reasons given for not attending the GP with their emotional problems was that they felt the doctor only treated physical symptoms. When the physical symptoms appeared they went to the GP for treatment. Hence the emotional problems remained undetected (Patel, 1992). The study also identified some characteristics, which were common to those who reported distress. One factor was gender, in that females reported distress more than males. Another factor was that housewives and the unemployed were most vulnerable to mental distress.

1.8   *The Role of Traditional Healers in Treatment*

One of the cultural specific ways to deal with problems is the use of 'alternative/ traditional healers' (Kakar, 1982). It has been described that traditional healers use a range of intervention tools that include religious texts, spiritual awareness and herbal

remedies found in religious texts. The prevalence and use of traditional healers is unclear in the UK however research does indicate that traditional healers are accessed alongside western medical help rather than in the place of it (Cochrane and Sashidharan, 1996).

Battachaya's (1986) research explored the belief systems that underpin forms of illness. Three categories of illness were found; these were ghost possession, black magic and 'malfunctioning in the head'. The participants in this research believed that whilst the first two should be treated by a traditional healer, the last should be treated by a doctor. However, the question that was not explained by this study was how did participants know what category of illness was present and who to access first. It has been suggested that preference for religious healers can be explained by the beliefs that they are aware of and work within the cultural framework of the patient.

It appears that the traditional faith healer has a level of understanding of the person's beliefs and experiences connected to culture. One of the experiences connected to culture is racism and stereotypes, which will be briefly explored. This will be followed by a discussion of women's health, men's health literature and finally the aims of the study and use of qualitative methodology will be explored.

1.9   *Racism and Cultural Stereotypes*

Racism within mental health is a theme that has been mentioned in many researchers (Fernando, 2002; Littlewood & Lipsedge, 1982; Bhui, 2002) but the views of those experiencing racism had not been explored in any great depth. O'Connor and Nazroo's (2002) qualitative study explored this in further detail and they found that experiences of racism were central to the accounts of the 'non-white' respondents they interviewed. The respondents referred to racism in various contexts and were seen as painful, creating considerable impact on their lives. School, workplace, public places were some of the places they described racism occurring. It was found that the effects of racism on respondents' mental and physical health were clearly profound in that coping with racism was 'tiring' and there was an enormous amount of effort

needed to cope, handle the situation and sustain and encourage themselves to move on and get over it. Other studies have contributed to the debate of the impact of racism on mental health (Currer, 1984; Fenton and Sadiq, 1990). For example one study found that respondents had experienced racism and hostility, and this increased their anxiety and inability to deal with depression (Fenton and Sadiq, 1990)

McKenzie and Murray (1999) talk about understanding racism in mental health. They suggest that racism is demonstrated at a variety of levels with regards to social and political policies, which have an impact on the individual, the community and on health. They continue to state that we have to conceptualise racism as discriminatory forces that mould both the psychological and physical world of the individual; that have an effect on the structure and functioning of cultures and communities.

A recent study by Burr (2002) explored the construction of cultural stereotypes within mental health discourse with specific reference to stereotypes of women from South Asian communities. Interviews took place with mental health care professionals working in both in-patient and community services. It was found that mental health care professionals held pre-conceptions, which were rooted in stereotypical assumptions about repressive Asian cultures. They viewed women from South Asian communities to be suffering with depression, which was assumed to be located in Asian cultures and felt depression could be treated by adopting a more Western lifestyle. However, this was a small-scale study with distinct problems of generalisability, nevertheless it suggested that 'stereotypes can become incorporated as 'fact' and have the potential to misdirect diagnosis and therefore also misdirect treatment pathways' (Burr, 2002, pp 835).

1.10   *Asian Women's Health*

There has been considerable research conducted in the area of Asian women and mental health. The National Service Framework (1999) has recommended that appropriate and accessible services are made available to Asian women, as there is an increased risk of suicide and attempted suicide in this group (Burke, 1976; Biswas,

1990; Merrill and Owen 1986; Raleigh, 1996). Raleigh found that the risk of suicide and attempted suicide appears to be high in both foreign born (Raleigh, Bulusu & Balarajan 1990, Raleigh and Balarajan, 1992) and UK born (Merrill and Owens 1986, Merrill, Owens, Wynne and Whittington, 1990) young Asian women.

It has been suggested by various authors that there is a greater risk of self-harm in British Asian women in terms of the stress and social isolation. This has been associated with intergenerational or marital conflicts, arising particularly from restricting relationships and pressures to conform to traditional expectations (Sheth, Dziewulski & Settle, 1994, Merrill & Owens 1990, Handy et al, 1991, Kingsbury, 1994, Biswas, 1990). In contrast, a study carried out in Nottingham by Drury (1991) on how Sikh girls maintained their culture found that there were few signs of overt inter-generational conflict. Sikh girls reported being comfortable with both socio-cultural systems and felt they were neither fully culturally assimilated into British culture, nor entirely encapsulated within their parental culture.

Cochrane & Stopes-Roe (1985) conducted a similar study on the assumption that young Asians would 'envy' the apparent freedom of their English counterparts. However they found that less than half of the young people they interviewed had a positive view of the English way of life and a further quarter were ambivalent.

A study investigating South Asian women in UK and depression, conducted by Fenton and Sadiq (1990) found that the main precipitating factors to women's problems in their sample were bereavement and interpersonal disputes, usually within the family. In addition the prime vulnerability and exacerbating factors were social isolation, material difficulties (housing, employment, financial), problems with childcare and racial hostility and abuse.

A model of depression (Brown and Harris, 1978) was adapted (by Fazil and Cochrane, 1998) to address cultural issues that affect Pakistani women. They identified six factors in their sample's lives that were associated with depression. Two of these factors were the same as Brown and Harris's (1978) original model (that is, low intimacy and loss of mother). However, they identified four culturally specific

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variables; social isolation, living with extended family, unhappy marriage and inter-generational conflicts, which were *stronger* predictors of depression than non-culturally-specific factors. Their research suggested that shared gender does not explain depression *across* cultures.

As previously mentioned studies have shown that crying and praying are behaviours that Asian women use when experiencing distress. Loewenthal and Cinnirella (1999) investigated the use of religion in dealing with depression and schizophrenia in women from ethnic minorities. They found that Muslim women were negative about seeking help outside religious counsel and healing. This may apply to all South Asian women as praying is a coping mechanism they actively use, and perhaps this mechanism is used initially to help deal with the problem being experienced. Therefore this may explain why Asians don't present to primary or secondary services early on.

It has been suggested that "prayer and other forms of religious help may be resorted to prior to seeking professional attention, and their palliative effects can be perceived as quite high" (Lowenthal and Cinnirella, 1999, pp 500). If professional help is sought, mention of any religious means that have been tried will be avoided. However this is a complex area to investigate as measurements of levels of religiosity and defining how religious a person is across different groups is difficult to compare since indices of religiosity are quite different in each of the groups (Loewenthal and Cinnirella, 1999).

1.11   *Perceptions of Asian women*

Studies have shown that women express distress more readily than men however Raleigh (1996) postulates that there are reasons for believing that young men of Indian origin (including east African) may also be at risk of developing mental health problems, although the causes are unclear. In many cultures, males and females are exposed to different expectations. Expectations within Asian communities are just as pronounced as with any other culture. Women are seen as "retainers of cultural purity and repositions of moral value"; they hold the family "izzat" (honour) and when a

daughter is born, it is not an occasion for celebration as she will have to be fed and clothed and will require a dowry. She will not be expected to provide economic security for her parents in their old age and this may be why some families endorse higher education, as it will bring in a potential economic contribution to her new extended family. Marriage is an Asian girl's destiny in life, hence the importance of keeping her virginity (Raleigh, 1996). O'Connor and Nazroo (2002) found that some of the younger women that had migrated from Pakistan, Bangladesh and India had particular problems related to becoming a bride and coming to a new country at the same time.

When a son is born there is celebration that he would provide economic security for his parents in their old age. Males have less of the *izzat* emphasis in comparison to females because what they do or how they behave does not carry the same level of social disapproval and disgrace for the family. However, there are still high expectations placed on males to uphold the family honour within the community. Therefore, one may theorise that the high expectation placed on men influences their ability to present to services with mental health problems (Raleigh, 1996).

A recent qualitative (2002) study conducted by O'Connor and Nazroo found that difficulties surrounding the arrangement of marriage were a recurrent theme in the accounts of both men and women in the Pakistani, Bangladeshi and, to a lesser extent, Indian groups. This study provides a large amount of information about the view of all ethnic minorities not only Asian sub-groups. The study also recruited both male and female participants, however it did not attempt to look at differences between the two sexes and whether they hold similar or conflicting views on their context and experience of psychiatric illness.

1.12 *Men's health*

Bhui, Chandran, and Sathyamorrthy (2002, pp 52) postulate that 'men's health has been neglected and is often regarded as an homogenous entity, irrespective of culture, age, and health expectations'. Cameron (1998) investigated these inequalities across

gender and they presented some thoughts about men and health. They maintained that men regard health as a women's problem, know little about their own health, and tend to keep quiet about health problems that threaten masculinity and traditional male gender notions of control and strength. They postulate that men fear loss of control more than their health problems and they see the body as a machine and delay seeking help.

Coping strategies in men differ to those that women employ (Nolen-Hoeksema, 1994 as cited in Hussain and Cochrane, 2003). Research indicates that men tend to have less ruminative coping styles and focus less on mood compared to women, which are influenced by specific psychosocial/environmental and social factors (Hobfall, Dunahoo, Ben-Porath and Monnier, 1994: Stein & Nyamathi, 1999; Woods, Antoni, Ironson and David 1999). Considerable research has explored coping strategies in women from ethnic minorities however there is a dearth of literature on the coping strategies employed by men from ethnic minorities.

1.13   *Alcohol use and Asian men*

Cochrane and Sashidharan (1996) hypothesised that the excess use of alcohol in South Asian men could represent a form of self-medication. They postulate that perhaps this form of self-medication allows them to maintain gender roles, whilst distancing perceptions of risk from ill health. Cochrane and Bal (1989) looked at hospital admissions in England and found the rate of mental hospital admissions for alcohol-related diagnoses for men born in India but living in England was considerably higher in comparison to their white counterparts. This figure had increased considerably over the preceding decade. However, this was treatment-based data and does not reflect the true prevalence with any reliability, as only a small percentage find their way into formal psychiatric care. In addition, the hospital demographics looked at country of birth and not ethnic origin. Therefore those born in the England who were of Asian ethnicity would not have been included in the analysis.

Studies have also shown low levels of alcohol consumption within the Afro-Caribbean population (McKeigue and Karmi 1993, Balarajan and Yuen 1986) and within the Gujarati Hindus, Muslims and all Asian women. However it has been found that Sikh men drank heavily in comparison to the other sub-groups and their alcohol-related psychiatric admissions were conspicuously higher. Various reasons have been suggested that could explain this high alcohol-related psychiatric admission rate. One hypothesis put forward was that perhaps it is the migrants from India who account for the high rate of alcohol-related admissions in the Indian born population. However there has been no concrete evidence found to support this.

Another supposition was that perhaps Asian men show the deleterious effects of alcohol at a lower consumption threshold than White men. It has been suggested that a liver that is already affected by hepatitis or another factor may more readily incur damage from lower doses of alcohol and perhaps men from India were exposed to more damage/ disease of the liver than their white UK born counterparts. This would explain the vulnerability to alcohol related illnesses.

The final hypothesis is that Asian men do not readily use alternative sources of help for alcohol problems and are therefore more likely to be admitted to psychiatric hospitals. However there is no conclusive evidence that supports any of these hypotheses but each appears consistent with the high rate of hospital admissions for alcohol-related problems. Very little is known about what could lead to Sikh men using alcohol more than their other South Asian counterparts. Within the Sikh religion, as well as within Hinduism and Islam, a person should abstain from using any intoxicating drinks but Sikh men regularly use alcohol in social activities, drink alone and more often than other groups.

Perhaps alcohol is a way of coping with mental illness or stress. There is a dearth of studies into the sort of coping mechanisms Asian men use to deal with stresses placed on them. As already noted there is an increased number of Sikh men being admitted for alcohol-related psychiatric admissions, but there has been no research conducted on why they use alcohol. It is not known whether alcohol helps them deal with stresses in life or whether it is a cultural expectation or a health belief. In addition,

there is a lack of knowledge on men's perspective on being hospitalised for alcohol-related problems and how it has an impact on their lives, their relationships and the community. Cochrane (1999) indicated that the second generation have moderated their drinking patterns significantly as there was a tendency to drink amongst the Sikh and Hindus.

Bhui et al (2002) found that irrespective of cultural origin, men reported similar levels of common mental disorder. This suggests that Asian men are no different in accessing services compared to men from other cultures. In addition it has been suggested that suicide rates are lower in men with origins in the Indian sub-continent (Gupta 1999), which contradicts Raleigh's findings. Gupta postulates that evidence suggests gender related patterning of distress, except the absence of distress is conspicuous among south Asian men. Wild and McKeigue (1997; cited in Bhugra & Bahl 1999) found that there were higher rates of hypertension and coronary heart disease in south Asian men. Anxiety and depression have been associated with heart disease however this area requires further investigation.

1.14 *Asian men's perception of mental health assessment*

A recent qualitative study conducted in 2002 on Asian men's perception about mental health assessment, its value and its impact on their lives found that Asian men were dissatisfied with how they were understood in assessment. The authors (Bhui *et al.* 2002) found this contrasted with practitioners' perception that users with 'a good command of English' do not need specialist services. They recommended that interpreters are used in assessments because men may choose to speak English as it may be less distressing to them or because they wish to show their level of competence and speaking in their mother tongue might be looked down upon by English speaking professionals.

However, using interpreters brings its own limitations in that some meanings are not easily translated into the users' language and vice versa. This study found that even though they matched interviewers' language with the clients' language, there were

times when the clients would use professional jargon and the interviewers would also resort to professionalized terms. This suggests that even with a language match, there are certain terms used by professionals that do not have equivalent terminology in other languages.

In this study the men were not given the chance to discuss issues of religion or culture and they were all unanimous in saying such an opportunity would have been beneficial. They felt that if this area had been discussed then the practitioner would have got a better understanding of the user and the user would have been able to explain his perspective. The authors concluded that an understanding and acceptance of users' religion plays a crucial role in them feeling recognised and understood.

1.15   *Conclusion*

There has been a huge number of studies conducted in the area of Asian mental health however the term "Asian" encompasses so many variations of different cultures, languages, religions, values and beliefs that it is difficult to hypothesise that a particular behaviour is common for all Asian people. However what studies have shown is that Asians experience mental health problems similar to the rates of the indigenous population. However, there are particular aspects/problems, which show abnormally high rates of distress such as suicide in women and alcohol-related problems in men. There have been many thoughts put forward about why Asians are not accessing psychiatric services. With the standards set by The National Service Framework for Mental Health and other white papers, changes are happening and services are being made acceptable, accessible and culturally sensitive. Nevertheless we still need to investigate the reasons, beliefs, values and ideas that Asians hold as similar to any other culture, it is constantly changing and evolving. People are adopting and adapting some western values into their own value systems.

Ethnography of Asian men's distress is notably absent from literature. The experiences of Asian men within the psychiatric services and their communities might

be similar to that of Asian women, or other men. However the area of Asian men's mental health is lacking in research.

1.16   *Aims of this study*

The broad aim of this study was to gain an insight into the perspective of UK men of South Asian origin[1] on having a psychiatric diagnosis and the wider implications. Therefore there were three main questions:

- To gain an insight into how South Asian men[2] perceive their culture within a mental health context.

- To explore the perspective of South Asian men on having a psychiatric diagnosis.

- To consider the wider implications of the experience South Asian men have when given a psychiatric diagnosis.

This intent of this research is not to generalise from the accounts of the participants involved in this study. It is not possible to formulate the experiences of South Asian men who have a psychiatric diagnosis. The aim is to inform further research about South Asian men's perspective of having a psychiatric diagnosis by grounding the findings in their experiences and meanings.

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[1] Throughout this study, UK men of South Asian origin will be referred to as South Asian men, with an implicit understanding that the men in this research have all been born in the UK

[2] It should be noted that in the UK context the use of the ethnic category 'South Asian' broadly refers to those people whose familial or cultural backgrounds originate from the subcontinent of India, Pakistan, Bangladesh and Sri Lanka. The term 'Asian' is used in a broad and heterogeneous sense. It is recognised that it is diversified along lines of religion, class, migration patterns, language, traditions and identifications with regional areas 'back home'- places that may be urban or rural (definition from Woolett et al 1994, cited in Marshall and Yazdani, , 1999, pp 413).

1.17   *Use of Qualitative Methodology*

It was felt that the research question would be appropriately addressed using a qualitative methodology. There were three broad reasons that informed the decision to undertake a qualitative methodology. Firstly, current research literature indicates that the topic area has received very little interest and it has been suggested that qualitative methods are particularly important in exploring such areas (Turpin, Barley, Beail, Saige, Slade, *et al.* 1997). Secondly, Henwood and Pidgeon (1992) suggest that qualitative research lends itself to using participants' perspectives thus defining phenomena in terms of experienced meanings and to developing theory from fieldwork. Charmaz (1990) suggests that qualitative methods offer a way of generating considerable information exploring how individuals construct their reality therefore providing researchers with "...alternative understandings of participants beliefs and actions more than those readily available in clinical settings" (pp 1161). Finally, the lack of literature suggests that there has been a lack of research aimed at eliciting the views of ethnic communities on their own situation. Researchers in this area recommend that people need to be understood using their frame of reference and taking into account the individual cultural and belief system and qualitative methodology allows for this to occur (Patel, 1999, Burman, 1998). Studies conducted with ethnic minorities that used a qualitative methodology highlighted the sensitivity of these methods to subtle variations in language and concepts and allowed in-depth information gathering to take full account of cultural and linguistic limitations (Bhui *et al.* 2002; O'Connor & Nazroo, 2002).

The researcher was aware that accounts of Asian culture may be different for men and women within those cultures from ideas put forward by Burman et al (1998) and her own frame of reference as an Asian woman. The literature demonstrated that Asian women expressed their distress in many ways, e.g., self-harming, suicidal behaviours, use of religious activities as a means of coping, but there was very little research in the attitudes and behaviours of South Asian men. With the exception of Bhui et al (2002) and O'Connor & Nazroo (2002) very little qualitative research has been undertaken in understanding the meanings and experiences held by South Asian men.

Qualitative research was essential for the detailed investigative approach that the study required. However it was important to note that qualitative research was not designed to be statistically representative of the researched population but for where relationships were described, the purpose was to present explanations identified explicitly and implicitly by participants and hypotheses for further research.

Qualitative research encompasses many approaches and for the present study a Grounded Theory approach (Strauss and Corbin, 1998; Charmaz, 1995) was adopted. This approach allows for the development of a social theory which is grounded in the actual experiences of participants and this is considered important as research of this nature contributes greatly to developing fields of enquiry (Henwood and Pigeon, 1992; Bhui *et al.* 2002; O'Connor & Nazroo, 2002).

CHAPTER TWO- METHOD

2.0 Method

2.1 *Overview of Chapter*

As discussed in the Introduction section, the most effective form of enquiry for the present study was to use a qualitative approach. A context to this research will be provided through a brief introduction to the qualitative research paradigm and the chosen method of Grounded Theory. This includes a review of grounded theory's development, structure and application in psychological research. The procedure that was used to recruit participants, and collect and analyse the data is subsequently described. Finally, issues of validity, reliability and reflexivity are considered.

2.2 *An Overview of Qualitative Research*

In recent years there has been an explosion of interest for qualitative research in psychology (Yardley, 2000; McLeod, 2001; Smith, 2003). This has prompted a major shift in psychology's research practices, which traditionally emphasized the importance of quantitative methodology. McLeod (2001) states that there has been a shift in the focus of research and researchers have become interested in looking at participants' subjectivities hence the increased use of qualitative approaches.

The traditional research practice was to test pre-ordained hypotheses in an attempt to discover laws of cause and effect that governed phenomena. This practice was called the 'quantitative paradigm' (Henwood and Pidgeon, 1995). Within this paradigm, research would provide data, which could be statistically analysed in order to provide objective, reliable and generalisable 'scientific truths'. Quantitative research which is underpinned by a positivist conception of science (Madill, Jordon and Shirley, 2000) allowed psychology to maintain 'scientific' respectability and the dominance of objectivity in relation to the production of psychological knowledge (Stevenson and Cooper, 1997).

It has been acknowledged that the quantitative approach has made invaluable contributions to the understanding of social and psychological processes across disciplines; however what was questioned, was whether too great an emphasis was being placed on verification of *a priori* theories. It was felt that within the quantitative paradigm there was a general absence of the roles of language and meaning within the research setting and that human behaviour was being reduced to a set of quantifiable variables. In comparison, qualitative methodologies do not force people's experiences into pre-established categories but instead encourage and enable researchers to understand the complexity and range of meanings that people ascribe to their experiences (Strauss and Corbin, 1990). In this respect, some methodologies have been viewed as similar to traditional clinical practice (Yardley, 2000) as many of the techniques and skills used are similar to those used in therapy (McLeod, 2001). For example, people's stories are elicited within therapy and the research processes. The therapist and researcher have to listen sensitively to what is being said by the client/ person being studied and throughout the process have to build up an understanding and confirm they have understood the client's/person's experience.

However in recent years qualitative research has been described as having its own distinctive role to play in the creation of a knowledge base for practice and policy (McLeod, 2001, pp 1) and is a field of inquiry in its own right that crosses disciplines, fields and subject matter' (Denzin and Lincoln, 1994b, pp 1). Within the qualitative paradigm, there are a number of epistemological positions and methods of analysis that can be utilised by researchers (Yardley, 2000; Madill et al 2000; McLeod, 2001). Qualitative research is not a unitary, unified activity or approach and it assumes that, at least in human affairs, reality is *constructed*, hence there being many alternative and complementary definitions or understandings of reality, reflecting the backgrounds and interests of those involved (McLeod, 2001, pp 6-7).

There are a specific set of features that define qualitative research. These are the correct choice of appropriate methods and theories; the recognition and analysis of different perspectives; the researchers' reflections on their research as part of the process of knowledge production; and the variety of approaches and methods (Henwood & Pidgeon, 1992; Parker, 1994; Flick, 1998; McLeod, 2001). Hence most forms of qualitative research occur in naturalistic settings rather than laboratory or

controlled settings (Guba, 1981; Flick, 1998) and the data tends to be gathered from interviews, observations and transcripts. Finally qualitative research does not start with *a priori* hypotheses, as it enables the researcher to explore multiple meanings and interpretations from the data (Henwood and Pidgeon, 1995) therefore allowing for theory to emerge from the data (Guba, 1981, Henwood and Pidgeon, 1992).

Initially a simplified version of the quality-quantity debate (Bryman, 1988) was used as a framework to firstly make choices on which approach was most suited to the research question, or problem at hand, therefore, suggesting methods should be tailored to particular problems. Secondly, questions were asked regarding the nature and practice of science, and the generation and legitimation of knowledge. However, Harding (1987) argued that a researcher should distinguish their *epistemological position* that is their assumptions about the basis of knowledge from their research *methodology* (a theoretical analysis defining a research problem and how the research should proceed) and from the specific *method* (strategy or technique) adopted. Therefore, a framework had been proposed that places the method of analysis on a continuum (Henwood, 1996). This ranges from the more empirical position adopted by content analysis (e.g. Krippendorf, 1980), in which the discovery of valid representations is sought, through to a more constructionist approach adopted in discourse analysis (e.g. Potter and Wetherell, 1987; Burman and Parker, 1993) which, focuses analytically on the reflexive functions of language.

However, it is not as straight forward as this, in that it is perhaps possible to adopt a grounded theory method of analysis from a different epistemological stance. Madill, Jordan and Shirley (2000) demonstrate that a grounded theory method of analysis can be understood within three distinct epistemological frameworks, which are realist, contextualist and radical constructionist and hence the positions of reflexivity, reliability and validity will differ accordingly.

Traditionally, qualitative and quantitative research has been perceived as being in diametric opposition to one another (Parker 1994; Elliot, Fischer and Rennie, 1999). As quantitative research was seen as a 'hard' form of research (that is, relatively precise, and typically numerical) and qualitative research was seen as the 'soft' approach (relatively imprecise) when answering scientific questions. Within this belief system, qualitative research was seen as different from the norm and of

secondary importance (Henwood, 1996). Therefore, qualitative methods of enquiry were used to promote an understanding of phenomena that had not been previously researched or where there was no existing theory (Strauss and Corbin, 1990).

In accepting the differences between qualitative and quantitative approaches, it should not be implied that they are in practice two mutually exclusive research paradigms (Stevenson and Cooper, 1997) as both methods have the same goal, i.e. greater understanding of psychological processes and that neither paradigm is better than the other. Researchers within psychology have recommended that a combination of quantitative and qualitative methods can be used (Silverman, 1985) however there are advantages and disadvantages to this discussion (see Henwood, 1996).

Henwood (1996) postulates that qualitative analysis 'aims to become the production of a meaningful account that knits together the multiplicities, variations and complexities of participants' worlds'. Therefore it was perceived to be an appropriate method for the present research, with its aim of investigating the process through which Asian men experience having a psychiatric diagnosis. A realist position was taken for this study and will be considered later in this chapter. The methodological approach of grounded theory was employed and this is described below.

2.3   *History of Grounded Theory*

The qualitative approach of grounded theory was introduced during the 1960s by two sociologists, Barney Glaser and Anselm Strauss, as a method for developing theory from social research data. Henwood and Pidgeon (1992) stipulate that Glaser and Strauss' (1967) principal concern in writing the monograph The *Discovery of Grounded Theory* was to free researchers in sociology from the theoretical straitjackets of a few 'grand theories'. At that time they observed that sociological practice was becoming dominated by sophisticated quantitative methods (Charmaz, 2003) which were rooted in positivism. This promoted the logico-deductive model in which theory informed quantitative research, hence leading to impoverished theory which did not fit the real world (Pidgeon, 1996). Therefore they aimed to close this 'embarrassing gap between theory and empirical research' (Glaser and Strauss, 1967,

p.vii) as most quantitative researchers were ignoring human problems that did not fit positivistic research designs (Charmaz, 2003).

They developed an approach that was in contrast to the more traditional approaches in sociology (and psychology) of using information to verify existing theory (Rennie, Philips & Quartara, 1988). They proposed turning the method 'upside down' and using qualitative data as a source for developing rather than verifying theory. Therefore, to begin with Glaser and Strauss invoked the notion of grounding *theory* in experiences, accounts and local contexts and other researchers have used it to signify the 'goodness' of a particular piece of research. Secondly, they use it to describe a method, which involves specific analytic strategies formulated for handling, and making sense of, initially ill-structured qualitative data. Therefore, the approach of grounded theory is suitable to use in semi-structured interviews, fieldwork observations or other forms of textual material of participants' own accounts of social and psychological events and of their associated local phenomenal and social worlds.

2.3.1 *Relevance to Psychology*

This method is considered to be particularly useful for psychologists who wish to study the varied groups of people they work with and there is considerable literature demonstrating that grounded theory has clear relevance to psychological enquiry (Henwood and Pidgeon, 1992; Charmaz, 2003). It has been used in areas as diverse as clinical psychology (Rennie et al, 1988; Bolger, 1999), social psychology (Currie, 1988; Marsiglio, Hutchinson & Cohan, 2000) and health psychology (Charmaz, 1990, 1995). Studies using grounded theory demonstrated that they are equally as sensitive in identifying psychological processes, and sometimes can access information that are often difficult to access by using traditional methods of enquiry (Charmaz, 2003). Studies have been conducted into the experience of receiving family therapy (Howe, 1989, 1996), into the experiences of clients who had been abused in childhood (Dale, Allen and Measor, 1998) and by Rennie (1988) into client's experience of therapy. These studies aimed to help increase clinician's understanding of the internal worlds of their clients (McLeod, 2001). These studies have been very important for promoting insight and obtaining a deeper understanding of how individual and

interpersonal processes develop, are maintained, or change therefore enabling psychologists to improve clinical outcomes (McLeod, 2001; Charmaz, 2003).

2.3.2 *Characteristics of Grounded Theory*

The method of grounded theory can be used with almost any form of qualitative material as long as it is approached without strong prior theory (Pidgeon, 1996) and it discovers, develops and provisionally verifies phenomena through detailed systematic data collection and analysis (Strauss and Corbin, 1990, Henwood and Pidgeon, 2003). Hence, a researcher begins with an area of study and what is relevant to that area is allowed to emerge. Charmaz (2004) postulated that 'we start with general research questions but they may lead us in new, unanticipated directions' (pp 991). As will be discussed later, researchers differ in the emphasis they place on different aspects of the procedure, but essentially analysis undertaken within a grounded theory approach proceeds in a similar way. Strauss and Corbin (1990) and Charmaz (1995) write in detail about how the process is undertaken.

A major contribution of the approach has been the development of rigorous procedure (Strauss and Corbin, 1990), in order for researchers to check, refine and develop their ideas and intuitions about the data (Charmaz, 1995). In the initial stages of the analysis the researcher must adopt a stance of maximum flexibility in generating new categories from the data and this is a creative process which taxes the researcher's interpretive powers (Henwood and Pidgeon, 2003). The researcher breaks down the data into small meaningful chunks and creates codes by defining what they see in the data therefore capturing the essence of what is said (Charmaz, 2003). Then the task is to continually sift and compare elements (basic data instances, emergent concepts, cases or theoretical propositions) throughout the research process. Thus allowing the researcher to become sensitised to the similarities and differences within the data, as its complexities are explored hence promoting dense conceptual development (Henwood and Pidgeon, 2003).

Those codes that are similar are placed together to form a category and constantly compared with each other. This process is known as the constant comparative method

(Strauss and Corbin, 1990). This analytical method is described as a central feature of generating theory, as well as of building conceptual and theoretical depth of analysis (Pidgeon, 1996). Glaser and Strauss postulate that this comparison of basic data instances in an emergent category 'very soon starts to generate theoretical properties' (1967, p.106).

Another distinguishing characteristic of grounded theory is theoretical sampling and it involves the active sampling of new cases as the analysis proceeds. Therefore sampling is driven by theoretical concerns and new cases are selected in order to generate new theory by extending or deepening the researcher's emergent understanding of the phenomena being studied (Henwood, 1996; Backman and Kyngas, 1999). Another aspect of theoretical sampling is where the researcher explores negative cases, those that do not appear to fit the emerging conceptual system. Negative case analysis is seen as a valuable process as it challenges initial assumptions and categories and can prevent building indefensible arguments from a corpus of data (Turner, 1981; McGrath and Johnson, 2003).

Both constant comparison and theoretical sampling involve the researcher in a highly interactive and iterative process in which the traditional distinctions between data collecting and analysis are blurred, as he or she moves to develop a rich and detailed grounded theory (Henwood and Pidgeon, 2003)

A pre-requisite to many types of qualitative research is that of theoretical sensitivity. This is also required in the effective application of grounded theory (Strauss and Corbin 1990; Henwood and Pidgeon, 1992, 2003). This refers to the researcher's capacity to appreciate and recognise salient aspects of the data and to make coherent associations as the research progresses. This capability is suggested to be fundamentally important as it helps to develop theory by drawing on a number of sources. Strauss and Corbin (1990) describe four main sources. The first source is sensitising the researcher to the phenomena under study via literature in the area of interest. The second source is professional experience which is invariably obtained through knowledge and understanding whilst working within the field of interest. The penultimate source has been described as the researcher's personal experience and the final source is through the process of interacting with the data itself. Charmaz (2004)

has developed similar principles that encourage the researcher to have intimate familiarity with their studied phenomena (see Charmaz, 2004).

2.3.3 *Criticisms of grounded theory*

A number of criticisms have been levelled at the model of grounded theory. These criticisms can be split into two broad strands, the first relating to pragmatic concerns and the other to epistemology.

To begin with, one of the pragmatic concerns relate to data collection. It has been noted that grounded theory researchers often treat their participants' accounts as reflections of reality. Whereas, the reflections obtained are a product of the interaction between the research and the participant and is only one account of the phenomena being studied. Therefore one could question whether it is ever possible to know the reality of another's internal world. One could also question whether the participant has provided the researcher with an accurate account of their experience. This account may be censored for a variety of reasons such as the participants only providing partial information because they feel stigmatised or shamed or they may acquiesce or be conscious of the power imbalance between themselves and the researcher (Smith, 1996; Tindall, 1996; Henwood, Griffin and Phoenix, 1998).

Similarly, these difficulties may apply to respondent validation. The concept of asking the participant to comment on the researcher's interpretation of their account is useful and appropriate as it may provide new areas for investigation. However it can be problematic if the participant does not understand the interpretation or if they do not understand aspects of their experiences and may have not thought about them at such an abstract level therefore not being able to comment on the theory being presented to them (Stiles, 1993). Some researchers feel that returning to participants for further information or clarification of a theory creates another data stream which can be incorporated into the final data set but cannot offer a superior check of validity (Henwood and Pidgeon, 1995).

A criticism of grounded theory is that some researchers (especially those new to the techniques) find themselves unable to generate an all-encompassing theory. Charmaz (1995) stated that an incomplete theory can still provide a conceptual description that can provide the reader with insight and greater understanding. However it can be problematic when there are no insights into the phenomena being investigated and what is obtained is no more than a glorified form of re-description or content analysis (Pidgeon, 1996). In order to ensure the quality of analysis researchers should follow the grounded theory procedures in a structured way, and thinking comparatively and abstractly will promote a theory which is conceptual in nature.

From an epistemological perspective another criticism comes from Glaser and Strauss's claim that theory simply emerges or is 'discovered' from the data (1967). They do not recognise that it may be pre-interpreted in terms of existing concepts and theory (Pidgeon, 1996). They imply that a set of social or psychological relationships exist in the world and are reflected within the qualitative data, enabling it to be uncovered by the research process and suggesting that some aspects of grounded theory can be aligned to a more positivist and empiricist epistemology.

This suggests an apparent contradiction between the inductivist approach to analysis and encouraging the researcher in the interpretative process of generating new theory. This tension has become known as the 'dilemma of qualitative method' (Hammersley, 1989). Researchers have argued that theory cannot simply emerge from or reflect data, because interpretation and analysis is always conducted within some pre-existing conceptual framework brought to the task by the analyst (Alvenson and Skőldberg, 2000; Henwood and Pidgeon, 2003). A number of researchers have argued for a constructivist revision of grounded theory in which data should *guide* but certainly not *limit* theorizing (Layder, 1993), hence using the term *generation of theory* as it accurately describes both the epistemological and practical realities (Henwood and Pidgeon, 1992; Charmaz, 1995). Therefore, the researcher engaging in qualitative analysis needs to be a transparent as possible to their epistemological position within the research process.

Traditionally, the discovery of general principles from a data set relies on the notion of induction and the very act of deciding what to study is in itself a deductive process.

The researcher needs a least some theoretical resources to guide the process of interpretation and representation and without this, no sense of the data can be made (Henwood and Pidgeon, 2003). Charmaz (1995) states that researchers will bring their own assumptions and biases based on their experience and this will inevitably affect how they interpret the data, which, in turn, will influence the emerging theory. Therefore, Glaser and Strauss's (1967) original version of grounded theory, which, noted that 'the researcher does not approach reality as a tabula rasa' (p.3) does not fit with the above arguments.

Finally, the ability of grounded theory is questioned as to whether it represents a uniquely rigorous and systematic approach to qualitative research. McLeod (2001) argues that there are many different ways of doing grounded theory and many researchers have developed their own distinctive but related methods of doing grounded theory (Glaser and Strauss, 1967; Rennie, Philips and Quartara, 1988; Strauss and Corbin, 1990; Charmaz, 1995). He argues that there cannot be a 'correct' way of doing grounded theory, however adds that if this is the case then these developments and differences in methodology can be viewed as a precursor to Lincoln and Denzin's (1994) notion of qualitative researcher as a *bricoleur*[3]. They use the image of the bricoleur as a means of explaining 'how researchers can come to terms with the confusing array of methodological genres that exist' (McLeod, 2001, pp 119, Henwood and Pidgeon, 2003). They suggest that researchers should negotiate their own personal path through the methodological terrain and be flexible within it but should not conform to neat, systematic research. Hence, the need to acknowledge that it is the application of the method that leads to further understanding of the phenomena. Constructionist researchers would point out that the resulting theory is one account of reality, and that it can neither be right or wrong as there are multiple realities constructed between the researcher and researched.

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[3] The meaning of *bricoleur* in French popular speech is 'someone who works with his [or her] hands and uses devious means compared to those of the craftsman'... the *bricoleur* is practical and gets the job done. (Weinstein and Weinstein, 1991: 161, cited in McLeod, 2001, p 119)

2.3.4 *Employment of Grounded Theory*

Grounded theory was employed within this study for a number of reasons. As noted earlier, it has developed systematic evidence that it can usefully investigate clients' experiences of therapy (Rennie, 1988; Dale, Allen and Measor, 1998). Secondly, it emphasises the exploration of meanings of experiences, which is what this study aims to explore. This study is interested in exploring how South Asian men construct explanations for their experiences of having a psychiatric diagnosis. As the study attempts to explore the meaning of subjective experiences, such methodology is widely accepted as likely to yield the most valid information (Silverman, 2000). Finally, grounded theory is considered to offer a systematic approach of conducting qualitative research and has been said to provide the scientific rigour required in applied health-care research (Dingwall et al, 1998).

2.4 *Procedure Employed in Present Study*

2.4.1 *Ethical Approval*

Ethical approval for this study was sought from Leicestershire Local Research Ethics Committee. This committee was then able to confer the ethical approval necessary to proceed with the study. A copy of the letter granting approval can be found in Appendix 1. No service users or clinicians were approached prior to this being received.

It was recognised that the sample frame used meant that participants were potentially vulnerable, as a consequence of their experience of Mental Health Services, of the psychiatric diagnosis given to them by professionals and the label they give themselves and that which is given by the wider community (which may have associated negative feelings). A number of procedures were followed to ensure that the participants were protected and respected.

Various methods were used to protect confidentiality. The clients could choose whether or not they wished the researcher to be given their names as potential

participants; individuals' psychiatric notes were not accessed; all data were stored securely and presented in such a way that preserved anonymity.

All participants were informed of the research and its purpose and were offered the opportunity to get feedback on the results if they wanted it. Participants were asked to provide consent at the beginning of the interview and were reminded they could terminate the interview at any time and withdraw consent. Although the participants could stop their interviews at any time, the researcher ensured that the interviews would last no longer than 90 minutes and brought it to an end earlier if the participant was showing signs of fatigue or distress. One interview was terminated after 45 minutes due to the participant being unable to concentrate; the implications of this are considered in the discussion section.

2.4.2 *Participants*

The large amount of data that is generated and the depth of analysis possible when working with a qualitative framework means that only a small number of participants need to be recruited. It is recognised that within grounded theory, data collection should continue until 'theoretical saturation' is reached. This is the point at which no new information is being discovered. However it is generally accepted that within the remit and limitations for a D.Clin.Psy qualification, between six and ten participants is satisfactory (Turpin et al, 1997).

The broad aim of the research was to conduct a study of South Asian men's experience of having a psychiatric diagnosis and the wider implications. The sample frame allows for the purposeful sampling of individuals that can generate data meaningful to the research question asked. In this study, the sample frame was made up of men of South Asian origin who have received a diagnosis of psychosis and who have been born and brought up in the UK (sample frame discussed further in section 2.4.3). The participants will be between the ages of 18-40 years old in order that the focus is on those that attend Adult Mental Health services and are of working age.

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All participants were recruited from the Adult Mental Health Directorate, which included the Treatment and Recovery Service within the Leicestershire Partnership NHS Trust. All the participants were users of the adult mental health services and had been given a diagnosis of psychosis (further elaborated upon in section 2.4.3).

Participants' cultural and religious identities were self-described and are detailed in table 1.

Participant	Cultural Identity	Religious Identity	Age	Marital status	Employment status	Age at onset of illness
1	British Asian	Muslim	38	Married	Unemployed	36
2	British Asian	Hindu	39	Single	Unemployed	19
3	Indian	Hindu	32	Divorced	Unemployed	19
4	British Asian	Roman catholic	30	Single	Unemployed, involved in voluntary occupation	21
5	Asian	Sikh	40	Divorced	Unemployed, involved in voluntary occupation	21
6 declined to take part	Asian	Muslim	38	Married	Unemployed	39
7	British Asian	Gujarati	32	Married	Unemployed	20

Table 1: *Self-described cultural and religious identities of the participants.*

The religion of individuals is given in recognition of the role it played in self-described cultural identity. All of the participants were able to understand and express themselves in English. The diagnosis, age and country of birth enabled some variables

to remain constant. Therefore any variables that were different or other differences found could be explored with regards to their experiences of receiving a diagnosis.

2.4.3 *Sample Frame*

The broad aim of the research was to look at South Asian men's perspective/ experience of having a psychiatric diagnosis, and the role that culture plays within it. The aim of the sample frame is to allow purposeful sampling of individuals that can generate data meaningful to the research question asked. In this study, the sample frame was made up of South Asian men who had received a psychiatric diagnosis and were currently receiving psychiatric care.

The use of the term 'South Asian' as a construction of ethnic/cultural grouping

The term 'South Asian' is being used as a means of constructing an ethical/cultural group. It should be noted that in the UK context the use of the ethnic category 'South Asian' broadly refers to those people whose familial or cultural backgrounds originate from the subcontinent of India, Pakistan, Bangladesh and Sri Lanka. The term 'Asian' is used in a broad and heterogeneous sense. It is recognised that it is diversified along lines of religion, class, migration patterns, language, traditions and identifications with regional areas 'back home'- places that may be urban or rural (definition from Woolett et al 1994, cited in Marshall and Yazdani, 1999).

This ethnic/cultural definition of South Asian provided the sample frame but within the interview the men were asked to provide their own construction of their cultural identity, and this allowed them to talk about living within this culture.

Having a Psychiatric Diagnosis

All participants were in contact with psychiatric services in one form or another (in contact with a psychiatrist, psychologist, or community psychiatric nurse) and had a psychiatric diagnosis of psychosis. A diagnosis has been specified as there needs to be

some similarity between the participants so one can consider the impact of other variables such as culture.

From the perspective of the research, the participants would be experiencing psychiatric services and living with a psychiatric diagnosis whereas if participants were interviewed after their care had been terminated then perhaps there would be a different response as it could be seen as living with the after effects of psychiatric care.

Men born in the UK

Considerable research has been conducted with people of South Asian origin, which have included those born in the UK and those who migrated to the UK. Consequently, it has been difficult to ascertain whether the migration experience has influenced research findings or whether findings represent the views of South Asian people irrespective of country of birth. Therefore within this study this variable was controlled and only UK men of South Asian origin took part therefore attempting to eliminate migratory experience, first generation men and language problems.

A further inclusion criterion with the sample frame was that all participants are English-speaking. Participants from the South Asian region can speak a range of languages therefore it was deemed appropriate that English was used as a common denominator and in addition would help avoid any distortion in the participants messages. Bhui et al (2002) conducted a study in which they interviewed their participants in their mother tongue and they found that both clients and researchers would resort to professional jargon and that some terms did not have readily available equivalents in other languages.

Exclusion Criteria

Participants would be excluded if they became too distressed to be interviewed. The exclusion criteria was used on individuals who presented with acute psychosis, a diagnosis of drug induced or transitory psychosis, co-morbid alcohol/drug dependency or an organic disorder. Individuals not born in the UK, under 18 and over

40 and not able to give informed consent and not of South Asian origin were excluded from this study. All relevant professionals involved in the participants' care would address any pertinent issues that arose from the interview.

Variables not considered

The level of service provision varied within the sample frame, from those participants who received multiple contacts from professionals, to those who received little contact from professionals. In addition, the level of interaction with resources such as statutory day hospitals, voluntary services and groups varied. These were not considered as variables because the question at hand was regarding the experience of having a psychiatric diagnosis, which was constructed from the clients' accounts.

2.4.4   *Recruitment*

The researcher approached professionals within the Adult Mental Health Directorate. Information regarding the sample frame, the aims of the study and an outline of the initial topics to be covered in interviews was discussed and provided. With reference to the inclusion criteria, professionals suggested current clients that they thought might be suitable and were provided with a letter regarding the study (appendix 2). They informed the clients of the research and provided a letter of invitation (appendix 3) and participant information sheet (appendix 4), which explained the study in detail. Interested participants were invited to meet with the researcher and if after the research was explained to them, they still expressed an interest in taking part, they were asked to consent to be interviewed (appendix 5). Participants were encouraged to discuss the research with whomever they wished to and were given the opportunity to ask any questions.

With the participants consent, a letter was sent to the General Practitioner to note that the participant had participated in the research (appendix 6).

Whilst recruiting participants, a balance had to be obtained between providing enough information in order for them to make an informed choice but not so much that they

would feel led to talk about specific themes or areas. In addition, prior to each interview, the researcher obtained enough information regarding the participants in order to satisfy herself that the inclusion and exclusion criteria had been met and to ascertain there were no specific risk factors concerning each individual's participation.

2.5   *Data collection procedure*

As mentioned earlier, the data for qualitative analysis can come from a variety of sources. Individual interviews were chosen as the means of obtaining participants accounts of their experiences and Reason & Rowan (1981) state that in-depth interviews enable a deeper understanding of the participant and provides the basis for validity of the research study. Interviews also provide a relatively safe environment where participants can talk about personal and potentially sensitive issues. Much has been written about interviews (see Burman, 1994, Smith 1995 and Jones, 1985). Once consent had been obtained from the participants, the interview process began.

Initially, an interview guide was constructed in order to address the research questions, detailing areas to be explored. It had the researcher's own ideas of what topics need to be covered in order to consider the role of culture and gender in having a psychiatric diagnosis. These ideas were drawn from the researcher's experience and knowledge and via a process of discussion with colleagues and within supervision. The completed version of the interview schedule can be found in appendix 7.

The main areas covered by the interview guide were as follows: -

- Various demographic data such as age, religion, marital status and employment status.
- Their construction of their culture/ related identity
- Their experience of having a psychiatric diagnosis.
- How they explain it to others.
- The affect their diagnosis has on their relationships with family, friends and the wider community.

- Their thoughts on professionals understandings of their culture

- How does their culture/ religion play a part in their understanding of their illness?

This guide was formed with the intention of eliciting information for exploration rather than limiting discussion. These questions were open-ended and each interview did not have a fixed sequence of how the researcher should proceed. This process allowed participants to express the meanings of their experiences and enabled them to play a major role in determining how interviews should proceed (Burman, 1994)

As one of the main characteristics of grounded theory is of data collection and analysis being a simultaneous process, the coding of the first interviews led to additional topics being added which were investigated further. For example, early interviews identified the importance of *stigma relating to mental health and responsibilities/ duties*. These issues were addressed in subsequent interviews and this encouraged exploring the relationships between *mental health* and *holding responsibility*.

Four of the participants chose to be interviewed within their own home and three in a voluntary resource centre. Interviews lasted between half an hour to one and a half hours depending on the participant's ability to concentrate and their willingness to explore their experiences.

Interview guidelines were followed (appendix 8) and at each location the procedure was similar. With each participant, they were asked: -

- Whether they wished to proceed with the research?

- They were reminded that they could withdraw consent at any time.

- The information sheet and the process of the interview were discussed before the interview began, including the use of the audiotape.

- Issues of confidentiality were reiterated prior to the interview commencing.

- They were asked if they had any concerns relating to the procedure and the use of their accounts as part of the data set.

- Finally, participants were reminded that if any issues arose from the interview, they could access their key- professional for support.

At each interview, considerable time was spent trying to create a safe environment to allow for a trusting and open expression (King, 1996) and to establish rapport. The researcher was careful not to ask leading or closed questions and was mindful to reflect back what was being said to check she had understood participant's meanings.

It is recommended that notes regarding the interviews, feeling evoked, thoughts about what may be occurring, reflections are taken (Charmaz, 1995) after the completion of the interview. The researcher recorded her thoughts, feelings and reflection in the reflexive journal.

As noted previously, Glaser and Strauss (1967) stated that in grounded theory data analysis occurs at the same time as data collection, therefore selection of participants should be theoretically sampled according to the emerging data. In the present study the first two participants were sampled in an opportunistic way, in order to begin the process of generating theory. The first participant was an Asian man who had removed himself from the Asian culture whereas the second participant was part of his Asian community. The subsequent participants were sampled more theoretically as the theory developed. The third participant was very involved in the Asian community; he lived in a group home run by Asians for Asians and attended an Asian run resource centre for Asian people with mental health problems. The fourth participant was of a different religion and not involved in any activities run by Asians for Asians. The fifth participant had been ostracized by his identified community and the final member (seventh participant) was revered within his community. Throughout this process, effort was made to sample participants from different religious backgrounds.

Participant six declined to participate in this study therefore only six participants were interviewed.

The researcher attempted to sample as theoretically as possible however it is important to note that this process was constrained by practical issues such as the

availability of willing participants and time in which to do a D.Clin.Psy (Turpin et al, 1997). This is a common difficulty, which has been recognised by qualitative researchers (McLeod, 2001).

2.6   *Data management*

The names of participants and other identifiable information were changed to protect anonymity. The researcher transcribed each interview. The transcripts of the six interviews are included in an addendum, which is bound separately. All interviews were transcribed verbatim, in accordance with Strauss and Corbin's description however linguistic details such as length of pauses and intonation were not included. This enabled the transcript to be ready for the process of analysis, which is described below.

2.7   *The Grounded Theory Analysis*

The grounded theory analysis has mainly followed the procedures laid out by Strauss and Corbin (1990) and Charmaz (1995), however the researcher was also influenced by Rennie et al (1988) and Henwood and Pidgeon's (1995) procedures and therefore they have also been incorporated into the analysis.

The first stage of the analysis was through the use of open coding of each transcript. This process refers to the naming and categorising phenomena through close examination of the data (Strauss and Corbin, 1990). In the initial stages of labelling chunks of meaningful data (Rennie et al, 1988), questions were asked of the data such as what is going on here?' and 'what does this represent?', this enabled the development of codes. Charmaz (1995) stipulates that engaging in open coding allows the analysis to be built from the ground upwards. An example of the open coding is included in Appendix 9.

Each code was initially recorded on the transcript and then transferred to index cards. This allowed the researcher to group similar codes together, which reflected what was

being conveyed. The index cards contained text direct from the transcript in the form of descriptive labels, as well as the locations of the codes. As the analysis proceeded and the number of codes increased, these cards were grouped together to form categories, which seemed to represent aspects of the same phenomenon (Strauss and Corbin, 1990). The codes began to add detail and density to the categories and some categories had considerable variation whereas other did not. The categories that displayed little variation became the focus of future data collection and participants were sampled so they could help to add information to fill these 'gaps' in the analysis.

The researcher wrote memos reflecting on ideas and thoughts that she had about the codes such as the properties or themes they contained and the ways they related to each other. Thoughts regarding the dimensions of a category were also documented; that is, for it's properties to be located on a continuum. This process involved the detailed comparison of categories and their components and enabled more conceptual categories to be formed. This process is known as focused coding or axial coding (Strauss and Corbin, 1990; Charmaz, 1995).

The components of each category were compared to one another, and categories were compared to other categories. During this process some categories were collapsed into other categories, whilst others were spilt to form new categories. This discovery and specification of similarities and differences within categories is often described as the most crucial aspects of grounded theory. Within the constant comparative method, negative case analysis was sought in order to systematically explore differences in the expanding data set. Therefore data that did not fit with the emerging categories were integrated into the account of data, as they provided an opportunity for the developing theory to be further refined and enhanced.

As the analysis continued and codes kept reappearing in the text that fitted prior codes and expanded upon those codes, saturation occurred. This takes places when codes have moved to a more conceptual level and no new themes emerge from the data.

Selective coding has been described by Tweed (1998) as the process of choosing a core category that represents the central phenomenon around which all categories are integrated. During focused coding the emergence of categories enabled the process of

selective coding to occur. The categories were placed together to make conceptual sense, in that they would tell a story that reflected and was all the time grounded in the accounts of participants (Strauss and Corbin, 1990). Hence being a descriptive narrative about the central phenomenon (Tweed, 1998).

Those categories that did not 'fit' or felt forced into the storyline were reviewed and re-examined to ascertain whether there were other ways to code them, this included the categories that appeared vague, judgemental or appeared to be assumptions of the researcher.

The development of the core category began with the researcher finding a story that reflected the participant's accounts and wrote a memo on this story. Strauss and Corbin (1990) postulated that initially this memo would be a 'general descriptive overview of the story'. The process that followed was to examine the memo analytically to find a category that encompassed the story. However the categories that the researcher had were only able to tell part of the story and none could bring the story together in an abstract way in order to explain the central phenomena/ main story. Therefore, the recommendation made by Strauss and Corbin (1990) of naming the central phenomena when no existing category could encompass the main story was followed. The researcher examined the central phenomena and developed a core category that incorporated all the other categories in providing an analytical version of the story.

Throughout this process, detailed definitions of each category, relationships between categories and speculation about 'what was going on?' were noted in the reflexive journal. This detailed documentation is an important aspect of grounded theory analysis (Henwood and Pidgeon, 1992; Charmaz, 1995) as it allows the researcher to keep track of the research in progress, as well as forming part of the constant comparative model (Strauss and Corbin, 1990) and allowing the researcher to consider her role within the research process (Henwood and Pidgeon, 1992). This process known as memo writing may be seen to be an intermediate step between coding and the first draft of completed analysis (Charmaz, 1995).

2.8   *Epistemological Stance*

Epistemology is the theory of knowledge (Holloway, 1996). It represents a 'world view' that helps define the nature of the world, ones own place and possible relationships within it (Guba and Lincoln, 1994). There is no way of establishing the ultimate truthfulness of such theories. However, epistemological considerations are central to the research process as help to define the relationship of the researcher to the participants.

Madill, Jordan and Shirley's (2000) paper on Objectivity and reliability in qualitative analysis: Realist, contextualist and radical constructionist epistemologies influenced the researcher's epistemological stance. Consequently, the research is positioned within a critical realist framework. Essentially, critical realism asserts that "the way we perceive facts, particularly in the social realm, depends partly upon our beliefs and expectations" (Bunge, 1993, pp 231, cited in Madill et al, 2000). Within this framework the accounts provided by the participants such as their experiences of their culture and diagnosis were accepted as their own, but that each individual perceived this differently. In addition, critical realism also asserts that people make sense of their experiences through complex interactions with other people and social factors. Therefore, the researcher adopted the critical realist stance for this study and accepted that the accounts that would be obtained from each participant would represent their own realities and experiences. However, the researcher also acknowledged that within the critical realist stance there is inherent subjectivity in the production of knowledge (Madill et al, 2000) and accepted that her position in the research would influence the accounts given by participants.

2.9   *Considering quality control*

Quantitative approaches employ certain quality control measures in order to provide explicit assessments of the information obtained in a study. The techniques are often designed to provide definite answers to questions about the reliability, validity and generalisability of a study's measures, its findings and of its conclusions (McGrath and Johnson, 2003). One of the major challenges for qualitative researchers has been

the struggle to establish agreement over the criteria which are to be applied when making judgements over the quality of a piece of research. However, Yardley (2000) states that these traditional techniques are not applicable in qualitative methodologies and they should be judged by criteria that are appropriate. Smith discusses two papers that propose general guidelines for assessing the quality of qualitative psychological research. The first is Yardley's paper (2000) and the second is Elliot et al's paper (1999). He states that they both provide a wide range of criteria and ways of establishing quality which can be applied to any theoretical orientation of a qualitative study. In the following section, Yardley's principles and Elliot et al's guidelines will be briefly discussed as well as other methods used to enhance the research quality for the present study.

2.9.1 *Yardley's characteristics of good (qualitative) research*

She offers three broad principles for assessing the quality of qualitative research (2000). The first principle proposed is *sensitivity to context*. She states that good qualitative research study should demonstrate sensitivity to the context in which the study is situated and this can be achieved in a number of ways. Firstly she states that researchers should hold an awareness of the relevant literature, the understandings created by previous researchers who have employed similar methods or have analysed similar topics and should hold a fairly extensive grounding in the philosophy of the approach adopted. She also suggested considering to what level the study is sensitive to the data itself. A third way of demonstrating sensitivity would be by holding an awareness of the socio-cultural setting of the study, as language, social interaction and culture are understood to be central to the meaning and function of all phenomena. Finally, the relationship between the researcher and participant itself is a further context one might be sensitive to, for example being conscious of the balance of power between the researcher and the participant. An attempt has been made to portray this principle, for example in the introduction, method and discussion sections.

The second principle is of *commitment, rigour, transparency and coherence*. Yardley comments that these are straightforward criteria as they correspond to the usual expectations for thoroughness in data collection, analysis and reporting in any kind of

research. Commitment refers to the degree of engagement in a number of domains such as experience using a particular methodology or extensive knowledge of the substantive field. *Rigour* refers to the resulting completeness of the data collection, interpretation and analysis. The data analysis (as described in the 2.7, Grounded theory analysis section,) employed in this study aimed for built-in validity. Silverman (2000) comments that all parts of the data must be inspected and analysed, which will then allow for comprehensive treatment of the data. In order to achieve this goal all the interviews were transcribed and open coded in full.

Within the *rigour* criteria, Yardley (2000) argues that it may be appropriate to employ triangulation of data collection or analysis in order to obtain a full understanding of the research topic. This method makes use of combinations of methods, investigators, perspectives etc., thus facilitating richer and more valid interpretations (Tindall, 1994). However, Silverman suggests that it is a less than satisfactory approach as it raises complicated issues about how to 'map' one set of data upon another (2000). Thus, triangulation has not been employed within this study.

If the write up of the research process is done in a clear transparent way and all relevant aspects of the research process are disclosed, Yardley would state that criteria of *transparency and coherence* will have been achieved. She states that the researcher may want to discuss their experiences or motivation which led them to undertake a particular investigation and to have made the thought processes behind each decision making transparent. This process is also known as reflexivity (see reflexivity section 2.9.4).

Yardley's third principle is *impact and importance*. She argues that any piece of research should be judged by its impact and utility and it should have a theoretical and practical impact. Smith (2003) points out that the key test of a research's validity is whether it tells us anything useful or important or makes a difference.
Smith postulates that Yardley's principles for assessing the quality of qualitative research make a useful contribution however it does not prescribe the particular ways in which these must be met (2003, pp 234).

2.9.3   Elliot, Fischer and Rennie's evolving guidelines

Elliot, Fischer and Rennie (1999) also presented evolving guidelines for reviewing qualitative research. They defined seven strategies (called 'credibility checks') in order to implement validity, which have been built into this study. The first guideline, *owning one's perspective* encourages the researcher to describe their theoretical, methodological or personal orientations as those relevant to the research.

The second guideline, *situating the sample* recommends the researchers provide basic descriptive data about their sample (see Table 1: Self-described cultural and religious identities of the participants). In the analysis section the third guideline called *grounding in examples* can be observed. In this guideline each theme is described by one or two concrete examples. The fourth guideline is to *provide credibility checks*, and the others are *coherence, accomplishing general vs. specific research tasks*, and *resonating with readers*. Elliot et al postulate that these guidelines are tentative and will evolve as the field of qualitative research develops.

Negative case analysis method is a further measure of quality. It is one aspect of comprehensive data treatment, which actively identifies and manages deviant cases (Silverman, 2000). This is essentially the process of identifying and focusing on aspects of the data where 'things go differently' (Peräkyla, 1997), that is the data does not fit the emerging categories. Attempting to integrate variation into the overall model seeks to generate a 'conceptually rich, dense and contextual grounded theory' as recommended by Henwood and Pidgeon (1992, pp 107). Therefore within this study, the researcher sought out negative cases in order to integrate them into the overall model.

The constant comparative method has been employed extensively throughout this study. This method defines the principal analytical task as one of continually sifting and comparing elements throughout the lifetime of a research project (Pidgeon, 1996). This process encourages immersion in the data aiding a grounding of the interpretative findings and encourages constant refinement of the category system as a whole (McLeod, 2001). The implications of this method were that the analysis remained close to the meaning of the text, enhancing the validity of the account that was developed (Rennie 2000).

Qualitative researchers question the usefulness of the concept of replicability in the evaluation of qualitative research (Marshall & Rossman, 1989), however they have a responsibility to demonstrate that if the research was to be replicated with similar participants, in similar contexts; its findings would be repeated (Lincoln and Guba, 1985). However transparency of the methodology employed, documentation of the procedure and the reflexivity of the researcher will allow others to track the progress of the research and will provide new researchers with a sound basis for similar studies (Henwood and Pidgeon, 1992; Silverman, 2000). Smith postulates that leaving an audit trail forces one to check the rigour of one's claims (2003) and allows a replication of the methodology. Madill et al (2000) postulate that within a realist framework, triangulation can be used to assess the reliability of qualitative analysis. The results are understood to be substantiated where different perspectives converge so that triangulation becomes a process of mutual confirmation. Madill et al's method of triangulation was not employed within this study due to the time constraints of a D.Clin.Psy (Turpin et al, 1997).

2.9.4 *Reflexivity*

Stevenson and Cooper (1997, pp 160) state that 'one way in which research may be evaluated is by the extent to which the researcher reflects on the process of his or her research' and Bryman (1988) commented that this was a crucial activity that psychologists should undertake in order to choose an appropriate inquiry position with regards to the phenomenon being researched. Wilkinson (1988) stated that in simple terms it could be considered to be disciplined self reflection and that the research topic, design and process, alongside the personal experience of doing the research should be reflected upon and critically evaluated throughout. She developed and identified three types of reflexivity, personal, functional and disciplinary, the first two being inextricably connected. Acknowledging who the researcher is and how personal interests and values influence the process of research from initial idea to outcome are what Wilkinson terms 'personal reflexivity'. Functional reflexivity is the continuous, critical examination of the practice/process of research to reveal its assumptions, values and biases. Disciplinary reflexivity involves reflecting on the larger issues that include research methodology and questioning psychology itself. Tindall (1994) adds

that reflexivity is about acknowledging the central position of the researcher in the construction of knowledge, that 'the knower is part of the matrix of what is known' (DuBois 1983), that all findings are constructions, personal views of reality, open to change and reconstruction. Finally, the last criterion of Yardley's second principle of assessing quality is *transparency and coherence* and this has been discussed here.

The researcher has endeavoured to employ the reflexive process throughout the process of conducting this research by using two broad procedures. Firstly, a reflexive journal was maintained throughout the research process (Lincoln and Cuba, 1985). Within this journal various assumptions, observations, ideas and critical evaluations regarding the interviews, values and analysis were logged (see figure 1). The other strategy employed was of having discussions regarding the research process with the field supervisor and within a qualitative research support group. The group discussed a broad range of issues, including the researcher's perceptions of the interviews and how her values might be impacting on the analysis.

It seems that most of the participants have an idea of what the other culture is like...that is the white/host culture we live in. Participant 1 appears to be more involved with the host culture than the Asian culture, whereas participant 3 has very little to do with the host culture and the others are somewhere in the middle. But I am left with a feeling that they have ideas, beliefs about the other culture, which they have found difficult to articulate.

They all seem to have a fantasy about the other culture being better, more understanding, laid-back and I have this fantasy too, which I too find difficult to articulate. How do I know what is in the other culture- am I just using my stereotypes too. Is it that I understand what they mean and therefore have not been exploring the fantasy as much as I would if I were not Asian.

Figure 1: Extract from researcher's reflexive journal

2.8.5 *Researcher in Context*

The specification of the researcher's perspective is listed by Elliot et al (1999) as an important guideline to follow, when conducting qualitative research. They emphasise that it allows the reader to interpret the researcher's understanding of the data, and to

consider alternative positions. The researcher in this study is an Asian female in her final year of clinical psychology training.

The researcher had no previous experience of using grounded theory, or other methods of qualitative analysis but had an interest and some clinical experience working with Asian people with mental health problems. From this work, and new government guidelines such as the National Service Framework, the researcher began to pay interest to the lack of clients from an observably ethnic minority. The researcher noted the need for services for Asian women and was aware of the difficulties within this group of people. However, one of the reasons given for the increased rate of suicide within this sub-group was that of culture, this led to curiosity regarding men's mental health within the same culture. The literature and discussions with clinicians indicated that generally there was an under representation of people from ethnic minorities, even in cities with a large ethnic minority population such as Leicester. Hence, the review of literature that introduces this study.

The researcher being Asian herself was aware of perhaps having a bias towards viewing the Asian men as being frustrated with their perceived culture for not understanding and she could relate to having a fantasy about the other culture. These biases were monitored throughout the research process in a reflexive journal and during regular research supervision. The researcher noted that it was not possible to be aware of all internal process pertaining to a topic (Rennie et al, 1988), but by keeping the reflexive journal, it enabled the researcher to gain some awareness of the role she played in the research process.

3.0 <u>Analysis</u>

3.1 *<u>Overview of Chapter</u>*

This chapter provides an account of the analysis of the six interview transcripts. This account offers one way of attempting to understand the experience of South Asian men[4] who have received a psychiatric diagnosis and the wider implications. Following the analysis procedures described in the previous chapter, a core category and five main categories were generated from the data. A process model has been developed to depict how these categories are understood to relate to each other and explores the movement between them. After the presentation of the model each category, comprising of intermediate level categories and sub-categories are described in turn.

To aid the reader, the different levels of categories are represented using different text formats as follows: -

> ***CORE CATEGORY*** – Represented in bold, italicised, capital lettering.
> **MAIN CATEGORY** – Represented in bold capital lettering.
> INTERMEDIATE CATEGORY – Represented in capital lettering.
> Sub-Category – represented in lower case lettering.

All the categories generated are grounded in the interview texts of the six South Asian men. The core category is also grounded in the participants' accounts, however represents an abstract conceptualisation of the accounts told. It attempts to highlight the account or central tenet contained within each transcript when read as a whole. The five main categories developed from the analysis were identified in all the participants' accounts. The characteristic and properties of each category will be

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[4] The terms 'South Asian men' and 'participants' will be used interchangeably throughout this chapter. South Asian in this chapter and throughout this study refers to men born in the UK and of South Asian origin.

described and illustrated with excerpts from the interview transcripts. After each excerpt a reference will be made to its location in the transcripts.

3.2   *Overview of the Core Category and Process Model*

The core category developed from the analysis was defined as 'Reconstructing a sense of identity'. This represented an overview of the analysis and was the focus of the story. The five main categories pertaining to the core category were essential in describing the account being generated. The five main categories were 'Identification with Asian Culture and Values', Contact and Experience with Mental Health System', 'Identity not being heard', 'Others Influencing the Integration of Identities' and 'Others Influencing the Formation of Separate Identities'.

'IDENTIFICATION WITH ASIAN CULTURE AND VALUES' as a main category was characterised by participants' identification with the Asian culture and the values held within it. The identification with the Asian culture is an important part to the participant's self-described cultural identities. The significance of the identification with the Asian culture(s) is the experience of the cultural values impacting on the achievements that the participants' feel they need to obtain. These identifications with the Asian culture and values highlight diversity, complexity and individuality, including identification with 'British Asian culture'.

> *"I would say I'm Punjabi Indian and brought up in England, I'm more British*
> *than Asian...you know British Asian...culture wise I do follow*
> *Sikhism...Sikhism is like you say my faith"*
> *('Ranveer', pp 2, 3-6)*

> *"...All I can say is family values, you know we have been brought up to*
> *respect our elders, and to look after them in their old age, that is the main*
> *cultural way of looking at life... one day we got to go old as well and expect*
> *our children to look after us"*
> *('Ranveer', pp3, 36-40)*

'CONTACT AND EXPERIENCE WITH MENTAL HEALTH SYSTEM'
reflected the participants' contact and experience with the mental health system. The
mental health system is constantly evolving and developing and is reflected in the
participants' accounts.

> *"And I found my local GP just fobbed me off but the CPN I got well she's*
> *bang on I mean she actually started to push the doctors and got you know the*
> *proper psychiatrists to see me and she helped me and she didn't patronise me*
> *as such well you find that with most doctors I've found that I've dealt with in*
> *the past couple of years do patronise you..."*
> *('Sameer', pp8, 163-169)*

> *"...So they took me to a doctor then, the doctor was an emergency doctor not*
> *my normal one so we went to him and he actually told us to go to a*
> *psychiatrist cause they actually deal with the people who has got problems*
> *with the mind... so when people have problems in the mind they have to go to*
> *the right person to cure you..."*
> *('Pardeep', pp 18, 415-420)*

'IDENTITY NOT BEING HEARD' as a category, represented participants'
attempts to understand who they are as a person. Contact with the mental health
system changed their path in life. Participants appeared to have an idea of what they
were doing and where they were going until they became ill. The illness changed the
way they perceived life, it changed people around them and it added another
dimension to their identity. They were Asian men who had been given a psychiatric
diagnosis.

> *"When I was in hospital I was told that I had this illness but no-one asked*
> *what is it like living in your community, what's it like living in your family,*
> *what's it like meeting your uncles and aunties. No one understood that part of*
> *my life, I'm not just ill, I have a life, there are expectations and*
> *responsibilities"*
> *('Deepak', pp 11, 231-236)*

"Well I felt at that stage when I first was coming back from the hospital talking to my dad... I said don't get upset if someone says that ohh I'm mental or mad but I'm not. In my own mind a that time I wasn't thinking what the illness was and how my illness was going to develop in the later stages... all I was saying was I'm not mad at the moment I am ill and I can cope with that... people will say I'm mad... that was the first reaction... talking to my dad on the way back from the hospital"

('Ranveer', pp 13, 281-289)

'OTHERS INFLUENCING THE INTEGRATION OF IDENTITIES' represented the participants' accounts of being able to integrate their mental health and cultural identity. This integration occurred as a consequence of many variables coming together and working well together.

"Yeah they have accepted it all and they don't put the pressure on me. They can see visibly you know that he is trying and he is doing this and that in the house, they can tell when they visit"

('Onkar', pp 21, 491-494)

'OTHERS INFLUENCING THE FORMATION OF SEPARATE IDENTITIES' as a category represented the participant's accounts of their mental health identity and cultural identity being separate. This spilt being created by many factors, which will be described further.

"...Mine was different because I was already in business and every time I had to go into hospital I would always say I am losing so and so much in my business and they would say ok we will let you out in a certain time and each time it was 28 days so after four weeks I stepped back into my market routine and pick up the pieces of the last four weeks what I lost...I got to catch up with that and I tried to do double work coming straight from the hospital straight into the business"

('Ranveer', pp 17, 397-405)

The process model illustrated pictorially in figure 1 depicts the interactions between the main categories involved in enabling participants to reconstruct their identity in relation to receiving a psychiatric diagnosis and living within a South Asian community.

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┌──────────────────────────────────────────────┐
│  RECONSTRUCTING A SENSE OF IDENTITY            │
└──────────────────────────────────────────────┘
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        ┌─────────────────────────────┐
        │  IDENTIFICATION WITH        │
        │  ASIAN CULTURE AND          │
        │  VALUES                     │
        └─────────────────────────────┘

        ┌─────────────────────────────┐
        │  CONTACT AND EXPERIENCE     │
        │  OF THE MENTAL HEALTH       │
        │  SYSTEM                     │
        └─────────────────────────────┘

            ┌──────────────────┐
            │  IDENTITY NOT    │
            │  BEING HEARD     │
            └──────────────────┘

┌────────────────────────┐   ┌────────────────────────┐
│  OTHERS INFLUENCING    │   │  OTHERS INFLUENCING    │
│  THE FORMATION OF      │   │  THE INTEGRATION OF    │
│  SEPARATE IDENTITIES   │   │  IDENTITIES            │
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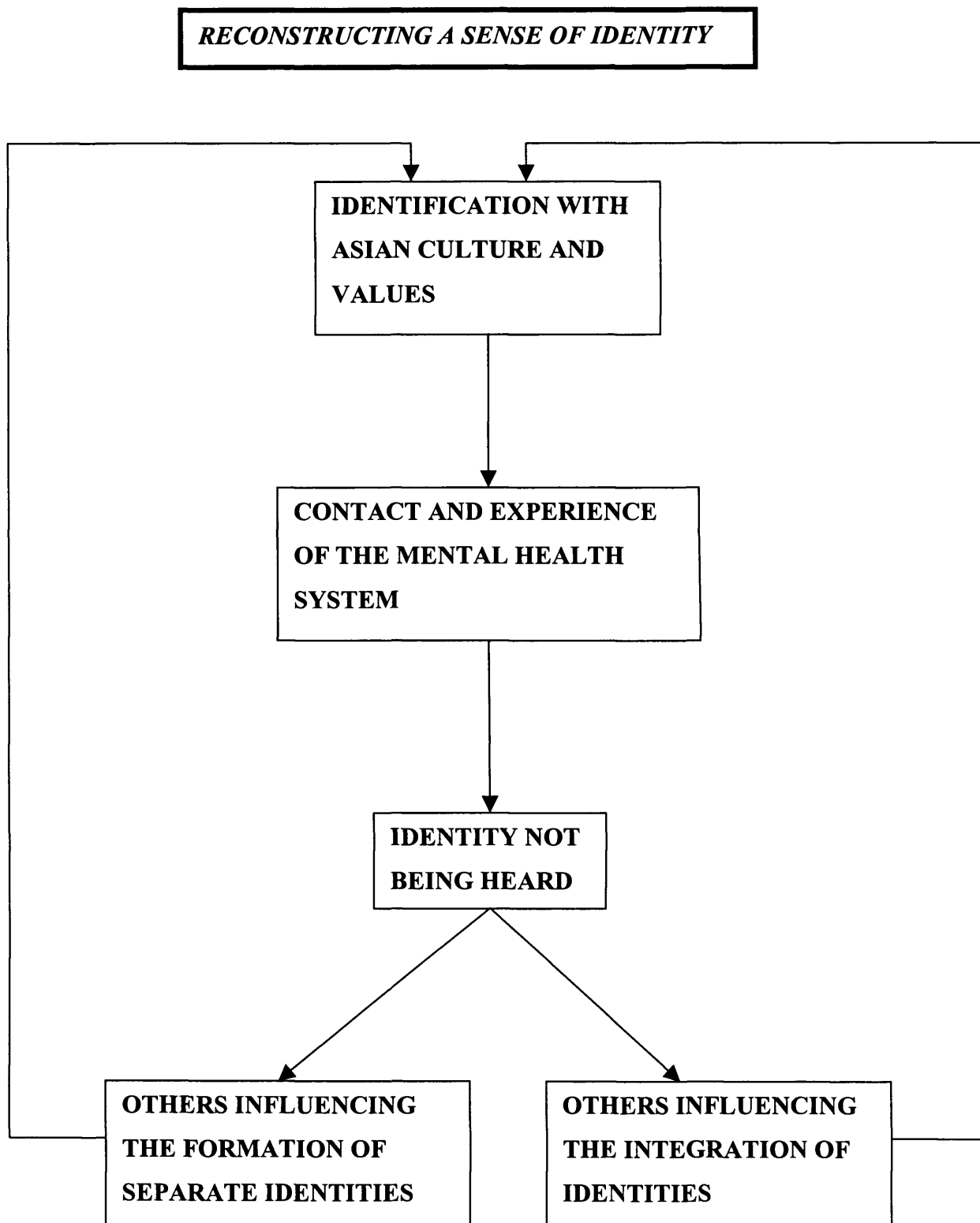
Figure 2. A process model relating to the experience of South Asian men having a psychiatric diagnosis and the wider implications.

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3.3   Core Category- <u>RECONSTRUCTING A SENSE OF IDENTITY</u>

The researcher interpreted this core category from this analysis as the overall understanding of how the six UK men of South Asian[5] origin experienced having a psychiatric diagnosis

All the participants described being able to relate to an Asian culture that was different to the host community that they were currently residing in. Participants described differences between their culture and the host culture, which centred on family values and they were able to integrate their Asian identity into their lives and were achieving the milestones and standards that one was expected to achieve in the Asian community. It also appeared with little direct grounding in the accounts that the Asian culture was collectivistic in nature, in that families did become heavily involved in people's lives and make decisions for the person because they knew best.

The contact and experience with the mental health system was a huge life event for all the participants. Accounts suggest that it stopped them in their tracks and made them think of this illness that had just been diagnosed. The experience in hospital and community services left them evaluating the illness, how it happened, what happened and how did they feel.

The analysis of the transcripts suggested that participants entered a stage where their identity was not being heard. The themes of being an Asian man alongside being diagnosed posed many implications of who they were. Their identity of an Asian man who was meeting expectations within his community became fragmented and in some cases shattered. A new identity had emerged which was of having a psychiatric diagnosis and the participants were trying to understand it. This stage highlighted participants questioning their identity because it was not being heard.

The model splits into two possible routes, one route leading to others integrating their sense of identity and the other route leading to others creating a separate sense of identity. The category of others integrating a sense of identity included many factors

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[5] Throughout this chapter South Asian men of UK origin will be referred to as Asian men.

that came together to enable the participant to see them-selves functioning as a South Asian man with a psychiatric diagnosis. The two identities were not fragmented but working alongside each other. Whereas the category of others creating separate identities found that participants reported that their identities of an Asian man and having a psychiatric diagnosis were not able to integrate, which prevented the augmentation of the two identities.

Whenever there are changes within the model at any step the person and others evaluates the identity and can take either route of integrating or separating the identities. The model is fluid as the participant and others are constantly evaluating the identities. The separate identities create tension and increase the pressure of trying to attain a normal life while the integrated identity allows a person to function within their own culture with an understanding of the diagnosis they have received. All the participants appeared to hold separate identities or integrated identities at any one time depending on the influence of various factors. There is considerable movement within this model and participants' expressed that in their accounts (see main categories of 'others influencing formation of separate identities' and others influencing the integration of identities').

Each of the main categories will now be discussed in greater detail. Intermediate categories and sub-categories add a deeper understanding to the main categories and will be diagrammatically represented.

3.4   Main category- **IDENTIFICATION WITH ASIAN CULTURE AND VALUES**

The first of the main categories is 'Identification with Asian culture and values. This category contains three intermediate categories and two of the intermediate categories contain two sub-categories each, the third intermediate category has one sub-category. This is presented pictorially in Figure 3. This main category refers specifically to South Asian men, reflecting the gender of the participants but also that the values of Asian culture described in the accounts were interpreted as being placed in the context of gender values specific or particularly relevant to men within that culture.
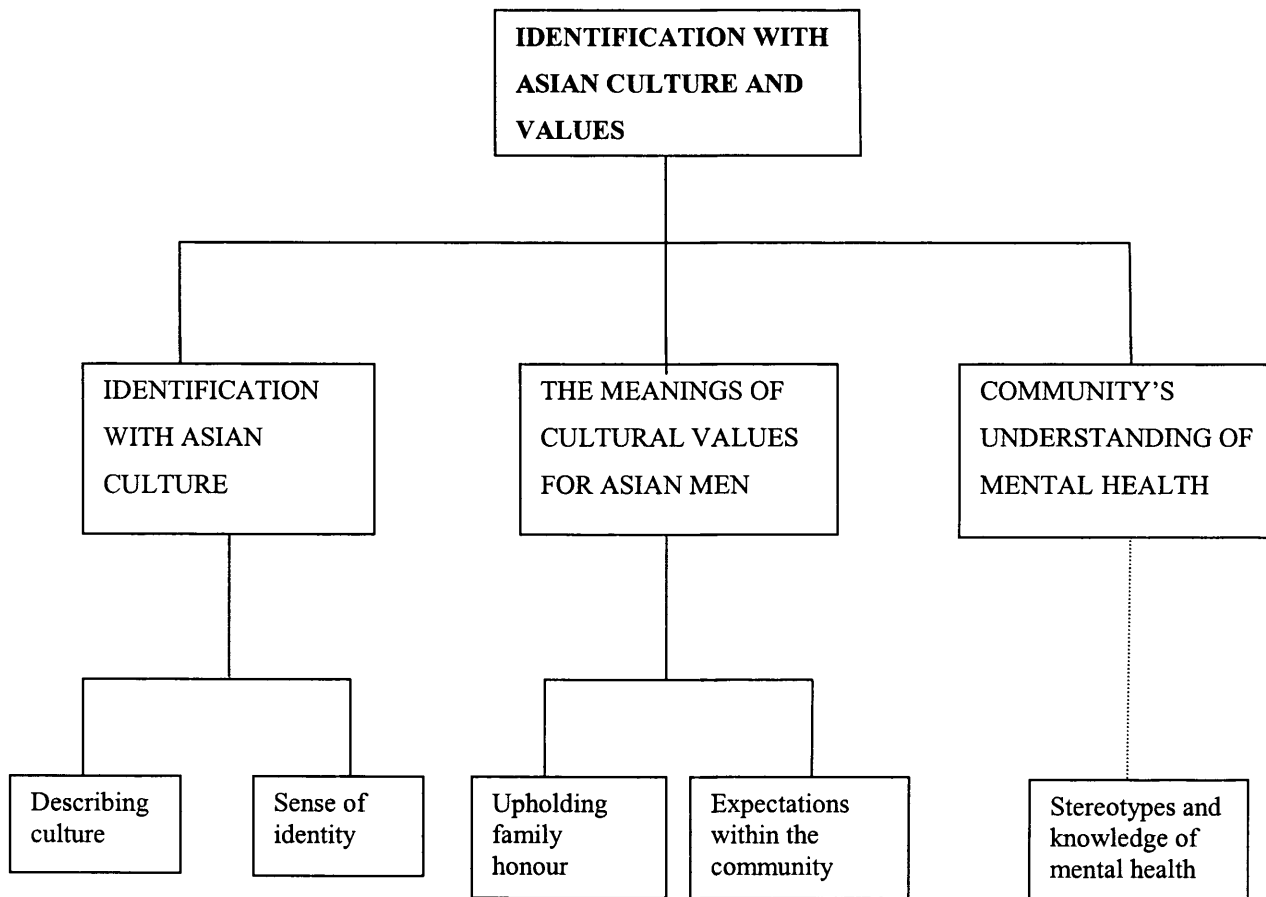
Figure 3 Identification with Asian culture and Values

3.4.1   Intermediate Category: IDENTIFICATION WITH ASIAN CULTURE

The first intermediate category is 'Identification with Asian culture'. It contains two sub-categories, 'Describing culture' and 'Sense of identity'. The sub-category 'describing culture' provides an account of the words used by these men in describing their cultural identities. The sub-category, 'sense of identity' aims to represent the factors that influence this and that it changes with the decisions that are made by the man and/or family.

Sub-Category: 'Describing culture'

All the participants during the interview process were asked to use their own words to describe their cultural identity. All participants drew on a number of constructs on which to hang their self-described cultural identity. There were four main themes identified in the analysis, however not all the participants used all four of these themes to directly describe their cultural identity. The following segment of transcript sets out two of the four themes.

> *"My culture is... I am a born in Leicester and been in Leicester all my life,*
> *I've been brought up in Leicester. My mum is from Goa and my dad is*
> *originally from Nairobi and I'm er I class my culture as being Asian definitely*
> *Asian roots and ethnic roots but born and brought up in Leicester that's how I*
> *kinda see it".*
> *('Onkar', pp 1, 3-8)*

Onkar's segment highlighted two themes of the four identified: parents place of origin and the concept of being Asian. The concept of being Asian is being related to ethnic roots. Pardeep's segment highlights the third identified theme of religion and also talked about Asian people bringing their roots and identifying features over to Britain with them.

"If I had to say what I was I would say I'm an Asian... with a Hindu
background... and obviously you have Hindu gods, that's part of your
culture... the gods... the way you dress up is part of your culture, the food you
eat is part of your culture... so everyone has it... so what Asians do is what
they do in India and they tend to bring all that and try to fit it into Britain
cause everybody prefers ... they have been used to it at home you see".
('Pardeep', pp 2, 9-15)

Ranveer talked about the identifying factors related to religion and how his
appearance is an identifying feature of the religion he belongs to.

Ranveer- "... The identity I have is Punjabi Indian, which is having a turban
and a beard, but I still cut my beard, I trim my them and I'm not like a
baptised Sikh and at the same time I'm thinking in weather like this I would
rather not wear a turban cause it's too hot...so I'll let my hair down once a
while"
Anita- "So religion is very important"
Ranveer- "Yeah, it is an important part of my identity".
('Ranveer' pp 9, 203-210)

The final theme is language, which Sameer describes as an identifying feature of
being Asian.

"Well I was born a Muslim, I ain't a practising Muslim like cause I drink umm
that's what I put myself down as, as Euro-Asian cause I mean... I got no
family in any other country, my brothers and that lot, I don't bother with none
of them, it's just... the only way I can explain it, I'm in limbo. Cause I can't be
Asian cause I can't speak the language well I can understand it but not speak
it fluently but it's like I know a bit of French and know a bit of Germany from
the army..."
('Sameer' pp 18, 421-428)

The importance of language has been a theme in nearly all the accounts from participants. Sameer felt that he could not be Asian because he was not able to speak his language however; Onkar could not speak his language but did not feel the same.

> *"Umm, my mum and dad speak Goanese language at home as well as English and the Goanese language is called Cocanee as well as English at my mum's home. It's a mixture there. But I can speak English, I can speak a few words of Cocanee but I understand everything so when I have a conversation I can understand everything. Sounds slightly strange but I can understand everything and I can speak a few words and that's the same as my brothers and sister".*
>
> *('Onkar', pp 2, 13-20)*

Deepak felt being able to talk in his language was important, as at times it enabled him to express himself when he could not in English.

> *"...Talk your language and that's important, I'm better at talking in English but sometimes I feel they can understand what I'm saying cause sometimes I can't find the words in English"*
>
> *('Deepak', pp 13, 288-291)*

Sub-category- 'Sense of Identity'

The previous section highlighted the complexity in describing cultural identity. All participants were born in the UK yet were attached to an identity other than British. This sense of identity appeared to vary according to environmental factors and the participants own decisions in life. These factors contributed to the participants' understanding of their sense of identity.

> *"Just Hindu, not really part of the western culture. Generally keep myself to myself, socialise with Asians more because that's how it's been, not really been involved with any other community. Most of the people I meet are Asians and Hindu. I have not really come into contact with other people".*
>
> *('Deepak', pp 2, 16-21)*

The environmental factors that have influenced Deepak's sense of identity is the decision made to socialise within the Asian community hence being separate from the Western culture and not being involved in other communities. Pardeep talks of an active decision he and his family made to stay in an area where more and more Asians were moving.

> *"...The only problem is that sometimes you feel people don't quite understand where you are coming from. I've lived in the same house all my life and at first there was more English people than Asians...there wasn't that many Asians here in Leicester then... but obviously as time went on the English people tended to move out and the Asians tended to go where the Asians were and we stayed where we were and obviously we expanded and brought houses in the same street and stayed near each other and the shops are nearby and it's convenient".*
>
> *('Pardeep', pp 22, 522-531)*

Sameer speaks of the themes, which are identified throughout his interview. He talks about the identifying factors of being an Asian person such as religion, language and parent's origins. However, due to decisions he had made prior to becoming psychiatrically ill, he does not fully identify with being an Asian and consequently questions his identity, as the following segment highlights.

> *"I find myself in limbo... to tell you the truth, you know because it is it's the you know I can't be part of my own people cause I married a white woman and I can't be white cause I ain't white if you know what I mean"*
>
> *('Sameer' pp 3, 61-64)*
>
> *"You understand, I can't go round acting like a white man cause I ain't a white man... but yet... erh I can't accept my own people for the way they treat me. You understand that in some kind of way"*
>
> *('Sameer', pp 4, 66-69)*

All the participants spoke of actively partaking in religious activities and for some the religious activities included social events, which they felt to be important. Indirectly they spoke of its connection to their identity through their discussions.

"Oh yeah, yes well when you go to the Gurdwara and all you hear... that the gurus have said this and that and you have to sort of supposed to follow that way of way, that lead, you know what they believe in... what is written in the holy Guru Granth".
('Ranveer', pp 2, 15-19)

"Religion is part of my life, I don't follow it strictly but I can't cause it is a way of life but I am not strict about anything. I am willing to try things out and I take what I want. My mum prays a lot and I sometimes join her. My wider family are religious and believe in God and go to the temple a lot".
('Sunny', pp 16, 334-338)

Finally, a theme that emerged that was not directly described by participants but was interpreted by the researcher was that Asian culture endorsed a concept of collectivism. Families supported each other, sacrifices were made for the good of the family and this can be seen in Ranveer's description of having to put his family before him.

"Yeah yes... I wanted to play football, wanted to become a member of the school team and it was not possible because Saturday was the football team match and Saturday was the main market day. And the market and my dad became first priority ... so being with father; being with family business was... that was more priority than playing in the game... so I did miss out in that way"
('Ranveer', pp 6, 122-128)

Whereas, the host culture was perceived as individualistic as people who made their own decisions and thought of themselves before others.

"Yeah well...I mean at the end of the day like a I said if the English had a
football match on they would go to the football match rather than go to help
dad. Their first priority is dad I'm going to the football match"
('Ranveer', pp 7, 132-135)

3.4.2   Intermediate category: THE MEANING OF CULTURAL VALUES FOR ASIAN MEN

The second intermediate category is 'The meanings of cultural values for Asian Men'
and this category has two sub-categories, the first being 'upholding the family honour'
and the second of 'expectations within the community' referring to their experience
within the Asian culture. The meanings of the cultural values for the men interviewed
highlighted the importance but also diversity and complexity of the values. This
intermediate category illustrates the unsaid expectations that are held by family and
community and how the participant knows this, follows and tries to achieve these
expectations.

Sub- Category: Upholding the Family Honour

Within the interviews, a theme that emerged was regarding family honour and the
importance of upholding it. Ranveer talks openly about family honour having to be
maintained by one's own actions and how easily it can be tarnished.

"Honour is more important you know family honour. If you disgrace your
name...family name you know...it goes long long way you know to
grandchildren and on"
('Ranveer', pp 7, 146-148)

Pardeep continues with this theme when talking about difficulties in his marriage and
how they have to work together to maintain a stable relationship because otherwise
the community will have something to talk about.

"I mean I can run away and go somewhere else but I mean at the end of the
day you are just going to burden someone else...it all comes down to what you
want to do or want to be... you certainly don't want divorce cause it's best to
stay together as a family... cause if you divorce it's like another hurdle where
you have lost and everyone says 'so and so has divorced' and it's another goal
to them"
('Pardeep', pp 8, 159-167)

Ranveer talks about the communities' curiosity and how they will ask questions to find out more, whether directly or indirectly. These are shown in the following two segments of the transcript.

"Yeah, they always ask questions like who's son are you and you say so and
so and they say he's well known and we know him very well and he's good
etc... and if he has been bad then they say oh yes oh yes we know and they put
a full stop to that... we don't want to know anymore".
('Ranveer', pp 8, 173-177)

"They will go round in a circle now to ask somebody is he the same person
who had a shop in there... they probably know I am the same person who had
*a shop in ****** rd but they go round in circle... they don't come and ask me*
they ask others".
('Ranveer', pp 28, 668-672)

Upholding Responsibilities

Another aspect of upholding the family honour is fulfilling duties and responsibilities. It was interpreted that for many of the participants, the role of having responsibilities and duties was a cultural norm, an unsaid criteria and a way of life. It was commented that this was seen as different in comparison to the host culture[6].

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[6] The term 'host culture' has been used in many different ways, participants have used the following terms; Western culture, English culture, European culture. It has been interpreted by the interviewer, that these terms are interchangeable.

*"Yes, I was brought up in like an Indian way, my parents background is
Indian, and I like the more Indian way of life, the family values are much
greater than ... in comparison to the European".*
('Ranveer', pp 2, 8-11)

*"I am the oldest and sometimes you feel that you have to take the
responsibility being the oldest, you have to be the wisest".*
('Pardeep', pp 9, 190-191)

Sub- Category: Expectations within the Asian Community

All the participants' accounts contained experiences regarding the expectations held
within the Asian community. They spoke in depth about what standards and
milestones had to be achieved in order to obtain respect and recognition within the
family and community.

*"In the Indian community we have to achieve certain things you have to get
your A-levels, a degree, get married, have a home and family and there are
these set things you have to achieve in order to be respected and part of the
community. These things are highly valued in Asian society... education is
seen as important for my family in that you need to have a standing within
society"*
('Sunny', pp 14, 287-295)

*"It is so important in this culture... the Asian culture to be strong, to look after
yourself and your own..."*
('Deepak', pp 18, 402-403)

All the participants held similar ideas of what the milestones/ standards were in their
community. They were aware that their roles within their family and community were
to provide the family with recognition of their achievements and to continue with
duties and responsibilities. It was interpreted that these values are not necessarily
gender specific however the consequences of not achieving them were gender

specific. The participants spoke of the negative consequences of not being able to achieve the expectations.

> "Yeah important and good if your child becomes an accountant, lawyer and then they, your family go and give sweets to everyone, you know cause they have achieved something cause their child has done something. When I went to university they didn't do that but I honestly to God, I don't know whether they were proud of me or not. I was intelligent and I wish I had completed my degree and that makes me sad I wish I could have made them proud"
> ('Deepak', pp 15, 338-346)

For the participants that spoke of the consequences of not meeting expectations, they appeared to have internalised them by feeling they were not good enough, or that they were lazy or there was something wrong in them for them not to have achieved. This was then manifested in various ways such as low self-esteem, anger, and anxiety etc.

> "They think I'm not ill but jealous and frustrated at other people's achievements who work hard for it cause I'm not interested in working hard or have no interests, talents or abilities and I won't take a job in factory and get a girl from India and live a normal life"
> ('Sunny', pp 11, 237-241)

3.4.3   Intermediate category: COMMUNITY'S UNDERSTANDING OF MENTAL HEALTH

Participants' accounts contained reference to the lack and level of understanding regarding mental health. They spoke openly of the stereotypes held and how it was difficult to translate mental health into their native language. There was a notion that once people within the community saw you as 'mad' there was a label attached that remained for life, a person would always be known as 'the mad one' and people would change their behaviours around 'the mad one'.

"Yeah I speak Gujarati and if you translate that it is 'gando' and that means
he is crazy... 'paagal' that what the translation is someone who cannot control
his mind is mad"
('Pardeep', pp 15, 341-343)

Mental health as a concept within the Asian community is difficult to explain and
understand.

"...There is no particular way of talking about illnesses because they are
different in Asian communities and western communities. Mental illness can
happen to anyone but it is a way of thinking as well".
('Pardeep', pp 15, 351-354)

"There is no such thing as mental illness in the Asian society, there's just no
such thing. They think you have gone loopey loo, mad"
('Sunny', pp 4, 61-63)

The participants felt that if the community did try to understand mental health it
would be viewed in only three ways. Ranveer talks of these three constructs, which
the community use to understand mental health.

"Yeah cause at first they thought hospital is a 'paagal kana' hospital for the
mad...this is it all the people go there was mad or there was black magic
somebody had done this to you, put something in your drink or something like
that".
('Ranveer', pp 16, 359-363)

"Sometimes others compare it to a physical illness and I think sometimes I do,
I mean it's tablets for life, it's just one of those things".
('Ranveer', pp 21, 500-504)

The three constructs featured in the majority of the transcripts and felt that they were
constructs taken from the home countries. The concept of mental health within the
western society is not discussed within Asian communities and Pardeep felt that it

would take time for people to adapt to the western way of thinking. Sameer felt that within his community not looking normal created hysteria. He felt that people did not know how to cope and would be ashamed.

> *" I would see other people like you know not just mentally handicap I'm talking about proper being handicap do you know being in a wheel chair and that and these people and I just used to look at them... and if there is something wrong the Asians seem to think it's oh the end of the world it's like the child should never have been born if you know what I mean".*
>
> *('Sameer', pp 6, 119-124)*

3.5   Main category- **CONTACT AND EXPERIENCE WITH THE MENTAL HEALTH SYSTEM**

The second main category identified in the accounts of the participants was termed 'Contact and experience with the mental health system'. This centred on the participants' experiences in hospital, community services and with the illness[7].

This main category referred to here to both the first contact with services and to ongoing contact. Some of the lower level categories that will be described here have greater applicability to either first or more ongoing contact and it is made explicit where this occurs.

A diagrammatic representation of this category is shown in Figure 4 on the next page. As can be seen, there are two intermediate level categories. The first intermediate category is the 'experience of hospital', which all participants encountered and attempted to understand, they appeared to understand this in two ways, 'professional approach' and the 'feeling evoked in hospital'. The second intermediate category is the 'experience with community services', which changed over time and was spilt into two sub-categories.

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[7] All participants' accounts identified the term illness, which will be used throughout this chapter.

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┌─────────────────────────────────────┐
│ CONTACT AND EXPERIENCE OF THE        │
│ MENTAL HEALTH SYSTEM                 │
└─────────────────────────────────────┘
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Experience in hospital			Experience with community services		
Professional's approach	Feelings evoked in hospital		Professional's approach	Available services	
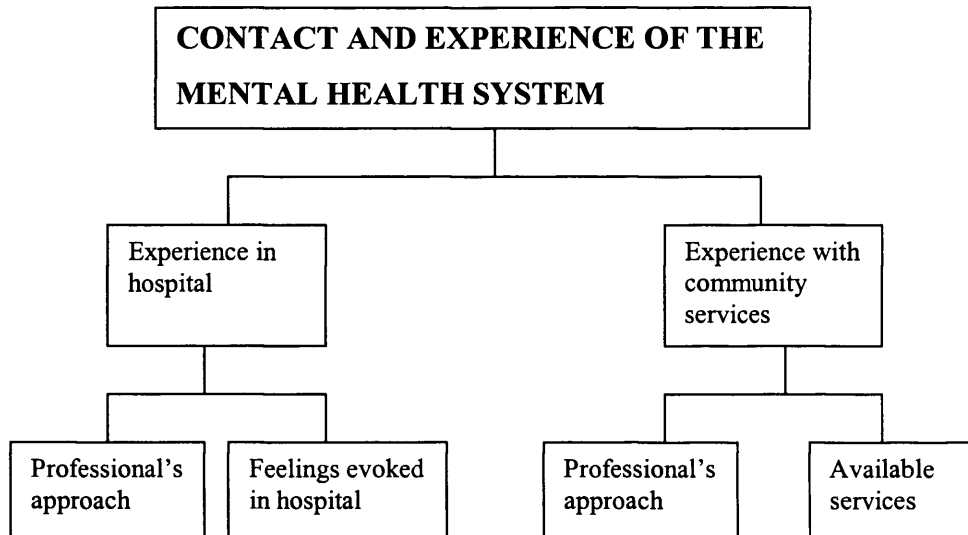
Figure 4. Contact and Experience of the Mental Health System

3.5.1 Intermediate category: EXPERIENCE IN HOSPITAL

Participants identified two main strands of their experience in hospital, the first regarding professionals' approach and the second regarding the feelings that were evoked whilst in hospital. These experiences were all concerning their first contact with the system.

Sub- Category: Professionals Approach

In this sub-category the participants referred to doctors and nurses whilst in hospital. Their experience of professionals approach ranged from not feeling understood by the professionals to feeling understood.

> " *I think I seen one shrink when I was in there and I was ready to leave".*
> *('Sameer', pp 17, 385-386)*

> " *But Dr **** who was fantastic, he really understood".*
> *('Onkar', pp 7, 133-134)*

All but one participant felt there was little or no liaison between the professionals and their families whilst they were on the wards. They all felt that they were the relaters of information regarding medication, the illness, and discharge dates etc.

Communication was an issue brought up by all the participants, but the experience varied as some had good opportunities to discuss feelings and others did not. The main emphasis within this category was upon doctors' attitudes, availability and decisions made rather than the nurses' role. It appears that nearly all the participants felt that the doctors had more control in hospital and used the medical model, assuming medication would cure them of the illness. Sameer grapples with this concept and finds it difficult to understand why doctors don't always listen.

> " ...But some doctors right, when they make a decision they are that so cock sure of themselves and even when you are telling them it ain't fuckin working... they'll still say no no give it time. That's the obnoxiousness I don't like, they are always there telling you that they know best".
> ('Sameer', pp 25, 595-600)

Sameer found trusting doctors was initially very difficult. He was the only participant to have described this view.

> "...At first I wouldn't tell them nothing... and even then if I sit there with a shrink I would not let them inside my head. Because I can't trust them... "
> ('Sameer', pp 26, 609-612)

The researcher interpreted this, as Sameer was the only participant to have become separated from his community through choice and therefore may not have been influenced by the views held by members of the Asian community. Pardeep's account highlights the respect given to doctors by families.

> "I don't think professionals would know what to say to Asian parents who thought they were God because they were going to cure their son of this horrible illness... "
> ('Pardeep', pp 26, 625-628)

Sub- Category: Feelings evoked in hospital

All the participants gave accounts of their experiences whilst in hospital. They all described the experience as being isolating, frightened and feeling vulnerable.

> " ...Yesterday my CPN came round and we were telling her about this
> [experience in hospital] ... how I felt the last time erh, they stuck me in a
> bed...and left me, that was it. Came in and took gave me different medications
> and you know that film one flew over the cuckoo nests, you know where
> they've got them mad gowns on with their arses hanging out... that's all it
> needed all they needed to do was to give me one of them gowns you know
> that's how it felt".
> ('Sameer', pp 16, 374-381)

Participants spoke of the medication regime and how the emphasis was placed on taking medication and less about the troubles they were experiencing. They felt that alternatives needed to be considered. Interestingly, those participants for whom medication had been beneficial agreed with this point. They all felt that there was an over-emphasis placed on medication, which was often seen as impersonal.

> " You line up like an idiot you know this little plastic cup and stick your
> tablets in it and then watch you take your medication and that was it, all day
> long nobody bothered you... and no-body asked you are your voices troubling
> you, what's the matter".
> ('Sameer', pp 17, 381-385)

Deepak elaborated on his feelings regarding the lack of understanding held whilst he was in hospital.

> *" When I was in hospital I was told that I had this illness but no one asked*
> *what is it like living in your community, what's it like living in your family,*
> *what's it like meeting your uncle and aunties. No one understood that as part*
> *of my life, I'm not just ill, I have a life, there are expectations and*
> *responsibilities ".*
>
> *('Deepak', pp 11, 231-236)*

Many of the participants openly spoke of their feelings whilst in hospital and how it felt that the emphasis was more on the illness and getting better rather than the underlying reasons. They all felt that the medication regime was the main focus of the wards and that there was very little time for them to talk about their experiences and feelings. However the majority of the participants felt that the best place for them when they were ill was hospital and it was a place where they felt safe.

> *" No when I am ill. It feels safe there. Ward 26, it's safe I know the staff*
> *there ".*
>
> *('Deepak', pp 14, 318-319)*

3.5.2   Intermediate category: EXPERIENCE WITH COMMUNITY SERVICES

This intermediate category emerged from the analysis as continually changing with new ideas, opportunities and attitudes. They identified two strands - professional approach and available services that impacted on the way they viewed the mental health system.

Sub- Category: Professional's Approach

All participants' accounts acknowledged that hospital based staff and community based staff were different in their approaches. Professionals in the community were seen as empathic, understanding and trying to support them in maintaining good mental health. The emphasis was less on medication and more on the person's well being, which included doing day-to-day activities and supporting family.

" I like the [Asian Resource centre], they are nice, they take you out, look after you, give you an education, talk your language and that's important".
('Deepak', pp 13, 287-289)

" ...Once I, I mean erh, once erh CPN got her things like to do, how she could cope, she could help me".
('Sameer', pp 17, 396-397)

Sub- Category: Available Services

A theme that emerged from four of the participants was the development of new services since they first became unwell. Community services such as Asian resource centres, voluntary support groups were felt to have been of benefit to themselves and their families.

" ...If you go to a place that is run for everyone then people only see the mental health problem not the pressures that have caused it and in Asian society the pressures are different. Here [Asian Resource Centre] people understand what the pressures are, they can feel them too and majority of the time they have experienced it as well".
('Pardeep', pp 21, 504-509)

" ...The wife looks after everything so I don't need anyone and she obviously gets some help from friends from different help groups [Resource centre & carers group] and you know sometimes when you get so much paperwork to do and things she gets someone to help her out filling in the forms".
('Pardeep', pp 13, 304-308)

Pardeep and Ranveer have had their diagnosis for approximately 20 years and their experiences suggest that if the services available now were available when they first became ill they themselves and their parents would have benefited from the input.

" Nobody ever sat down and tried to explain to them, my parents were better in 1990's and 2000 cause people were able to go to centres like this...all you had was hospital and day centre and they just had limited time to sit down with you ".

('Ranveer', pp 15, 352-356)

" ...My wife gets to talk to people in her support self help groups but she didn't in the early days cause it just wasn't available...this centre helps in making families understand what is going on for the person with the mental illness and they can do it in Asian language which does help ".

('Pardeep', pp 26, 617-622)

However, Sameer talked about the services in hospital being too full and not always receiving a service due to shortages.

" It's like the mental health places I mean nine times out of ten they are so full they are kicking them out onto the street again. So the person that needs help with mental health can't get it sometimes ".

('Sameer', pp 16, 356-359)

The shortage of services were related to his own experiences and his friends' experiences and affected the way he viewed the mental health system. It is interpreted from the participant's accounts that they accept that the illness may never go away and don't expect professional/services to alleviate this illness but would want empathy, understanding and time to talk about their distress and experiences. During the analysis the researcher felt that participants held positive views of the mental health system when they received a caring and empathic service, it appeared less to do with the illness.

" I know there is no super drug, no 100% cure, you will get side effects ".

('Onkar', pp 7, 132-133)

3.6   Main category- **IDENTITY NOT BEING HEARD**

The third main category pertained to the beliefs held regarding the origins of mental health, consequences of illness and the experiences of having the illness. This category initiated the process of their identity not being heard. Within this category participants gave details of their experiences, which the researcher has interpreted as questioning who they are, which appeared to be influenced by others. This appears to be the first process that participants undergo to evaluating their role within their society, and how the illness and cultural beliefs impact on this process.

This category contains three intermediate-categories. The second intermediate-category named consequences of illness has two sub categories called 'loss of normality' and 'medication'.
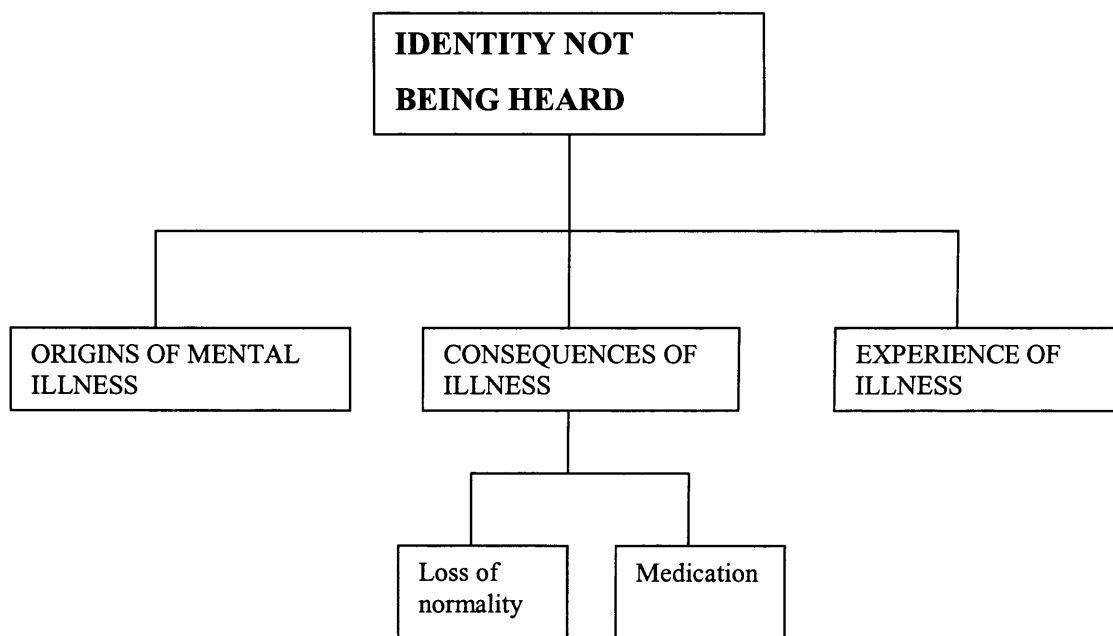
This main category is presented pictorially in figure 5.

Figure 5. Identity not being heard

3.6.1 Intermediate Category: Origins of Mental Illness

This category derived from the analysis contained two perspectives, that of the person with the diagnosis and that of the family surrounding the person[8]. The participants questioned the origins of their mental illness trying to understand it within their frame of reference. They used two themes to describe the evolution of their mental health problem. The following segment of Pardeep's transcript describes the two themes.

> " We both think that the illness comes from people putting too much pressure on you so we are careful about what we will do for others. Some people can take pressure and some people cannot...it's as simple as that and it has a lot to do with inheritance as well... you know genes in your body, I know my granddad couldn't take pressure and I know I can't take pressure too much and I know my son ... looking at him if he gets any pressure he gets very ratty and wound up and he starts raising his voice and getting angry and things... I know in my family in the male side I know between my granddad, my dad, me and my son we can't handle pressure... "
>
> ('Pardeep', pp 14, 310-319)

Participants have explained pressure as having demands placed on them by family, jobs, and stresses regarding appearance and achievement. They also try and understand that maybe they were predisposed to mental health problems through their genes or personalities. Sunny commented that some personalities are more prone to mental illness because they are not stable enough. Mental health being passed through the genes was a theme that all the participants touched on however there seemed to be a lack of knowledge regarding the subject, which the researcher interpreted as them not wanting to know the origins. It appears that it would be helpful for participants to know the origins in order to challenge other people's beliefs but yet at the same time would not really provide them with any security or relief.

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[8] The community's perspective of mental health was described in section 3.3.3. There is some overlap however the family's perspective is involved in questioning their identity as an Asian man with a mental health diagnosis

Participants described how their families viewed their illness and similarly they viewed them using the same two themes.

> *"I don't know if they've got something they think could be passed on through the genes. I don't know whether mental health is passed on through you know the genes but that's what you know they've got a taboo about init...".*
> *('Sameer', pp 7, 137-141)*

However, a third theme began to emerge from the accounts which was not a theme that the participants thought relevant to their understanding of the origins of mental health but their families thought relevant and believed in strongly.

> *Deepak: "When I told people of my thoughts ... when I came from hospital I went home and when I told them of my thoughts... that I was the devil"*
> *Anita: "What did they say when you shared with them your thoughts?"*
> *Deepak: "They just said to ignore it; they did lots of religious stuff, Maha Devi [great goddess] and other things to make them go away but didn't stop. They took me to lots of Mandirs, did lots of poojas [religious ceremony], I didn't really like it but I didn't tell them not to do it, they knew best, they knew what to do but the thoughts...voices didn't go away"*
> *('Deepak', pp 19, 446-457)*

All the participant accounts except for one described religious activities being conducted in order to remove black magic spells, which in turn would remove the illness. Sameer did not mention religious activity being conducted to remove his illness; this could have been due to him segregating himself from the Asian community at an early age and before the onset of the illness.

During the analysis the researcher interpreted that the participants of the families that engaged in religious activity went along with the concept but did not necessarily think it would cure them of the illness as Ranveer felt.

> *Ranveer: "my mother took me to Birmingham in this place and said somebody had done this and you give them money and they tell you to do this and then go home. Once they said get a bottle of brandy, break it and pour it*

down the river and you will feel fine again. We did all these things and you
know they don't help".
Anita: "How did your mother react when they didn't help?"
Ranveer: "Well she never gave up and always said try this and try that and go
there and go there everything until she died".
('Ranveer', pp 16, 375-383)

3.6.2   Intermediate Category: CONSEQUENCES OF ILLNESS

This intermediate category has two sub-categories. The first describing participants
accounts of the loss of normality and the second sub-category described their
experiences of medication, which played a role in controlling their illness.

Sub- Category: Loss of Normality

This was a theme that all participants related to and it was acknowledged that they
mourned this loss, as they couldn't function as 'normal' people due to their
medication, severity of the illness and secondary complaints to the illness. These loses
had a profound effect on participants' sense of self and took a variety of forms. For
example Sameer's account illustrates the severity of the illness preventing him from
functioning.

> " Tell me about nearly ended up getting divorced man you know it was
> horrible I mean erh I couldn't handle it no more I thought I was going crazy
> you know I was ready for gone cause I mean the voices you know like when
> they really really start playing, I mean I couldn't function as a normal human
> being before they put me on the drugs that I'm on now Olanzapine, you know
> they are helping me".
> ('Sameer', pp 10, 221-227)

Deepak has been diagnosed with Schizophrenia and suffers with anxiety as a
secondary compliant and this causes him to isolate himself and not meet people or
socialise.

" I wouldn't go, no I can't go because I don't go outside much and I feel
anxious cause I have to go out and to meet people just too anxious ".
('Deepak', pp 5, 93-95)

The participants were mourning other losses such as their achievements and inability
to achieve milestones and recognition within the family and community. Deepak felt
that when he became unwell he was in the middle of doing his degree and wished he
could have completed his degree to make his parents proud.

"I was intelligent and I wish I had completed my degree and that makes me
sad I wish I could have made them [parents] proud".
('Deepak, pp 15, 344-346)

Deepak experienced the loss of his marriage and the loss of friends due to the illness,
which made him feel sad and angry about the injustice of the illness.

"I got married once, now I'm divorced, I don't have any kids and that. I got
married about, a while ago. It was after I became ill. It was hard going
through the marriage and divorce. I was angry and sad. It was similar to that
when I lost my friends. My friends just stopped talking... ".
('Deepak, pp 9, 185-189)

All of the participants mourned the loss of their normal life and found it difficult to
forget what they had lost. They also described how their ability to function had
changed due to the illness. The difference in how they were and what they have
become is laden with a lot of emotion. This could have been explored further however
was not, but Sameer talked about he impact of the illness for him.

"Yeah puts fear into you, you start thinking you know, it's horrible, horrible.
It wouldn't wish it on my worst enemies this kind, these kinds of problems
honestly".
('Sameer', pp 15, 346-348)

Deepak described the impact of the illness for him and mourning the loss of acceptance and recognition within the community as achieving certain standards within the Asian culture was perceived as being important

> *"It is so important in this culture ... the Asian culture to be strong, to look after yourself and your own and when you can't do it... they see you differently. If you are not married, don't have children you just are not right you have not met those expectations nobody can take you seriously. It's as if you become something or show people hey I've done it—a sign of coming of age, becoming mature being a man, I don't know but it feels like this unsaid thing. They don't say it directly to you but they say it to each other... Asian people do talk. It does make me feel sad. Cause then I don't talk about things with people, I stay quiet and I try to live with my own thought".*
> *('Deepak', pp 18, 402-414)*

Sub- Category: Medication

A theme that emerged from all participants' accounts was how they needed to take medication to control their illness. There was a sense that both participant and professionals placed considerable importance and emphasis on taking and prescribing medication to help the illness.

Participants identified definite advantages to taking medication: -

> *"Now I know I have control cause I take my tablets that help control my mood"*
> *('Pardeep', pp 25, 586-587)*

None of the participants' identified disadvantages to taking the medication however did adopt a pragmatic view: -

> *"I still have voices now and I take medication but the voices haven't gone away they are still there, they have got a little bit less".*
> *('Deepak', pp 7, 130-132)*

Participants appeared to be resigned/compliant with the fact that they may have to take medication for life in order to control their illness.

> *"I never miss my medication, I've asked them to lower it but never miss it. I've only ever missed it once and I was on the ward and they had run out of the stuff and they said it would be ok to miss it just the once. I always take it and I've been told I've got to keep on taking it. And with my outpatient appointment you know my mum and dad think it may be that one day I'll never need it but I said to them well as far as Dr **** told me it would be long term..."*
> *('Onkar', pp 20, 476-484)*

Participants appeared to be reliant on medication, they did not feel emotive regarding being told they had to take medication and accepted the negative consequences of taking medication. The researcher expected participants to be frustrated by the process of taking medication, it affecting their ability to function and for some not alleviating the illness.

> *"I think you know the medication has affected me in that I can't do the stuff I used to be able to do"*
> *('Onkar', pp 14, 313-314)*

> *"... The doctor told me that the tablet I'm on I have to take for life and if I ever come off it I will have a relapse again so ever since then I take them regularly without any fuss and I need to take them so I just take it".*
> *('Ranveer', pp 21, 483-487)*

Participants were able to converse fluently about their drugs. They knew names, doses and uses for medication and often actively became involved in discussions with doctors about changes to their medication.

> *"At the moment I am taking lithium and what the psychiatrist says it does is keep you steady in the mind...it doesn't let you go high and it doesn't let you*

go low and just keeps you stable. I have to have regular blood tests...every three months so to make sure it's in the blood system. They tell you there is a certain amount you have to take if you take too little then it won't have any affect...you have to take the right amount... if you take too much then obviously I mean I tend to suffer from headaches when I take too much of that so I've cut it down to 1½ tablets which is 6000mg which is right for me".
('Pardeep', pp 13, 292-302)

However one participant felt that sometimes doctors just did not listen to how he felt about the medication.

"You know my experience with professionals has been is like once they've given you the tablet after that they think you should be ok now. And that's you know that's the worst thing I find about them they they I mean like this guy now, I mean I'm on Olanzapine... now there's another guy right and he's probably on depixol or something and what works for him might not naturally work for me but some doctors right when they make a decision they are so cock sure of themselves and even when you are telling them it ain't fuckin working... they still say no no give it time ".
('Sameer', pp 25, 589-598)

3.6.3   Intermediate Category: EXPERIENCE OF ILLNESS

Participants had strong feelings regarding their illness. It appears that participants rarely recalled the time the diagnosis was given but more of the process leading up to admission, which resulted in the diagnosis. They recounted their first experiences of becoming ill and all participants had been taken into hospital by their families. Deepak talks about his first episode and recalls not being part of the decision making process which resulted in him being admitted to the ward.

'It just happened. Yeah. I don't know why it happened and I just became psycho. It was very stressful, I was at university and I went to hospital straight away. My dad took me to hospital because he was probably worried about me but they didn't say much about me going to hospital'.
('Deepak', pp 13, 275-280)

For the majority of the participants the illness engulfed their lives and functioning 'normally' became difficult. The participant's accounts contained descriptions of their emotions, which varied from being depressed to angry to anxious. The researcher felt that the emotions being experienced varied according to the life events occurring in the person's life. Deepak raised the question of why did he have to become ill, as can be seen from the following segment and this resonated within the other accounts.

'Makes me feel sad, sometimes angry but angry at myself, cause why did I become ill, why is my life ruined, why me and that's how it is init cause it's happened'
('Deepak', pp 19, 444-446)

There were times when the illness became too much to cope with and some participants contemplated ending their suffering. Sameer talked about his experience of wanting to end his life because he could not cope and others could not understand his suffering.

'When I'm angry they [voices] will make you a lot more angrier, when you are feeling low they can really really make you feel even worse man, yeah. I've come close I've stuck a gun in my mouth what sitting there one afternoon with a gun in my mouth thinking lets finish it, lets finish it, lets get it out of the way. And you know you just start thinking things like that all the time, why is it me this is happening to, what did I do to deserve this you know, because it's not like I mean erh... it's not like if your leg was amputated you can see that, if someone amputates your leg you can see that its physical but a lot of people don't understand when you are hearing voices...it's in your head but it's real, I mean my voices are as real as you are talking to me now. You know that's how real they are; you know I can hear them as clearly as I can you. If you

> *raise your pitch they'll get higher, if you start whispering they'll start*
> *whispering you know'.*
> *('Sameer', pp 14, 316-331)*

Sameer's extract highlights his and others plight in understanding what reality is as the illness feels real and part of everyday life but how others cannot observe it as one would a physical illness.

3.7   Main category- **OTHERS INFLUENCING THE INTEGRATION OF IDENTITIES**

As the process of attempting to understand their identity continued, participants' accounts indicated two ways of understanding their identity. This is the first understanding of their position as a South Asian man with a psychiatric diagnosis. The second understanding will be further explored in section 3.8.

Three different traits were identified in order to understand the process that occurs by which a sense of integrated identity can be achieved. This integrated sense of identity is influenced by 'others' (professionals/ services/ family). These three different traits form the intermediate categories described below. These were 'Support Received', 'Coping with Illness' and 'Others Reaction/ Perception of Illness'. There is considerable movement within this category as the participant's psychiatric career progresses, environmental changes occur and other's reaction/ perception changes. As noted earlier, all participants identified an integration of identities through their narratives but this was dependent on the influence of various factors over time.

This main category is depicted in Figure 6.
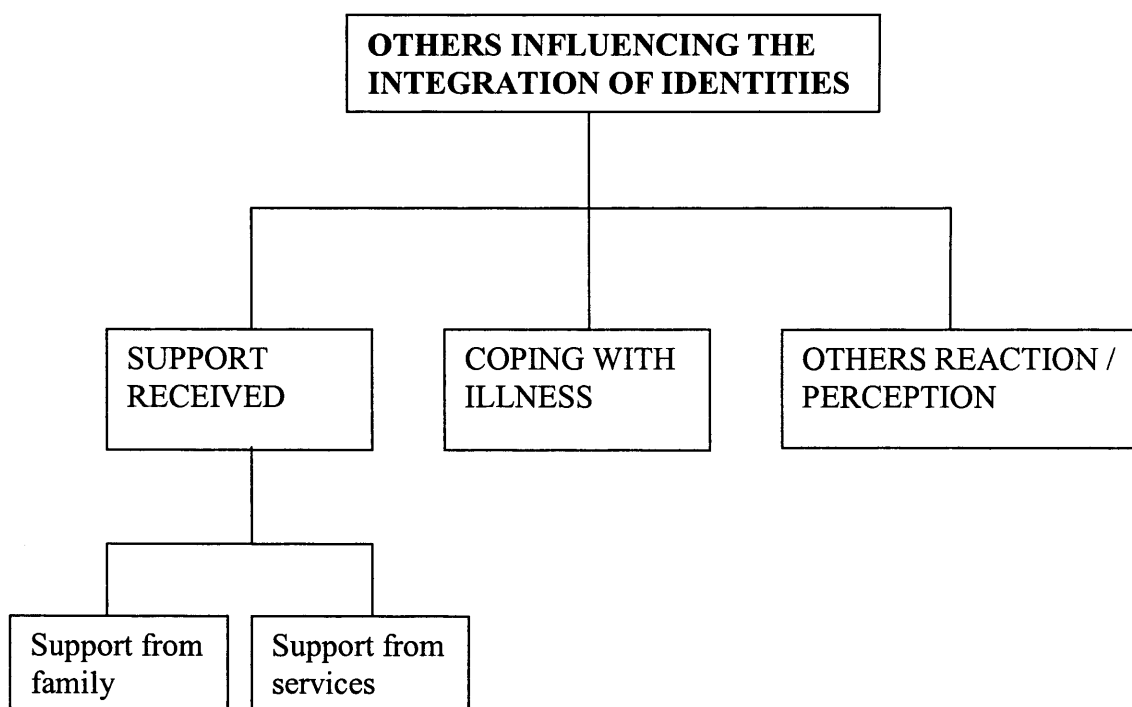
Figure 6. Others Influencing the Integration of Identities

3.7.1 Intermediate category- SUPPORT RECEIVED

Support received from different sources proved to be one of the factors that were helpful in forming an integrated sense of identity.

Sub-Category: Support from families

One of the sources of support was family and how they used different strategies to help integrate them-selves into the mental health system.

> *"Yeah I think they [professionals] did cause they sometimes used to say Onkar would you mind leaving the room so they could talk to my parents and they used to tell them what medication I was on, how to help, what they need to do. I felt ok about that cause I think they needed to know and I don't think at the time I could really answer their questions".*
>
> *('Onkar', pp 24, 558-563)*

Having professionals explain the problems being faced helped this participant and the knowledge provided helped the family gain an understanding of what was going on for the person.

> *"My mum and dad would occasionally come to ward rounds, mum would take time off work and that was cause she worried about her son in it".*
>
> *('Onkar', pp 23, 552-555)*

To gain the knowledge regarding the illness, families actively attended ward rounds and out patients appointments or other resources.

> *"My wife goes to projects where she learns about these things, she knows what is happening and she is involved in it cause she actually has to keep an eye on me to see if I go too high..."*
>
> *('Pardeep', pp 12, 258-261)*

These families were then able to support the participant to maintaining their illness and to become aware of the signs of relapse. In addition it appears that families reduced the pressure of achieving milestones/ standards and supported the participant in achieving their own normality.

> *"... My mum and dad don't compare either, they don't say look what so and so has achieved, they never make me feel like I haven't got anything and they know I'm trying to better myself, to have a normal life, which is home, job eventually relationship and being stable and free of the illness. I used to get talks from my dad he used to say Onkar how long have you had this illness now, you've been it's been five years now and least you are coming out of it now..."*
>
> *('Onkar', pp 21, 495-503)*

It appeared that the participant was taking life at their own pace and it helped that families acknowledged this and provided praise for what they had achieved.

Sub-Category: Support from Services

The other form of source of support that participants found helpful was from statutory and voluntary services.

> *"In that sense the staff at the day unit supported me and I could have a chat with them".*
>
> *('Onkar', pp 25, 594-597)*

The opportunity to be able to converse with professionals allowed the participant to talk about their feelings, fears and desires. The opportunity for families to talk in a safe place was also of benefit as it allowed families to learn how to monitor the illness. As previously mentioned, Pardeep's wife attends projects, support groups to help her understand what is going on for him and Sameer's wife received support from Sameer's CPN for coping with the bad days that he experienced. This support for the family indirectly provided the participant with support, as there were some

things they did not have to make explicit, an understanding was there. Relating to other people who had experienced similar issues was a daunting prospect but once experienced, participants found it a useful forum to explore and understand their problems.

> *"It's been a few years now, and it was a service that I actually didn't know about. ***** Bhai [brother] came down my house, I was referred to this centre by my psychiatrist and he said go up there and I said no I don't want to go up there because I don't feel right being around mental people because I thought to myself that if I am ok then they might make things worse but actually found was that when I do get surrounded by them our experiences are similar and helps to talk to each other about it so it worked the opposite way round because some of these people aren't mental they... they are more saner than you and me... they are clever... and it's just pressures that they haven't been able to cope with"*
>
> *('Pardeep', pp 20, 456-467)*

Sameer's account resonated this experience. He used his forum to alleviate frustration regarding aspects of the mental health system.

> *"You ask anybody at the hv group [Hearing Voices Group] you know, I mean they've been let down, I mean ask anyone of us at the group we've had bad experiences with the shrinks"*
>
> *('Sameer', pp 20, 462-464)*

> *"I think that's the only thing with the group cause most of the time us lot can talk between ourselves"*
>
> *('Sameer', pp 21, 478-479)*

3.7.2   Intermediate category- COPING WITH ILLNESS

Another factor that appeared to be involved in forming an integrated identity for the participants was the way they coped with the illness. Once the diagnosis had been provided, they had to come to terms with and live with the illness. The attitudes of the participants who were managing an integrated sense of identity suggested that they were trying to maintain a normal life that was at their standards and not imposed by others.

> *"I have my voluntary work, living and supporting myself, inviting family over for meals and that so they can see that I am trying to live life as normally as possible"*
>
> *('Onkar', pp 12, 268- 270)*

Living life normally suggested that the participant had control over his life. It also appeared that having a role provided a sense of self, awareness of one's own ability and of others relying on you. The sense others relying on you were not viewed negatively by participants but perceived as being needed and involved in other people's lives.

> *"Yeah, I do lots of stuff I do, you know the family comes round every Thursday and I cook for them you know. Cause it would be nice for my mum and dad to have a change of environment and I'll cook for them you know like, rice, chicken curry and the family like coming".*
>
> *('Onkar', pp 14, 322-326)*

Involving people in their lives and doing things to please gives a considerable amount of satisfaction to the participants who have managed to integrate their role as a South Asian man with a psychiatric diagnosis. However, this integration of identities also means that the participant needs to be able to assert themselves in situations, be able to make their feelings aware to others and be able to say no when demands become too much.

"If people try to burden me with responsibility and I don't want that burden and I don't want to be a donkey where you know you burden somebody with too much so I tend to say just look I've had so many breakdowns I don't want the burden so just leave me alone, otherwise I ain't gonna move just like a donkey you put too much on it... it won't move so I am the same way you know if you burden me with something I don't wanna do I ain't gonna move".
('Pardeep', pp 9, 195-204)

Being able to inform people of extensive demands placed on self is difficult because participants appear to be constantly evaluating their duties, responsibilities and cultural values/standards. However, decisions have to be made that go against those values/ standards and pressures have to be reduced in order to maintain their health.

"No I used to but I don't now cause I can't take the pressure. It is important in our society to have a job, have financial security but for me the pressure got too much and in order to be in control of my mental health I needed to leave my job".
('Pardeep', pp 16, 376-379)

Participants spoke extensively of trying to maintain normality and/or cope with their illness. One major coping mechanism that was described was of religion. It was a theme that appeared in all the transcripts as a way of coping with their illness, events in their life and praying that they would be relieved of the illness by God.

"I believe in religion that is very important. I believe in god and I pray, no god in particular, believe in all of them and pray as and when I could"
('Deepak', pp 6, 119-121)

"My mum always prays and says to god that relieve me of the illness and those are good wishes and I'm sure god looks over us and helps who he can and sometimes he just makes you stronger to deal with it yourself and sometimes gives strength to your family so they can support you and themselves..."
('Onkar', pp 27, 646-651)

"I did mediation with the 'Brahma kumari's' (religious group). That was good cause I felt on a different place. It took me away from my day-to-day stuff and thoughts that I was having".

('Sunny', pp 15, 327-330)

Religion was one of the constructs that participants hung their self-described identity as an Asian man on; therefore it appeared that this is one way for them to maintain their identity as an Asian man. It suggested that they still had links with the Asian way of life.

3.7.3 Intermediate category- OTHERS REACTION/ PERCEPTION

The final factor described by participants who appeared to have successfully integrated their identities was other people's reaction and or perception to the illness and/or to them.

"Yeah they [family] have accepted it all and they don't put pressure on me. They can see visibly you know that he is trying and is doing this and that in the house, they can tell when they visit".

('Onkar', pp 21, 491-494)

Accounts of participants suggested that the positive support that others gave helped reduce the pressure on them to achieve certain standards. The families' acceptance of the person's ability allowed the participant to maintain their own sense of normality and take life at their own pace.

"...I think my own family respected that [mental health problem] privacy and treated and respected me accordingly".

('Onkar', pp 16, 357-359)

Allowing participants their privacy regarding sharing the mental health problem contributed to the person feeling empowered to make their own decisions, which in

turn allowed them to integrate their identity. Accounts identified suggested that the way the family shares information regarding the illness to others can have an impact on how others perceive the person and how he perceives himself. Family not providing full information suggested that others could not hold opinions or access stereotypes and beliefs about mental illness.

> *"You know in Cocanee "boohaara" which means is he well so they [extended family] definitely know I was unwell... as to why I was unwell or whatever, they don't know nothing really what's going on and now my mum says "thoo boohaara" which means he's good now, he's good now, cause they don't want to go into the ins and outs of it all so they generally wanna know how things are and my parents just generally say how things are. And "mashaa boohaara" he's getting better. It's a bit personal my problems that I've had and they don't go into much you know details and just say he's all right".*
> *('Onkar', pp 15, 343-353)*

Excluding information proved to be beneficial to Onkar, however Pardeep benefited from psycho-education being provided by the introduction of new services. The development of new services focused on providing information on mental health problems to families. Therefore it enabled participant's families to develop and increase their understanding of the mental health problems being experienced by their relative. The development of new services for Pardeep allowed his spouse to get support, talk about her feelings and understand the illness. The knowledge obtained by families helped in how they perceived and reacted to the illness.

> *"My wife gets to talk to people in her support self help groups but she didn't in the early days cause it just wasn't available... this centre helps in making families understand what is going on for the person with the mental illness and they can do it in the Asian language which does help..."*
> *('Pardeep', pp 26, 617-622)*

All the above factors helped participants integrate their identities as an Asian man and someone who has a psychiatric diagnosis. However, participants accounts suggested that if any of those factors do not come together, then an integrated identity is difficult

to maintain, hence the formation of a separated identity, which will be discussed in the next section.

3.8 Main category- **OTHERS INFLUENCING FORMATION OF SEPARATE IDENTITIES**

As the process of attempting to understand their identity continued, participants' accounts indicated two ways of understanding their identity. The first understanding was of their position as a South Asian man with a psychiatric diagnosis indicating that these aspects of their life were integrated hence an integrated identity. The second understanding identified from participants' accounts was the inability to integrate the Asian culture/values and psychiatric diagnosis into their lives, hence holding separate identities. Professionals, services and families heavily influenced participants holding separate identities. The researcher felt that these identities appeared to be viewed and held separately by the some participants and 'others'. It did not appear that the identities were discussed in either context unless the participant's functioning became impaired.

The three traits that were identified in 'Others influencing formation of integrated identities' are used to explain the process that occurs for a participant whose identities are separate. These three traits form the intermediate categories described below. These were 'Support Received', 'Coping with Illness' and 'Others Reaction/ Perception of Illness'. There is considerable movement within this category as the participant's psychiatric career progresses, environmental changes occur and other's reaction/ perception changes. As noted earlier, all participants' narratives expressed the formation of separate identities, which was dependent on the influence of various factors over time.

This main category is depicted in Figure 7.

```
┌─────────────────────────────────────┐
│ OTHERS INFLUENCING FORMATION         │
│ OF SEPARATE IDENTITIES               │
└─────────────────────────────────────┘
```

```
┌──────────────┐   ┌──────────────┐   ┌────────────────────┐
│ SUPPORT      │   │ COPING WITH  │   │ OTHERS REACTION /  │
│ RECEIVED     │   │ ILLNESS      │   │ PERCEPTION         │
└──────────────┘   └──────────────┘   └────────────────────┘
```

```
┌──────────────┐   ┌──────────────┐
│ Support from │   │ Support from │
│ Others       │   │ services     │
└──────────────┘   └──────────────┘
```
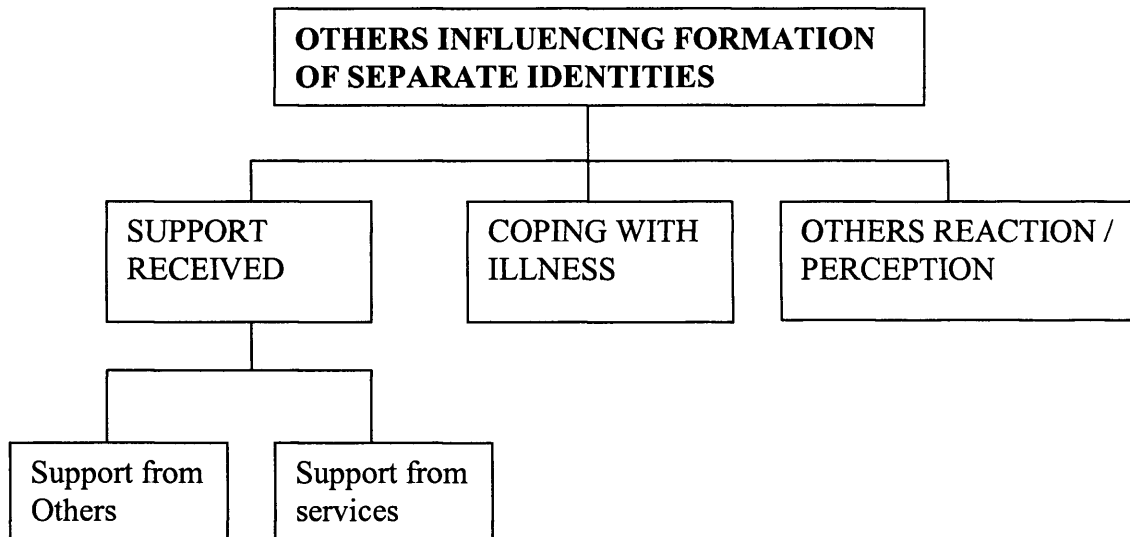
Figure 7. Others Influencing the Formation of Separate Identities

3.8.1   Intermediate category- SUPPORT RECEIVED

This intermediate category contains participants' accounts of the types of support that have led them to develop separate identities. Participants did not appear to perceive this support as negative, however the researcher interpreted that this support and other factors were not conducive in developing integrated identities.

The two sub-categories indicate the areas from where support was received, 'support from others' and 'support from services'.

Sub-Category- Support from Others

From the participants accounts it appeared that the support they received from others was more about dictating how the participant should live their life. It was interpreted that sometimes the participants were not able to make decisions themselves.

95

> Deepak: "I don't say it to the community, they tell me. They tell me do this do
>
> that you know. Go there, go here, do that they give me orders"
>
> Anita: "How does that make you feel?"
>
> Deepak: "Sick"
>
> Anita: "Do you think people understand what you are going through?"
>
> Deepak: "No I don't think so. The orders they give are about how... ordinary
>
> life how I should in behave".
>
> ('Deepak', pp 4, 62-70)

However, for some participants it appeared that support was seen as the family protecting them from the consequences of the illness, a sense of being protected from the illness. This is described in Ranveer's account, when he is high and wanting to do things, which would be problematic, his family intervene and prevent him going out by locking him in.

> "They found it very difficult they tried to hide my van keys and they locked all
>
> the doors and all that so at the time I couldn't get out. In a way they were
>
> trying to protect me..."
>
> ('Ranveer', pp 15, 333-335)

A commonality that was interpreted as occurring across the narratives of the accounts of support received was the level of control the families imposed on the participant.

> "They never asked me whether I wanted to go they just took me. That's what it
>
> was like sometimes, that someone would tell them about this guru or that
>
> Mandir [Hindu place of worship] and we would have to go straight away.
>
> Only god could take this away, but then god gave me this".
>
> ('Deepak', pp 20, 458-462)

However it appeared that this level of control was based on fear. Pardeep spoke about overprotection and that people who cared would take things into their own hands and take control. It appeared that the families were afraid of what had happened to the

participant, they wanted to make the person better and actively attempted to do things or say things that would help the person.

> *"Sometimes I think they may have been scared knowing that I was in a mental place but they always used to emphasise the hospital bit rather than the mental bit. You are in hospital to get better and that's all they used to say... eat this it will give you strength to fight your illness... take your tablets cause it will get rid of the illness and that's all they used to say and do"*
> *('Pardeep', pp 25, 597-603)*

All of the accounts contained the theme that family did care about them and would come to see them in hospital. The support was seen as helpful especially practical support such as making sure the participant had clean clothes etc.

> *"They [family] always used when I was on ***** ward and they used to bring me fresh clothes and nice things to wear, all my property but that was left at home, they used to bring that and come and see me at weekends and week"*
> *('Onkar', pp 10, 210-214)*

Sub-Category- Support from Services

Throughout the participant's accounts an acknowledgement was made about the benefits of hospital and services. However, considering the part that family/others played in the participant's life there appeared to be no communication process occurring between hospital and family.

> *"...They used to come in the evenings and it was only nurses on duty so they didn't really meet anyone to explain things to them... I was the one who told them of any changes and my discharge dates..."*
> *('Pardeep', pp 26, 614-617)*

Sunny identified the lack of communication that occurred with him about his life whilst in hospital. He felt that he was only ever questioned about his illness.

"My mum took me to hospital and doctors and nurses didn't talk to me much other than asking me how I was feeling and what I was feeling but these questions were related to my illness. No one asked me my background or about my religion or anything".
('Sunny', pp 14, 308-310)

It appeared that participants saw problems holistically and that it was not just the illness that needed addressing. It was interpreted that medication could possibly alleviate the mental health illness but the underlying reasons would still be there. Pardeep felt that doctors might not have any understanding of the problems that initiated the illness therefore considered it best not to address them.

"Really speaking the doctors would not have known what the pressures were that lead to the problems in the first place so for them it was better just to treat the illness not the underlying reasons..."
('Pardeep', pp 26, 629-632)

Sameer felt that doctors would probably have no understanding of the Asian culture and if they did it was probably based on stereotypes (see pp 20, 635-645).

" I mean I'm not being funny about this, the shrinks the shrinks don't know much about Asian culture at all..."
('Sameer', pp 27, 635-637)

However, for Ranveer it was a simple case of lack of services. For many years he did not receive aftercare.

"I didn't have that follow up and every time I got released from hospital I didn't get that follow up until 1995".
('Ranveer', pp 18, 419-420)

3.8.2   Intermediate category- COPING WITH ILLNESS

Participants' narratives identified many coping mechanisms. One theme that emerged was the need to talk about their feelings as touched on previously, however it transpired that for some participants they could not share how they felt, this was due to others not understanding or trying to protect them from the illness. Either reason led them to internalise those feelings, as Deepak's states in the following segment.

> "Talked a bit about it but they didn't understand the illness. I wanted to talk about things but I bottled things up and the only people that I could talk to were staff. It was not easy to talk to the family"
> ('Deepak', pp 12, 253-256)

> "Yeah, it's hard, it brings back so many memories, but these memories I think about everyday, I think about how my life has changed but I can't tell people, it makes me very sad and it hurts inside so I just stay quiet I don't tell because it cannot get better, the memories can't go away. They are there and they hurt no one can take that away. Making me feel sad".
> ('Deepak', pp 7, 141-147)

However, for Sameer it was a case of protecting the children against the illness and not letting them see the distress that the voices could cause.

> "My wife and me discuss it because obviously I never let my voices affect me with my children..."
> ('Sameer', pp 9, 183-184)

Sameer was able to share his feelings with his wife and consequently felt supported. However Deepak felt he couldn't cope and relied on others to support him, which in turn suggests that Deepak's coping mechanism, was the need of others support.

"I can't cope, I don't. I need support, people need to tell me to get up, to eat, to go there and here, they have to tell me I can't do anything on my own. I can't remember anything and feel anxious all the time"

('Deepak', pp 5, 86-89)

For Ranveer the reason that kept him going was that he had to get better quickly and return to working within the family business. This business provided for his parents, brothers and sisters, wife and children. He was coping with his illness for the sake of his family and that mechanism was getting involved with the family business.

"...Because I was already in business and every time I had to go to the hospital I would always say I am losing so and so much in my business and they would say ok we will let you out in a certain time and each time was 28 days so after four weeks I stepped back into my market routine and pick up the pieces of the last four weeks what I lost... I got to catch up with that and I tried to do the double work coming straight from the hospital straight into the business".

('Ranveer', pp 17, 397-405)

However this way of coping was not helpful for Ranveer and he would have a relapse and be admitted again which was a pattern that continued for many years.

"Every time I came out of hospital I had my responsibilities there facing me and every two three years I had a relapse because of the pressures building up".

('Ranveer', pp 18, 420-423)

Many other coping mechanisms were described such as being involved in religious activities as discussed earlier. One interesting theme that emerged was the coping mechanisms that were not helpful.

"But a couple of years ago I had nothing and all I was doing was drinking
drinking drinking smoking smoking smoking... till I completely pass out wake
up drink drink drink smoke smoke and till pass out until that was becoming a
routine"
('Sameer', pp 10, 227-230)

These maladaptive coping mechanisms appeared to be beneficial as they reduced the affects of the illness.

"Yeah that was my way of coping with it you know dampening them down"
('Sameer', pp 11, 232-233)

Wanting to dampen down the illness and/or to remove it was a mechanism that two of the six participants could relate to. They actively spoke of how they wanted to end their lives in order to remove themselves from the misery of the illness.

"It's hard to concentrate, attention goes, sure does go. I don't feel well now. I
want to be able to go out and enjoy myself but at the moment I can't. It used to
be so bad that I wanted to kill myself. Those feelings are still there but there
come and go"
('Deepak', pp 12, 257-262)

3.8.3   Intermediate category- OTHERS REACTION / PERCEPTION

Family, other peoples reaction / perception appear to influence how the person deals with the concept of mental health. Pardeep's parents felt it appropriate to take him to a priest because their view of his behaviour/symptoms was that he had been cursed.

"Yeah yeah... third time it happened to me my parents took me to see a
priest... they thought that the priest could get rid of the illness... "
('Pardeep', pp 17, 395-397)

Participants explained this religious intervention, as a way the Asian community could understand mental health. For example Deepak describes the Asian community not understanding the concept of mental health.

> *"No, I don't think they understand mental health. The centre I go to is for*
> *Asian people and there is a lot of people there that have mental health*
> *problems but the community don't understand. I sure do feel that there is*
> *Asian people out there that don't understand"*
> *('Deepak', pp 8, 169-173)*

The researcher interpreted this as mental health being a western concept and within the South Asian cultures this was not a view that was held. There was little direct grounding of this interpretation within the transcripts and it was not fully explored. The following three extracts describe Asian people's reaction to finding out that a person has mental health problems.

> *"I went to my friend's house before and after I was diagnosed ill and then they*
> *shunned me at the door, that this guy is totally looney. They think mental*
> *illness is that you have gone mad but it's not really that".*
> *('Sunny', pp 2, 19-22)*

> *"I don't always tell people in my community about the illness, not always ... it*
> *depends on who you talk to and who's there and word does spread around*
> *very quickly and erh..."*
> *('Ranveer', pp 22, 523-526)*

> *"I don't discuss it, I discuss it with my wife but I mean I wouldn't discuss it*
> *with Asian people or people from my own culture because I would think they*
> *would think he is fruitcake"*
> *('Sameer', pp 6, 113-115)*

It appeared that participants felt that they would be rejected, talked about and be labelled by the community. However Sunny talked about his friends he made whilst in hospital who were not of Asian origin. He felt understood by them with regards to the

mental health diagnosis but described them not quite understanding his South Asian identity.

> *"But I have lots of friends that I made in hospital and they understand me but not all-together cause I am different, I have a different colour skin and talk another language and have different beliefs".*
>
> *('Sunny', pp 18, 388-391)*

4.0   Discussion

4.1   *Overview of Chapter*

This chapter contains a discussion of the results and the research process. First, it seeks to discuss these findings with reference to wider psychological theory, research and mental-health practice. The chapter continues to discuss the implications of this study in relation to clinical practice and policy development. Consideration is also given to methodological issues and reflections on the research process are also presented. Clinical implications regarding the research are discussed and finally, suggestions are put forward for further research. However, before continuing with the discussion chapter the reader is reminded of the aims of the study.

4.2   *Aims of this Study*

The aim of this study was to gain an insight into the perspective of UK men of South Asian origin on having a psychiatric diagnosis and the wider implications. The intention of this is study is not to generalise from these accounts to broad formulations of South Asian men's experience of having a psychiatric diagnosis, but rather to inform research, professional understanding and service developments by grounding the findings in the meanings and experiences described by these men.

A critical realist position was adopted as a way of understanding the knowledge produced in the accounts of these six men. The author acknowledges that there is inherent subjectivity in the production of knowledge and contends that 'the way we perceive facts, particularly in the social realm, depends partly upon our beliefs and expectations' (Bunge, 1993, p. 231, cited in Madill et al, 2000).

This chapter represents one interpretation of the findings, and additional interpretations are possible.

4.3 _Interpretation of the Analysis_

To aid the reader, the discussion of the results is organised through the use of main categories. Each main category will be discussed and then broader discussions relating to the overall model will be considered in subsequent sections.

As described in the analysis itself, the model incorporated both the first contact and further ongoing contact that participants had with their culture and mental health system.

The Core Category- 'Reconstructing a Sense of Identity'

For the participants in this study, the contact with the mental health system appeared to pose a threat to their existing sense of identity, which created a dissonance between their Asian identity, and their mental health identity. The dissonance created led participants to question their identity as South Asian men, as now they had a psychiatric diagnosis. In response to the dissonance the participants attempted to assimilate their mental health identity into their pre-existing sense of identity, however, for some participants the dissonance was too great to be assimilated. The result of this process was the emergence of a reconstructed sense of identity.

The model indicates that participants attempted to reconstruct their identity. The process by which the participants reconstructed their identity was both complex and constantly changing depending on the interplay of different factors. Individual personality factors, life events and interactions with others are a few factors that studies have shown to be implicated in the formation of identity (Crapanzano, 1982 cited in Estroff, 1989).

Studies have explored the recovery process for people with mental health problems. It has been suggested that an individual with mental health difficulties must reconstruct an enduring sense of self as an active agent in the recovery process, therefore enabling them to experience recovery. Hence, the suggestion that the individual must develop an internal locus of control and take responsibility for their own recovery (Davidson & Strauss, 1992).

Identification With Asian Culture And Values

This category illustrated the complexities and individuality of concepts of culture. Terms such as Asian were used to describe their cultural identity, which encompassed many differences and similarities and gave a sense of identity. The sense of identity emerged from community/ religious based activities, the environment they lived in and the collective nature of Asian communities. Participants had difficultly in articulating what their culture was as there were so many factors involved. The researcher interpreted that they all had a sense of belonging.

From the accounts obtained there were differences in the description of what it meant to be Asian, however there was an idea that the 'Asian' culture existed and incorporated differences as well as being able to distinguish it from other cultures such as the Western culture. These men situated their experiences and values within the Asian culture and this included their experience of having a psychiatric diagnosis. This finding has implications for professionals working within the mental health system, as it requires them to understand the concept and experience of Asian culture from their clients' perspectives.

This category identified that the differences that were described were regarding religious beliefs, activities and meanings but the similarities were regarding the milestones and standards that they were expected to achieve. The family honour, values, duties and responsibilities were all factors that they could relate to and that these factors were not explicit in the sense that someone had explained them but implicit in their understanding of the cultural expectations.

The participants' description of culture has incorporated all the factors that Acharyya (2000) identifies. Acharyya describes culture as 'the milieu, the process of living and the system of values and practices shared by particular groups of people'. This culture is dynamic and ever changing and includes a whole range of experiences and learning and includes all the distinctive practices of daily living, customs and attitudes. He continues to stipulate that culture encompasses all of everyday life, from the

mundane, such as the type of food eaten, even mealtimes, and clothes, to religious practices and important attitudes to others in terms of age, sex and social roles. For participants in this study, language was an important aspect of their culture and helped identify which group they belonged to. Fernando (2002) states that a sense of identity that involves a concept of culture or ethnicity could be termed cultural or ethnic identity and just as culture and ethnicity are not static, cultural and ethnic identity too cannot be seen as static.

Another important theme that emerged from this main category was the sense of the culture being collective which was deemed as being different from the western culture. Developmental theories share the idea of individuation (Erikson, 1963, cited in Dwairy, 1999), which leads to the belief that all children develop their own identity that is differentiated and independent of his/her family. However adults in the eastern/ southern parts of the world adopt a collective identity and are encouraged through a process of socialisation to see 'self' as part of the family or larger collective group (Dwairy, 1999). It has been argued that South Asian society cannot be seen in terms other than familial and communal (Laungani, 1992; Kakar, 1982 cited in Squire, 2000). However, some would argue that Asian family life has adapted to British life and moves have been made from the traditional pattern to a more individualistic pattern of life (Littlewood and Lipsedge, 1997). The findings suggest that family and a larger collective group still exists but perhaps not to the same extent. In terms of the participants' experiences, collectivism and individualism should be placed on a continuum and where they lie is dependent on many factors such as the environment they live in, the amount of contact they have with the Asian community and the intensity of their beliefs and attitudes regarding their culture. The stronger the attitudes, the more contact with the community and if the environment they live in consists mainly of Asians, it would be expected that they would be closer to living in a collective society.

Nonetheless, it appears that the values held within the Asian culture encourage collectivism and this can be observed from the participants talking about upholding family honour and the community having expectations. Laungani (1989a, cited in Sachdev, 1995) describes cultural ideology comprising certain salient parameters or values that may not have been precisely explicated by any one other than in general

terms, yet they pervade and influence the way which children are socialised and acquire the salient attitudes, beliefs and behavioural patterns which are unique to that culture. Therefore, perhaps it could be suggested that an Asian person will always have a feeling of being part of a collective, whether it is seen as a positive experience or not. For Sameer he expressed being part of a collective that he couldn't remove himself from and was perceived negatively whereas Deepak enjoyed being a part of a larger collective group.

All communities have an understanding of mental health, and hold ideas, beliefs and attitudes of what a person looks like, how they behave and how dangerous they may be. Within the South Asian culture the concept of mental health is seen as different in comparison to the Western culture. The findings suggest that a person with mental health problems is viewed as 'paagal' crazy, mad and not seen as ever being able to recover. The researcher interprets this, as 'once you are mad, you are forever mad'. Kam (1989) states that there is a cultural stigma associated with insanity with no graduations of emotional difficulty; there is only insanity and normality.

Current research suggests that the concept of mental illness in India is complex and stigma about mental health is clearly present in contemporary India (Bhatia et al, 1987, cited in Durvasula and Mylvaganam, 1994). Research with Asian Indians suggest that they subscribe to a holistic theory of health and the inter-relatedness of mind, body, and soul and consequently present with mental illness that is likely to be manifested both psychiatrically and with physical symptomology. This is supported by the literature, which indicates the somatisation occurs frequently in Asian Indian patients (London, 1986; Ramakrishna & Weiss, 1992; cited in Durvasula and Mylvaganam, 1994).

The traditional medical system of Ayurveda[9] is not comparable to the medical approach of the West. However, South Asians include those from India, Pakistan, Sri Lanka and Bangladesh and the Ayurveda is an Asian Indians concept of health. The other Asian groups may prescribe to this method or have a religious orientated

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[9] Ayurveda centres its interest on the person rather than the disease - the person being conceptualised as a totality including physical, psychological, social and metaphysical aspects. The treatment in Ayurveda for 'mental' disorders is not differentiated from that of bodily illness; and there is no systematic theory of 'mind' and 'mental' processes as there is in Western thought.

concept of health, for example Loewenthal (1993) found that Pakistani Muslim women used cognitive factors particularly religious faith and prayer to manage their depression.

The accounts of participants compared and contrasted the Asian culture to the dominant culture. However there generally was an absence of data regarding the dominant/western culture. This may be due to the questions asked in this study and perhaps participants omitted any narratives they had about the values of 'Western' culture or may not have felt (or were not aware) that Western values impacted on their life. Deepak spoke of having very little contact with the Western community and did not have many thoughts/feelings about it. However, research suggests that dominant cultures are talked about less explicitly than minority culture, yet they may still contribute important factors to cultural identity (Marshall and Woollett, 2000).

Contact and Experience with the Mental Health System

Five of the six participants had an acute episode, which lead to contact being made with the psychiatric system; only one of the participants went through the primary care route. Literature in this area suggests that members of some ethnic minority groups are particularly reluctant to contact psychiatric services or be admitted to hospital. In consequence they may be particularly ill by the time they are finally admitted (Johnson & Orrell, 1996).

Two interesting themes emerged from this main category; experience of hospital and community services. The reader is reminded that this category and the others categories are constantly changing, adapting and evolving to demands placed upon them.

Participant's experience within hospital services compared to community services was less than satisfactory. In hospital they felt as if their illness was the main concern and who they were as a person was not given importance. Mind (1994) conducted a study and found that isolation and distress is exacerbated if people are suffering from a mental health problem and feel they are in a hostile and unsympathetic environment.

They have found that cultural differences between patients and professionals who are trained in the European psychiatric tradition account in large measure for inappropriate mental health service provision to Black and minority ethnic people. The consequences of this can have alarming and complicated impact on a person's mental and physical well-being. Greater satisfaction with community-based treatment has been one of the main positive findings from studies comparing community-based treatments with more traditional services (Leese, Johnson, Slade, Parkman, Kelly, Phelan and Thornicroft, 1998).

Experiences in hospital were seen as degrading, impersonal and frightening for some participants. The participants' confusion regarding the illness and being placed in an environment that contained other people with mental health illnesses created distress. However, families responded by being practical and tried not to see the mental illness aspect and emphasis was placed more on being in 'hospital' rather than being in a 'psychiatric hospital'. These findings appear to reflect the results of a Mind survey (Mind, 2000, cited in British Psychological Society, 2000). They found that 30 per cent of hospital patients surveyed felt unsafe in hospital, a further 37 per cent felt they did not have enough contact with staff whilst 82 per cent had less than 15 minutes of direct contact time with staff a day. These views were held by the indigenous population and the participants' accounts in this study supported these results. Pardeep spoke of feeling unsafe whilst in hospital and Sameer spoke of being isolated in hospital with very little contact with staff. Therefore, this may suggest that most people may feel the same way when admitted to a psychiatric ward, irrespective of cultural background.

Participants had considerable positive regard for community services as they were perceived as a whole person, who has a life, responsibilities, desires and aspirations. Another positive factor of community services was the time to talk and consult with families. The professionals' approaches were seen as positive, supportive and understanding. The opportunity to share thoughts and feelings was seen as a cathartic experience that participants and significant others experienced.

Participants spoke of noticing services developing over time. This suggests that what once was seen as a negative experience would be viewed differently over time with an

increase of positive experiences. Ranveer spoke of the Asian resource centre not being available when he first became ill and consequently there was little understanding of mental illness. However the new centre helps to provide services that were not available 20 years ago. Therefore each time contact is made with the mental health system participants had different experiences, leading them to re-evaluate their mental health identity.

All participants were born in Britain and therefore did not feel they experienced problems with expressing or understanding the English language. However, it may be assumed that their parents' English was at a different level and this may have led to the creation of language barriers, which may have contributed to their lack of understanding. Pardeep stated that an important advantage of the Asian resource centre was that they were able to converse in different languages therefore making the service more accessible and able to relay important mental health information.

Identity not being heard

During the analysis the researcher wondered why participants did not express particular feelings regarding medication. Why had it not created a power struggle within hospital or the community? It was interpreted that perhaps taking medication for an illness was more acceptable within the Asian culture as it represented a treatment for an illness. Perhaps having medication prescribed by the doctor may have been seen as having something wrong with the body. Therefore medication was evidence to say there is something wrong, even though people couldn't physically see it, and they should be believed because the doctor has said so. Pardeep spoke of his parents thinking, *"Doctors were God because they would cure their son of this horrible illness"('Pardeep', pp26, 625-628)*. However this comment also suggests that perhaps there are unrealistic expectations of what doctors can do, which could be explored in another study.

The loss of normality caused clients to wonder who they were. One day they were functioning normally, achieving their milestones, expectations and own aspirations. Then the illness appeared and they were stopped in their tracks and their ability to

function became impaired. As a consequence, participants lost their role within their family/society, lost friends, family and status. This experience of loss left participants questioning who they were as a person within the mental health system and within their own culture.

It appeared from participants' accounts that the diagnosis did create an impact on their lives and their ways of thinking and behaving. However it did not appear that the diagnosis itself created many difficulties in their understanding of their identity. It appeared that the onset of the illness, the consequences of the illness and the beliefs held about the illness did create a serious threat to their identity. There could be a few possible reasons for this:

- The diagnosis was seen as a label and that perhaps it was not understood what the diagnosis meant in the Asian community. It appeared from the accounts that the family/others/community judged on what they perceived. For example, if they see a person achieving their milestones then recognition is provided.

- As a man they have roles to fulfil and one of those roles is that they are the breadwinner and should be providing for their family and the illness does not always allow for them to fulfil this function causing a threat to their identity.

- It was interpreted that it is not necessarily the diagnosis that affects their self-esteem about not achieving their status but more that the reaction of others affects the way they perceive themselves and cope.

- There may be less importance placed on diagnosis, as it is not particularly useful in informing a person about the course the illness is going to take, therefore it may be viewed as not so important. Another point that Pardeep made was that there have been occasions where psychiatrists could give two different diagnoses. This could explain why having the illness is seen as more important than the diagnosis. There are several studies describing the differences within psychiatry regarding diagnoses (see Littlewood & Lipsedge, 1997).

Others influence on the formation of Separate Identities and Integrated Identities

These two main categories have been placed together for this part of the discussion. Both categories contain polar opposites of factors that have emerged from the

participants' accounts and it is deemed appropriate for advantages/ disadvantages and theory links of factors to be considered together.

The study found that participants' identities formed in one of two ways. There were some participants who integrated their identity as an Asian man and a person with a psychiatric diagnosis and there was the other group whose identities were very much separate. The way the identities formed was dependent on the influence of professionals, services and family/friends. The findings suggested that those who formed integrated identities felt more secure in who they were and experienced more control over the pressures and demands they faced. The other group who formed separate identities had little control over the decisions in their lives and experienced tension, shame and annoyance/ anxiety over their mental health and their culture.

A debate that contains similar ideas to the present findings in this research is about how black people may respond to being marginalized and socially excluded on the grounds of cultural difference (Bhui, 2002). He states that there is a choice of either being part of a mainstream that demand conformity and a diminution of those cultural differences that mainstream finds difficult to accept, or to retain those differences and be socially excluded, or modify those differences in the hope of being more easily socially included. A similar issue seems to be experienced by the participants in this study, in that they can either remove themselves from the mental health system or their culture both resulting in the formation of separate identities, or they can make modifications with both identities and integrate them allowing them to be more socially included in 'both camps', however this is influenced by 'others'. Bhui adds that the situation is never so clear-cut as the choices people make depend on many different factors similar to what the participants described in this study. These factors include their own internal and personal resources, their family and community supports and the sort of opportunities they have to influence their own position. For example with the participants in this study the formation of an Asian resource centre created considerable opportunities for them-selves and their families and on some occasions for the community.

The study found that one of the factors that helped with integrating identities was the support received from families. This support appeared to be influenced by an

awareness of the diagnosis and symptoms/ behaviours and the use of coping strategies to support the participant. This contrasted with the support received by the participant whose identities had not integrated. Their families were supportive and not seen negatively but they had a more controlling manner, made decisions on behalf of the participant, and offered practical support but did not understand the diagnosis/illness. The families' way of supporting the participants was strongly influenced by the amount of direct contact they had received from the mental health system including the Asian resource centre. Psycho-educational work has been indicated as being a very useful tool in enabling people with mental health difficulties and families understand and cope with an illness. This finding has implications for the way we work with clients who have strong family ties. In this study the six men interviewed had strong links with their families, and participants felt that their families did attempt to support as much as they could.

In a study comparing Asian, Afro-Caribbean and White patients with regards to the influence of ethnicity and family structure on relapse in first-episode schizophrenia it was found that there was a marked difference between ethnic groups in the integrity of family structures. Asian families were found to have retained extended family structures allowing for greater social integration and tolerance as 90 per cent of their Asian patients remained with their close family (including nearly half who were married) (Birchwood, Cochrane, MacMillian, Copestake, Kucharska & Cariss, 1992)

One important factor that emerges from the stress-illness relationship literature is the form of social support. Social support buffers the effects of stressors, has a direct impact on psychological well-being and has been inversely related to depression, suicide and anxiety (Lazarus and Folkman, 1984). The type of social support participants received in this study was dependent on family's level of knowledge and understanding of mental health and their beliefs about how to manage the illness. For example some families used priests whilst others accessed medical care to deal with the illness.

The support received from services suggests that the more a service invests in the person and family the more possibility there is of an integrated identity being formed. For the majority of the participants the formation of the Asian resource centre (a

voluntary service) offered a valuable service to them and their families in comparison to the statutory mental health services.

Coping with the illness was a factor in the way the two identities developed. Folkman and Lazarus (1988) note that 'emotion and coping influence each other in a dynamic, mutually reciprocal relationship'. Therefore culture plays a large part in determining the way in which a particular event of emotional distress is conceptualised in the first place, for example whether it is seen as 'illness' to be cured or endured, or as a spiritual crisis to be resolved or experienced; the former would call for coping and the latter for understanding. Onkar's family received considerable input from the mental health system and they viewed 'Onkar's illness as being cured one day and it was a test set by God that they had to experience' and they held the attitude that Onkar was in control and trying to get on with his life. He was seen as 'a person who had a diagnosis' rather than being seen as the 'ill person'.

Others reaction and perception of the illness can lead to the person losing aspects of his identity and gaining others that are not helpful. For Deepak and Sunny friends either disappeared or ignored them or could not understand the concept of mental health and viewed it as frightening and dangerous. This affected their self-esteem and their own perception of the diagnosis creating poor self-image, feeling a lack of control and viewing them-selves as the illness alone. People's acceptance of mental illness influences this process and a person can begin to view them-selves as a man with a diagnosis.

Religion was a very important concept for the participants interviewed. They all engaged in religious activities and practices and perhaps this was a link to the Asian culture. At least people would accept that they were still following their faith even though they could not necessary complete all the other duties and responsibilities.

Considerable research has been conducted in the role religion plays for people with mental health problems and it has been found that religious beliefs impact significantly on mental health and help seeking behaviours in Asian cultures as well as other cultures such as the orthodox Jewish communities. Cinnirella and Loewenthal's (1999) research suggested that in an Asian sub-group, the Muslim

participants felt religion did have an impact of their choice of strategies for dealing with their mental health problems. Furthermore they spoke of the fear of community stigma associated with mental illness and the act of seeking help. In another study conducted by the same authors (Lowenthal and Cinnirella, 1999) they found that religious forms of help, particularly prayer could be as helpful as or more helpful than medication or psychotherapy.

Morjaria and Orford (2002) found that religion and spirituality played an important role in the experiences of recovery described by Alcoholics Anonymous members and also of South Asian participants recovering from drink problems. South Asian participants described religious beliefs as an intrinsic part of their cultural values and "having faith" concerns the common experience of south Asian participants of having a set of cultural values to draw upon. South Asian men had a pre-existing foundation of belief. They expressed their spirituality through more traditionally religious means, partly because their religious beliefs were to some extent culturally embedded within their worldview. This was different to the Alcoholics Anonymous members' concept of faith; they had a notion of 'developing faith' whereas the South Asian men had a notion of 'having faith'. Religious prayer, activities, and visits to the priest/ guru appear to be a part of their way of life for the participants, which are strongly connected to their cultural identity.

Dein and Sembhi (2001) suggested that attending a healer may be a way for younger patients to reassert a cultural identity that is already strong in older patients. In their study they found that the age of participants showed a significant relation to the use of traditional healers with younger people more likely to consult a traditional healer. They continued to add that the choice of treatment chosen by members of a particular society reflects their view of ill health, availability of treatment and financial constraints. This health-seeking behaviour appears to be influenced by power relations within the family or wider social structures.

A theme that did not emerge from the findings was feelings and experiences regarding racism. This surprised the researcher as she was expecting racism to have impacted on their mental health problems. However the reasons for it not being described could be that the researcher did not explicitly ask about this issue and perhaps participants did

not feel comfortable enough to discuss if they had experienced racism or not in their interviews.

However the concept of restructuring a sense of identity is a very complex process. Identity changed in relation to participants' awareness of changes within themselves, their environment, others and the mental health system. Therefore identity is not fixed or static and changes occur in response to the many factors that were highlighted earlier. The account of the analysis here does not suggest that it is inclusive but represents one way of attempting to understand the perspectives of South Asian men with a psychiatric diagnosis. More research in this area would be needed to explain the process more fully. However, a number of implications for clinical practice can be made from the findings of this study.

4.4 *Clinical Implications*

From the analysis many thoughts emerged about the clinical implications of the participants' accounts. The first that struck the researcher was the lack of family involvement within the psychiatric consultation, which from the researchers' limited experience is not unusual in Adult Mental Health services. However, the accounts suggested that when families received psycho-education, support, and learned coping strategies it helped the participants form an integrated identity. Therefore, using a systemic type approach and involving the family with client's permission could prevent separated identities forming and increase understanding. This would fit with the premise that South Asian communities are collective in nature and services need to consider that in service provision.

Another approach that would consider the community's beliefs and attitudes towards mental health would be to use a community psychology approach. This would explore the stresses and demands placed within communities and investigate ways to create awareness of mental health, which in turn may enable people to access mental health services sooner and consider use of alternative remedies such as religious priests and gurus. For example, creating awareness in schools, through Asian media and religious

venues. A similar approach of creating awareness of the impact of culture would benefit professionals in their early stages of training and throughout their careers.

Community psychology can be practised at many different levels, through clinical intervention with individuals, families, and groups. There could be involvement with local groups and communities and finally through ecological intervention (which includes influencing the development of policy and planning at a political or organisational level).

There is considerable complexity and diversity within South Asian cultures and to gain an understanding of them all would be time consuming and difficult. However, it is important for professionals to be aware that any culture is a very important part of a person's identity and that they should move away focusing on the symptoms of an illness and look to understand the meanings it has in a person's life. This is a common criticism of mental health services, nevertheless it is important for professionals not to use ethnic and cultural differences to pathologise clients and the presentation and symptomology of mental illness is not identical in all cultures. The means by which people signal distress are culturally grounded; therefore it is important to understand clients in their cultural context.

Encouraging and promoting links between statutory and voluntary services would be helpful. In this study the Asian resource centre has supported participants and their families in many ways as well as promoting and educating the community regarding mental health, for example, having a stall at the local 'mela' (fair) enabling them to access the community.

Religious practices and beliefs have been very important to the participants and their families in this study and they have delayed seeking professional help for mental health problems partly in the hope that religious resources would be helpful and perhaps partly for the fear that their religious beliefs and behaviour may be misunderstood. Being aware of this professionals should be encouraged to improve trust by understanding that religious beliefs and behaviours are important, and understanding the total context of client's lives.

Many of the points discussed would be pertinent for clinical psychologists to consider in their practices, as traditionally psychologists have seen people on an individual basis when a problem causes difficulty in their lives. In addition many of the psychological therapies utilised, centre on the individual needs' and emphasize their experience and perception of the problem and little emphasis has been placed on the family's needs, experience and perception. However as this piece of research indicates, the client's family was an important factor in them assimilating their mental health problems into daily life. Therefore it may be prudent for clinical psychologists to consider involving the family in assessments, appropriate interventions and evaluations.

There are some psychological therapies that are individualistic in nature, in that they centre on a person questioning and/or changing their own belief system and approach to life. However for an individual who has been brought up in a collectivistic society and wants to retain those values and beliefs, the aims and approach of therapy may need to change. For example, for an individual who comes from a collectivistic society, it may be beneficial for them just to understand and contain their distress as it may not be helpful in changing their belief systems. At times it may be necessary to use an individualistic approach in therapy but it may also be advantageous to adopt a systemic over-view in order to understand the interactions/dynamics in the individual's world.

4.5   *Methodological Considerations*

There are a number of methodological issues that need to be considered when evaluating the research. Firstly, this was the researcher's first experience of conducting a grounded theory piece of research. The researcher was conscious throughout the research process of the interpretative nature of the research, and was constantly questioning whether the interpretations represented the participants' accounts. There were occasions where the researcher felt that she was asking questions that would foster pertinent responses. For example the researcher asked 'How is your culture different to that of the European culture?' Charmaz (1995) states that the researcher may need to do more work to discover the subtlety and complexity

of participants' intentions and actions and therefore suggests that researchers need to generate data by investigating aspects of life that the participant takes for granted. However some qualitative researchers may feel that data is forced by asking pre-conceived questions (Glaser, 1992).

In order to recruit participants many services were approached and were given general information about the research. Theoretical sampling techniques were applied but were less than ideal, due to time constraints and difficulties with access to participants. This meant that recruitment of participants occurred on a more opportunistic basis. It is recognised that the lack of theoretical sampling has implications for the resulting model, as it may not contain much variation and richness (Charmaz, 1995, Pidgeon, 1996). This also had implications for saturation of the categories. Qualitative researchers (Rennie et al, 1988) have suggested that saturation generally occurs after the analysis of five to ten participants and although seven participants were recruited only six were involved in this research. Therefore some of the categories did not achieve the position of full saturation and more interviews would have been needed to claim full saturation.

As discussed in the method section, participants were not re-interviewed nor asked to give feedback in light of the emerging theory. However the researcher acknowledges that given more time it would have been valuable to try and engage in some form of respondent validation. This could have been done by taking the emerging theory to the individual participants or to an Asian men's group held at the Asian Resource Centre.

Another point to consider was the use of interview data in the generation of the model. In this study, six men's accounts were analysed however not all the men contributed equally to the generation of the model. This was due to various reasons. Firstly, the interviews were of varying length due to the participants' ability to engage and concentrate. For one participant the interview was terminated early because he could not concentrate on the interview questions. This also affected the ability of the participant to articulate their experiences. In addition, for some participant's the ability to articulate their experiences was dependent on their ability to converse in the English language. Even though the participants' first language was English some

participants were not able to express themselves fully and resorted to explaining terms in their native language[10].

A limitation of this study is that although the participants were all born in the UK, they are heterogeneous in terms of country of origin and religious affiliation. Research indicates that specific ethnic minority populations' experience of mental health problems can vary (Bashir, 1997; Cochrane, 1999). Finally, in considering data collection techniques, the researcher felt perhaps she could have been more flexible in the questions asked and chosen a more open-ended, unstructured interview.

4.6   *Reflections on the Research Process*

As previously mentioned this was the first piece of qualitative research undertaken by the researcher and posed a few challenges. The first challenge was its difference to quantitative research, which the researcher was more familiar with. It is advised that the literature is not consulted until after the analysis is completed to avoid bias in the interpretation of the data (Lincoln and Guba, 1984; Strauss and Corbin, 1998). However, the researcher had conducted a literature review regarding 'Issues of Mental Health in Asian Men' and had worked with people from ethnic minorities and therefore had some prior knowledge and a degree of familiarity with some of the key themes. Hutchinson (1993) suggests that literature review should occur before data collection and analysis in grounded theory, as it is the review of the literature that can identify the gaps in knowledge, or help provide a rationale for the proposed research. However during analysis literature was not consulted. The rigorous use of the constant comparative method and reflection in research supervision hoped to ensure that prior knowledge did not bias the analysis or close down alternative lines of enquiry.

All the participants had a diagnosis of psychosis, which included diagnoses of schizophrenia, manic depression and schizoaffective disorders. Although all participants were stable at the time of interviewing, at times it was difficult to follow the thought processes of some of the participants. 'Sunny's' interview was an example

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[10] The term 'native language' is used to emphasis the language spoken within the family home.

of this however it felt appropriate to allow 'Sunny' and other participants the space to explore their thoughts rather than referring back to the topic guide. Allowing participants this space provided the researcher with some insightful and important comments from what initially appeared as irrelevant information. This also encouraged rapport between the researcher and the participant and enabled the information to be shared.

The power dynamics between the researcher and the researched are complex and sometimes contradictory and can be especially so when a woman is interviewing men (Willott, cited in Henwood, Griffin and Phoenix, 1998). During reflection and the fieldwork the researcher became aware of the conflicts and contradictions around power in her relationship with men she talked to as a researcher, a professional, and an Asian woman. She became aware of the dress code she had adopted and chose clothes which best mirrored the professional stance. This was at times used to distance herself from identifying with the cultural aspect of the research alongside reducing the power differential that exists between Asian men and women. However, the attire could also have been seen as increasing the power differential between 'professional' and 'patient/client' [11].

A concern the researcher had throughout the research process was to ensure that the data collection and analysis reflected attempts to understand the experiences of South Asian men within their culture and with their psychiatric diagnosis and not the researcher's thoughts on the subject. It was particularly important as the researcher was also working clinically with people with severe and enduring mental health problems alongside being a member of the Asian community.

The researcher was aware of not reinterpreting clients experience into professional language. Bhui et al's (2002) study discussed the limitations in the use of language, in that researchers could have influenced the interview by resorting to professionalized terms. Therefore attempts were made to ensure the coding of the interviews reflected the participants' experiences and not the researcher's interpretations.

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[11] The terms 'professional' and 'patient/client' is used in the context of providing a mental health service and in receipt of a mental health service.

On all occasions an implicit understanding occurred between the researcher and the participants on the understanding of the culture. Sameer would regularly say throughout his interview 'you know what I mean' suggesting that the researcher would have prior knowledge of the workings and attitudes held within the Asian culture. Awareness had to be cultivated regarding this implicit understanding and as a response participants were asked to make their experiences, beliefs and thoughts explicit. There were occasions when participants would comment on the differences between their Asian culture and the other culture[12]. There appeared to be a fantasy about the other culture, which the researcher could relate to and found herself reflecting on what they were and how they could be expressed. However, this also created a sense of collusion that there was something in our culture that the host culture did not have or had better than us. Using the constant comparative method it was hoped that the analysis remained grounded in the experiences of participants. However, this also led to the understanding and conclusion that the research cannot be impartial and admits there is an inherent subjectivity in the production of this knowledge (Madill et al, 2000).

During the interviews and analysis, the researcher became aware of the tension between her role as a researcher and clinician. The tension appeared to be concerned with her clinician role of supporting clients and helping them to understand distress being contrasted with the role of the researcher who was there to obtain an insight into their experiences. This on some occasions left the researcher feeling overwhelmed with the content of the interviews. The use of reflective supervision helped to make the researcher aware of this process and reintroduce the role of the researcher.

Henwood and Pidgeon (1992) discussed the role of researcher in qualitative research and postulated that the researcher should not remain unchanged by the process. This study has made the researcher aware of the dynamics that occur within relationships, of difference such as gender and culture, and the role-played within the mental health system. It also highlighted the importance of understanding both the individual's

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[12] There were many terms (Western, English, White) used in defining the other culture and the researcher interpreted them as referring to the host culture. The host culture being this country and the society they live in.

social, cultural history and their experiences of having a psychiatric diagnosis and reiterated the importance of working within clients' frameworks.

Whilst conducting the research, the researcher could relate to the identification and values held with the Asian culture, the religious activities and community expectations. The research made explicit many factors that were implicit in the researcher's life and at times made her very conscious of differences between her as an Asian and others from different cultures. The participants experienced difficulty in being able to say what the Asian culture was and this was particularly pertinent for the researcher as at times she also found it difficult to define her culture and at times could only describe her culture as a sense of belonging to a collective.

4.7   *Areas for further research*

Whilst conducting the analysis there were aspects of participants' accounts that would be interesting to explore further and obtain a fuller understanding of those aspects that was not possible due to the constraints of time. Therefore future research might involve a larger number of participants, which might enable saturation of categories. Re-interviewing participants may also enable expansion of the categories, as they may feel more able to talk about sensitive/difficult issues on subsequent meetings.

Families were seen as important in the way the participants viewed themselves and how they coped with the conflicting identities they had to hold. For some families the first reaction was to obtain support from religious priests and gurus rather than accessing the mental health system. Access to the mental health system appeared to be the last resort. Therefore it would be interesting to investigate the experiences of the families of people with mental health problems on how they perceive mental health and the system. In addition it would be interesting to explore the impact of religious interventions on a person with a mental health problem and how that influences their perception of their identity. It would also be interesting to compare this with lay people in the community who have no or little experience of the mental health system.

One aspect that emerged from the accounts was the participants who were parents had not explained their diagnosis/illness to their children. Participants held a number of reasons for not doing so and the children appeared to have gone through the process with the parents without any information. Family work suggests that it is important to provide children with enough information so that they do not create their own fantasies about what could be occurring with their parent and within the home (Street, 1994). Therefore, it would be interesting to investigate the experiences of children/ adolescents/ adults whose parent received a psychiatric diagnosis and how they perceive the mental health system and culture.

Finally, a factor that was seen as important in the reconstruction of participants' identities was the relationships they had with professionals. Therefore it would be interesting to interview hospital based and community based professionals working in this area to increase our understanding of their experience of being part of the mental health system and their understanding of cultural implications. In addition, participants accounts emphasised the advantages of having an Asian resource centre run by Asians in helping reconstructing their identity, therefore it would also be pertinent and interesting to investigate the views of the professionals who run these services.

Further research in the above areas would allow services to respond to identified gaps or adapting current ways of working in their service provision to the South Asian community whilst continually being aware that there is considerable diversity yet similarity within this community.

Appendices

LPT 293, Ethics ref: 7137

Leicestershire Local Research Ethics Committees

Lakeside House
4 Smith Way
Grove Park
Enderby
Leicester
LE19 1SS

Ethics Administration
Direct dial: 0116 295 7591/2

27 November 2003

Tel: 0116 295 7591
Fax: 0116 295 7582

7137   Please quote this number on all correspondence

Ms Anita Kumari Sudan
Trainee Clinical Psychologist
School of Psychology - Clinical Section
University of Leicester, Ken Edwards Building
University Road
Leicester
LE1 7RH

Dear Ms Sudan

Re: South Asian Men and Psychiatric Diagnosis, ethics ref: 7137

The Chairman on behalf of the Leicestershire Local Research Ethics Committee
(Committee Two) has considered your response to the issues raised by the Committee
at the first review of your application on 16 October 2003, as set out in our letter dated
21 October 2003. The documents considered were as follows:

Your letter, dated 6 November 2003
Amended application form
lpt0293is-p031106
lpt0293is-dr031106
lpt0293il-p031106
lpt0293cf-p031106

Please address the points laid out in the second section of our letter date 21 October
2003:
1. Question B46 on the form states that data will be stored for 6 years. It is
recommended that data should be destroyed at the end of the study (the Data Protection
Act). Interview tapes should be destroyed once they have been transcribed.
2. Please do not store data at your home. Please be advised that no patient-identifiable
data should be kept on a home PC unless you are registered as a data controller on the
data protection register (http://www.dpr.gov.uk/downloads/selfassess.doc may be
useful).
3. On the PIL, please include your name, affiliation and contact details at the top, and
also details of your supervisor and the responsible clinician, once identified.
4. Also on the PIL, please use the standard paragraph to explain the remit of the REC
(under the heading 'Who has reviewed the study?'), available from R&D.

The Chairman, acting under delegated authority, is satisfied that your response has
fulfilled the requirements of the Committee. You are therefore given approval for your
research on ethical grounds providing you comply with the conditions set out below.

An advisory committee to Leicestershire, Northamptonshire and Rutland Strategic Health Authority
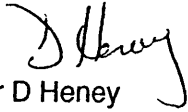
Appendix 1

Conditions of approval

- Where approval is given before receipt of CTX, please let the LREC have a copy of the CTX when it is available. If changes to the protocol are required by the MHRA (Medicines and Healthcare Products Regulatory Agency), the LREC approval will become void until those changes have been made and the revised protocol will need to be approved.

- You do not undertake this research in any NHS organisation until the relevant NHS management approval has been received.

- You do not deviate from, or make changes to, the protocol without the prior written approval of the LREC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases, the LREC should be informed within seven days of the implementation of the change. Likewise, you should also seek the relevant NHS management approval for the amendment, or inform the NHS organisation of any logistical or administrative changes.

- You complete and return the standard progress report form to the LREC one year from the date of this letter and thereafter on an annual basis. This form should also be used to notify the Committee when your research is completed and should be sent to the REC within three months of completion. For a copy of the progress report please see www.corec.org.uk.

- If you decide to terminate this research prematurely, a progress report form should be sent to the LREC within 15 days, indicating the reason for the early termination. For a copy of the progress report please see www.corec.org.uk.

- You must advise the LREC of all Suspected Serious Adverse Reactions (SSARs) and all Suspected Unexpected Serious Adverse Reactions (SUSARs).

- You advise the LREC of any unusual or unexpected results that raise questions about the safety of the research.

- The project must be started within three years of the date of this letter.

- You should be able to assure the Ethics Committee that satisfactory arrangements have been made for the labelling, safe storage and dispensation of drugs and pharmaceutical staff are always willing to provide advice on this.

Your application has been given a unique reference number. Please use it on all correspondence with the LREC.

LPT 293, Ethics ref: 7137

Yours sincerely

Dr D Heney
Chairman
Leicestershire Local Research Ethics Committee Two

(N.B. All communications related to Leicestershire Research Ethics Committee must be sent to the LREC Office at Leicestershire, Northamptonshire and Rutland Health Authority. If, however, your original application was submitted through a Trust Research & Development Office, then any response or further correspondence must be submitted in the same way).

Appendix 2

Wednesday, 10 December 2003

Dear Professional,

Re: *An insight into the perspectives of UK men of South Asian origin of having a psychiatric diagnosis and the wider implications.*

My name is Anita K Sudan, and I am currently carrying out research as part of my training to become a Clinical Psychologist (Doctorate in Clinical Psychology being undertaken at the University of Leicester).

I am interested in finding out about South Asian men's experience of having a psychiatric diagnosis and the impact this has on self, others and the community. The sample will aim to compromise of

- South Asian men between the ages of 18-40 years old.
- Born and brought up in the UK
- Psychiatric diagnosis of psychosis (severe and enduring)
- Will have contact with Adult Mental Health & Rehabilitation Services.

This will be a qualitative piece of research using Grounded Theory.

I have received approval from the University of Leicester Research Committee and the Leicestershire and Northamptonshire Strategic Health Authority Research Ethics Committee (Ethics Ref- 7137; LPT ref 293).

I was wondering whether you had any South Asian men that would be interested in participating in this research that I could approach. The interview will be approximately 1-1½ hours long. I would only be able to reimburse travel expenses. If the person agrees then an information letter will be sent to them. You and their GP will receive a letter to say they have agreed to participate in the research.

If you have any further questions about this study or wish to have a copy of the proposal please contact me on the above address and telephone number.

Yours sincerely

Anita K Sudan
Trainee Clinical Psychologist
Tel: - (0116) 223 1648 or (0116) 225 6845
E-mail: - AKS14@le.ac.uk

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Thursday, 18 December 2003

Dear Participant

My name is Anita K Sudan, and I am currently carrying out some research as part of my training to become a Clinical Psychologist. I am interested in finding out about Asian men's experience of having a psychiatric diagnosis.

This letter is to ask if you would be willing to take part in this research. Please would you read the enclosed information sheet, which explains more about the research and what you would be asked to do if you agreed to take participate.

To help me, some professionals have agreed to send out letters like this one to people they are working with. This means that I do not know your name or address, so it ensures your privacy.

However I would like to contact you directly to find out if you would be willing to help with the research. If it would be okay for me to contact you, please complete the tear-off slip below, and return it in the enclosed stamped addressed envelope.

If you have any further questions about this study please contact me on the above address and telephone number.

Yours sincerely

Anita K Sudan
Trainee Clinical Psychologist
Tel: - (0116) 223 1648 or (0116) 225 6845
E-mail: - AKS14@le.ac.uk

_ _

I am interested in finding out more about the research. Please contact me.

Name ....

Address ....

Telephone number (if available) ....

Appendix 4

Participant Information Sheet

An insight into the perspective of UK men of South Asian origin on having a Psychiatric Diagnosis and the Wider Implications

You are being invited to take part in a research study. Before you decide it is important for you to understand why the research is being done and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for reading this.

What is the purpose of the study?

There are an increasing number of people from ethnic minorities in the UK. Research shows that people from ethnic minorities experience mental health problems similar to the native population. However, literature indicates that people from ethnic minorities do not access Mental Health Services. There has been some research into why South Asian people do not access services and how they see mental health problems. There is very little research regarding how South Asian men perceive mental health, how they are affected and how they cope.

The aim of this study is to explore South Asian men's experience of having a psychiatric diagnosis and how it affects and impacts on them, their family and the community.

This information is useful because to work successfully with clients, professionals need to have a shared understanding with their client. They need to understand their client and their culture and how this affects their health.
Very little research has been done in the UK to look at Asian men on this subject. In order to try and help services develop it is important to understand the views of South Asian men.

The study will begin in November 2003 and the completion date is July 2004.

Why have I been chosen?

Your professional has identified you as I am interested in the views of South Asian men who have a psychiatric diagnosis (South Asian meaning anyone from India, Pakistan, Bangladesh and Sri Lanka), are between the ages of 18 to 40 years, were born in the UK and are in contact with mental Health Services.
Your professional has identified you as someone who may be interested in taking part in this study.
I will be interviewing eight South Asian men in total for this study.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you are still free to withdraw at any time and without giving a reason. A decision to withdraw at any time, or a decision not to take part, will not affect the standard of care you receive.

What will happen to me if I take part?

I would like you to help me with this research. If you agree to this I would interview you at the Brandon Unit or another convenient place. The interview will last no more than one and a half hours. You do not have to help with this research if you do not want to. If after deciding to help with the research, you later change your mind, then it is okay to withdraw your consent. I am unable to offer you any personal benefits, such as payment, for taking part in this study. However any travel costs that are incurred will be reimbursed (public transport & taxi only). Whether you decide to help or not, this will not affect any care that you are receiving now, or may receive in the future.

What do I have to do?

An interview will be conducted in which I will ask you questions on how having a psychiatric diagnosis has had an impact on you and those around you.
I am interested in knowing how you have understood your problem and how you have explained it to those around you. I am interested in knowing if any issues arose from cultural factors when you were given your diagnosis.

I would like to audiotape this conversation, as this would allow me to get a full picture as possible and not miss anything you might say.

What are the possible disadvantages and risks of taking part?

This research will be asking you some personal questions regarding your experience of having a psychiatric diagnosis and how it has affected you, your family and friends. It is possible that discussing personal experiences during the interview may cause some distress. You may ask for the interview to take place prior to an outpatient

appointment in order to access support immediately afterwards should you wish to do so.
If you would like support then your keyworker/CPN/ or allocated mental health worker may support you.

If any information that you share indicates that you may harm yourself or others will be discussed with you first and then shared with your allocated professional.

What are the possible benefits of taking part?

The information from this study would be shared with various professionals from your service, others services in Leicester, other forums such as the "Race and Culture" special interest group (British Psychological Society), and to voluntary agencies. This information may help professionals understand, treat and support South Asian men with mental health problems.

While you may receive no direct benefit it will give you the opportunity to talk about your experience and how you and family were affected when you received a diagnosis.

What if new information becomes available?

Sometimes during the course of a research project, new information can become available. If this happens, I will tell you about it and discuss with you whether you want to continue in the study. If you decide to withdraw I will make arrangements for your care to continue. If you decide to continue in the study you will be asked to sign an updated consent form.

Also, on receiving new information I might consider it to be in your best interests to withdraw you from the study. I will explain the reasons and arrange for your care to continue.

What happens when the research study stops?

Once I have completed all my interviews then the study will stop. The study will be written up and shared with services in and around Leicester and with other professionals who are interested in the relationships between mental health and race & culture.

What if something goes wrong?

It is not anticipated that anything will go wrong. However, if anything does go wrong, then the interview will stop and this will be discussed with you if you want.

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated during the course of this study, the normal National Health Service complaints mechanisms should be available to you.

Will my taking part in this study be kept confidential?

Your taking part in this study will be kept confidential. Professionals you are seeing will be asked to pass this letter on to you. A copy of the consent form will be sent to your GP and your allocated professional just to let them know you have agreed to take part in the study. They will not be told of things we have discussed, this will remain strictly confidential. However, if any information that you share indicates that you may harm yourself or others will be discussed with you first and then shared with your allocated professional.

No names, addresses or other information which would identify you will be held on computer or appear in any reports. The tapes and transcripts will be held securely and will be destroyed once the study has been completed. Any information about you on the transcripts will be removed so that you cannot be recognised from it.

What will happen to the results of the research study?

You will not be identified in any reports or publications. The results will be ready in July/August 2004. If you would like a copy of the results please tick the box on the consent form or contact me on the address below.
The results will be shared with professionals at various forums in order add to the current knowledge base and understanding of mental health in South Asian men. The results will add to an area of knowledge regarding South Asian Men's perspective on having a psychiatric diagnosis and the wider implications.

Who is organising and funding the research?

The research is being organised by Anita K Sudan, Trainee Clinical Psychologist. The University of Leicester and Leicestershire Partnership NHS Trust are funding the research.

Who has reviewed the study?

University of Leicester Research Committee and the Leicestershire and Northamptonshire Strategic Health Authority have reviewed this study and approval has been granted.

Contact for further information

If you have any further questions I can be contacted at the following address and messages may be left by calling the telephone number.

Anita K Sudan
Centre for Applied Psychology – Clinical Section
University of Leicester
104 Regents Rd
Leicester
LE1 7LT

Tel: - (0116) 223 1648 or (0116) 225 6845
E-mail: - AKS14@le.ac.uk

Thank you for your time in reading this information.

Anita K Sudan
Trainee Clinical Psychologist

Date: Thursday, 06 November 2003

Appendix 5

CONSENT FORM

Title of Project: *An insight into the perspectives of UK men of South Asian origin on having a psychiatric diagnosis and wider implications*

Name of Researcher: Anita Kumari Sudan, Trainee Clinical Psychologist

Please initial box

1. I confirm that I have read and understand the information sheet dated 28/08/03 (Version 1) for the above study and have had the opportunity to ask questions.

2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason, without my medical care or legal rights being affected.

3. I understand that any information I give will be anonymised. No names, addresses or other information, which identifies individuals, will be held on a computer or included in any report of the research.

4. I have had the need for audio taping of the interview explained to me and I give my consent to the recording of the interview. I understand that the audiotapes will be stored securely and their contents remain confidential and used for this investigation only.

5. I agree to take part in the study.

6. I would like a copy of the results. This will be available in July/August 2004.

Participant
Name (please print) ....
Signature... Date................

Person taking consent (if different from researcher)
Name (please print) ....
Signature.. Date...............

Researcher
Name (please print).. ....
Signature.. Date...............

1 for participant; 1 for researcher; 1 for participant's GP; 1 for responsible clinician

Appendix 6

[Date]

[GP name and address]

Dear [*GP name*]

Re: [*Participants name, date of birth and address*]

Your patient, named above, has consented to take part in a research study in conjunction with the University of Leicester and Leicester Partnership NHS Trust.

I am a Trainee Clinical Psychologist Clinical Psychologist based at the University of Leicester and this research forms a part of my Doctoral training in Clinical Psychology. The study is exploring the experiences of UK men of South Asian origin of having a psychiatric diagnosis and the impact this has on self, others and the community.

Consent has also been sought from the participants Consultant Psychiatrist and the Trust Ethics Committee has approved the study. Participation in the study involves a one-hour interview. No medication or other intervention will be used, the research only aims to gather information. A worker in the service with whom they are receiving treatment will provide clinical back up for the participant after the interview.

If you have any queries about the study please contact me on (0116 223 1648 or 0116 225 6845)

Yours sincerely

Anita K Sudan
Trainee Clinical Psychologist

Appendix 7

Interview schedule

Focus Points for Semi Structured Interviews

Initial ideas for topics to be covered in the semi-structured interviews:

These topics will be refined and made more accessible to the participants before the interviews begin. As the interviews progress, the topics will become more focused by the results of the on-going analysis.

The key themes:

- How they see their mental health problems.

- How they explain it to others and

- How they cope with that.

Other areas of discussion:

- How the individual's define their cultural background.

- Did they believe that their culture was relevant in any way to their experience of being diagnosed with a psychiatric label?

- Did they believe that professionals had an understanding of their cultural background?

- Did they think it was important that the professionals should have an understanding?

- Was there anything difficult/easy in explaining their psychiatric diagnosis to others (e.g. family, friends etc)

- How did they cope with explaining this?

- What affect did this have on their self esteem?

Appendix 8

Interview Guidelines

Consent

- Check prior to interview (i.e. telephone/letter).
- Explain research and obtain consent at the start of the interview.
- Provide option of withdrawing consent at the end of the interview.

Confidentiality

- Ensure nothing in reports, which would identify participants (names, descriptions, etc).
- There will be no disclosure of information to others (e.g. GP, Clinical Psychologist, etc) except when harm to self or others is suspected.
- The content of the transcripts may be discussed with research supervisors, but anonymously.
- Tapes, letters, transcripts, etc will be held securely (i.e. locked in draws).
- Tape recordings of the interviews will be destroyed on completion of the research.

Informing participants

- Information sheet will be provided several days before the individual is asked to participate.
- Brief description of the research at the beginning of the interview.
- Brief explanation on how to claim for travel expenses incurred due to interviews.
- Opportunities for questions on the phone and at the interview.

Opting out

- Make it clear that participants can choose not to answer any questions.

Role of researcher

- Use warmth, empathy & genuineness (counselling skills).

C:\Documents and Settings\anita\My Documents\My Folder\Anita University\research\ethics preparation\interview
guidelines 4.doc

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- Be alert to non verbal communication and using active listening skills (summarising, paraphrasing & reflecting).

- Be alert to engagement and detachment: not a friend and not a therapist (e.g. be aware of interpreting or providing therapeutic advice); but not a stranger (it is an interactive conversation).

- My disclosure may be useful to illustrate experience or encourage participant; however not to a point where I need support or risk my own confidentiality/security.

- Provide some direction, but beware of closing topics down.

- Be sensitive to participants' other commitments, e.g. childcare.

Responding to participant distress

- If communication (verbal or non-verbal; if appropriate) indicates change of would be appreciated then do so.

- If level of distress is high then change topic, but be aware of closing down.

- If distress is extreme it may be appropriate to end interview, or provide this option (but do not rush off).

- If it seems appropriate query participant's emotional state at the end of the interview.

- If the participant is distressed at the end of the interview then check what they intend to do next, find out if they can obtain informal support from family or friend, and if still concerned inform them that you will contact their GP or responsible clinician.

Ending of the interview

- Confirm consent.

- Provide debriefing (thanks, any questions, how to contact me, what happens next, would they like detail of the research results).

- Inform the participant that there will be no further contact with participant unless I have any queries about the information they have provided.

- Complete any forms regarding travel expenses.

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guidelines 4.doc

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Appendix 9

Example of Open Coding

152		actually lock me up. I was actually that you know it was only
153		because like the problems had got so bad that my marriage was
154		going to end you what I mean cause I couldn't handle no more
155		and I was seeing my local GP and he fobbed me off. Oh it's just
156		stress or whatever you know this and the other and we'll sort it
157		out ... and you know even the white man these days they think .
158		to themselves cause I smoke cannabis they say it could be
159		psychosis from cannabis and well I said how do you work that
160		out, the cannabis helps me. So how can you say that erh that you
161		are helping me and I know to myself that you're tablets ain't
162		working. I mean they had me on all sorts you know they try you
163		on different medication to see what was working. And I found
164		that my local GP just fobbed me off but the CPN I got well she's
165		bang on I mean she actually started to push the doctors and got
166		you know the proper psychiatrists to see me and she helped me
167		and she didn't patronise me as such well you find that with most
168		doctors I've found that I've dealt with in the past couple of years
169		do patronise you and look down on you cause they don't quite
170		understand it themselves do they cause mental health it's only
171		been in the past ten years that they really started to think about it
172		in't they before that... they just used to lock people up... or put
173		them on what it is chlorpromazine or whatever it is. And then
174		they just leave the geyser in the corner and till he drools like you
175		know an animal sitting in the corner.
176	Interviewer	How have you have explained your mental health to your

Margin handwritten notes:

be removed from society

seeking help forsaken, incomplete

illness becoming too much.

professionals not understand

labelling probs as something else

preconceived idea assumptions re coping strategy

preassumed reasons for illness occurring

illegal/non traditional coping method

maltterrors meds

Knowing meds right for self mal + errors med

supportive vs non supportive professionals

non supportive doctors

CPN supportive fought battle

non patronising Drs vs patronising

people c MH substance culture of M

MH new area of ways too

stereotypes of MH classifica problems

viewing a person with M.H probs

medication stripping your personality.

not treated humanely.

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