A Cultural Understanding of British Indian People's Views of Recovery in Mental Illness

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Preface

Papers one and two will be submitted to the Journal of Cross- Cultural Psychology. Their format and presentation conform to the author guidelines (see Appendix A, paper one). Paper three is not intended for publication and is presented according to the guidelines of Staffordshire and Keele Universities.

The term ‘mental illness’ has been used in all of the papers, although the researcher prefers alternative terms such as ‘mental health difficulties’ or ‘mental health problems.’ Mental health difficulties were described as mental illness in most of the previous literature in papers one and two and in the literature used to create statements for the Q set. Therefore, it would not have been appropriate to alter a definition that has been used consistently. Alternative terms have been used where appropriate.

The term ‘British Indian’ has been used to describe people of Indian origin who are from either a Gujarati or Punjabi background and are citizens of the United Kingdom.

Thesis Abstract

This thesis aimed to explore the views held by British Indians towards recovery in mental illness. Indian people in particular are under- represented in mental health statistics which can make it difficult to understand their views of mental illness. Understanding cultural perspectives can provide insight into the way in which Indian people conceptualise mental illness. Research related to Indian people's attitudes towards mental illness was reviewed. The research demonstrated that Indian people were able to identify signs of mental illness however, lacked knowledge of certain aspects of mental illness and its causes. Differences in attitudes were influenced by gender, age, profession, education and generation. The review demonstrated an absence of research conducted outside of India, examining Indian people's views of different aspects of mental illness such as recovery.

Due to this gap in research, Q methodology was used to obtain the views of British Indian people (from the Gujarati and Punjabi subgroups) regarding necessary factors for recovery in mental illness. A sample of 20 participants were asked to Q sort 52 statements pertaining to recovery based on their personal beliefs. Factor analysis revealed four factors representing a range of viewpoints related to recovery. A number of key aspects necessary for recovery were highlighted. Recovery was seen as a journey of self- discovery requiring insight and positivity and additionally, the importance of acceptance was identified. British Indians also preferred to keep mental health difficulties hidden due to a fear of stigmatisation from the wider community. The role of family members and spirituality was highlighted. Differences in viewpoints of British Indians born in the United Kingdom and those born in India and Africa are significant in understanding the impact of acculturation in help- seeking behaviours. The reflective commentary provides analysis of the research process and a reflexive account is presented.

Paper One: Literature Review
Attitudes Held by the Indian Community Regarding Mental Illness: A Cultural Understanding

For submission to Journal of Cross- Cultural Psychology (Please see Appendix A for author guidelines to this journal)

Milli Dave

Abstract

Mental illness significantly contributes to the global burden of disease and across the world there are organisations working to provide mental health care. In the United Kingdom (UK) the Government has invested in initiatives to ensure talking therapies are available to those who need them. However, in multicultural Britain people from Black and Minority Ethnic (BME) communities have faced many barriers in accessing mental health care. Indian people in particular are under- represented in mental illness statistics in the UK making it difficult to understand their views of mental illness. Understanding cultural perspectives on mental illness can provide insight into the way in which Indian people conceptualise mental illness. This review identifies research which examines Indian people's attitudes towards mental illness. Thirteen papers were identified through searching the EBSCO and Web of Science databases. The results highlight Indian people from both urban and rural communities saw mentally ill people as dangerous. Myths and misconceptions were also common among this population. A number of differences in attitudes were also found based on either gender, age, profession, education or generation. In conclusion more research conducted outside of India, examining Indian people's views of different aspects of mental illness such as recovery would be beneficial.

Introduction

The World Health Organisation (WHO) defines health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2005, p. XIX). Mental health is a fundamental part of health and well-being with individuals and groups in society potentially at a higher risk of experiencing metal health problems depending upon their local environment (WHO, 2013). About a quarter of the population will experience some kind of mental health problem in the course of a year (Mental Health Foundation (MHF), 2007). Mental illness has been identified to significantly contribute to the global burden of disease, and in 2004 mental, neurological and substance misuse disorders accounted for 13% of the global burden of disease (WHO, 2013). The burden of mental illness has economic consequences worldwide.

Across the world there are organisations working hard to promote mental health and provide some mental health care. Initiatives including reducing unemployment,

improving housing and working to reduce stigma and discrimination around mental illness aim to promote mental health (WHO, 2005). Organisations that provide mental health care include the WHO, which launched the Mental Health Gap Action Programme (mhGAP) which aimed to address the lack of care for those suffering from mental, neurological and substance misuse disorders particularly in low and middle income countries (WHO, 2010). This programme aimed to use evidence-based interventions such as Cognitive Behavioural Therapy (CBT) for priority conditions such as depression, psychosis and bipolar disorders. Furthermore, trained lay counsellors were introduced to primary care settings in Goa to provide mental health care. The lay counsellors were found to be effective in improving recovery from common mental health disorders in primary care settings (Patel et al., 2010).

"No health without mental health" is a strapline which the Government in England is using to highlight the importance of working with communities. Developing quality services that are accessible to all will result in improving the mental health and well-being of the population (Department of Health (DOH), 2011). The Government has invested in the Improving Access to Psychological Therapies (IAPT) initiative which was developed to ensure talking therapies were accessible to those who needed them in the United Kingdom (UK) (IAPT, 2009).

The implementation and evaluation of services located in the community, including at a primary care level through IAPT, has increased interest in the ways in which Black and Minority Ethnic (BME) groups have access to mental health care in the UK. Within multicultural Britain it seems it has been difficult for people from BME communities to access health care due to barriers such as culture, ethnicity, language and faith (IAPT, 2009). Kurtz & Street (2006) explored the perceptions and use of mental health services from the perspective of BME young people using a mixed methods approach including a literature review, interviews and focus groups. They found a prominent theme of stigma surrounding mental health. Furthermore, a study examining stigma and mental health through focus groups found people with mental illness experienced stigma from communities, with families being stigmatised as a collective group (Knifton, 2012).

Cultural Influences on Mental Health

Culture can be seen as “the worldview, experiences, values, symbols, patterns of behaviour, norms, creativity, institutions and traditions of a particular group of people” (Comas-Diaz, Griffith, Pinderhughes & Wyche, 1995, p. 1), which can influence and shape the way in which an individual experiences and deals with mental illness (Patel & Shaw, 2009). Cultural influences on mental health have become increasingly recognised by mental health services and professionals and have provided insight into the way people from different parts of the world conceptualise mental illness. It is therefore important to understand how communities’ cultures and values impact upon mental health and access to mental health services (Laura, Maiter, Moorlag & Ochocka, 2009). Asylum seekers and refugees have higher rates of mental health problems in the UK (Bacon, Bourne, Oakley & Humphreys, 2010). Studies have found that one third of refugees in the UK have suffered from anxiety or depression (Burnett & Peel, 2001).Therefore the increasing global growth of migration brings with it implications for mental health services which need to be culturally sensitive to people’s different needs. Exploring the beliefs and attitudes of people from different cultures can provide a window into their world and an insight into how different cultures conceptualise and experience mental illness (Patel & Shaw, 2009).

Purpose of Literature Review

In 2011 Indian people made up 2.5% of the population in England and Wales making them the next largest ethnic group after White British (Office for National Statistics (ONS), 2012). The West Midlands in particular was the second most diverse area in England with the Asian/ Asian British Indian ethnic group making up 3.9% of the population in the West Midlands (ONS, 2012).

It has been noted that Indian people are under- represented in mental illness statistics (Patel & Shaw, 2009). This can make it difficult to understand their cultural perspective on mental illness. This review will examine peer reviewed literature on Indian people’s attitudes towards mental illness. The first section of this review will present an overview and methodological critique of each study. The review will then

go on to present a synthesis of study findings, concluding with a discussion and identifying gaps in the literature for future research.

Method

Search Strategy

The EBSCO database including medline, psychinfo, ageline, CINAHL plus and academic search complete was searched using the following search terms: mental illness AND (beliefs or perceptions or views or attitudes) AND (Indian or India). Initially, 487 articles were identified and when limiters of English language and peer reviewed articles were applied, 359 results were yielded. Of the 359 results, titles and all available abstracts were studied for relevance to the review question and 22 articles were identified as relevant for this review based in their title and abstract. Their abstracts and full texts were studied in detail to identify specific articles appropriate for review with reference to the inclusion and exclusion criteria. Further searches on the web of science database yielded two studies that were relevant and after exclusion of articles which did not meet the eligibility criteria, a total of 13 articles were yielded and are included in this paper. Please see Appendix B for a flow chart describing this process.

Inclusion Criteria

Peer reviewed articles, published in English before November 2014 were included, no start date was specified. Studies exploring Indian people's views of mental illness or mental disorders and studies from any country were included in the review.

Exclusion Criteria

Literature that was not published in English, reviews, unpublished articles, studies solely exploring the views of mental health professionals on mental illness, studies with populations other than Indian, for example, American Indian and research focusing on beliefs about specific disorders was excluded. Research focusing specifically on help- seeking behaviours of Indian people was excluded from the

review because these studies did not focus solely on the attitudes of Indian people towards mental illness and would go beyond the scope of this review.

Critical Appraisal

Each study was critically appraised using checklists presented by the Critical Appraisal Skills Programme (CASP), (CASP, 2013) and guidance from Greenhalgh (1997). These tools enabled thorough review of each study and examination of their strengths and limitations. A full summary of all 13 papers identified for this review can be found in table 1 below.

Table 1: A table summarising the 13 studies included in this review

Reference	Location	Sample Size & Study Population	Aim of Study	Design	Data Collection	Summary of Findings
Salve, Goswami, Sagar, Nongkynrih & Sreenivas (2013)	Delhi, India	N= 100 adults from an urban community	To study perception & attitudes towards mental illness in the urban community	Community based cross-sectional study	Semi-structured interview scale, Opinion about Mental Illness for Chinese Community (OMICC)	There is a lack of awareness of bio-medical concept of mental illness. There is socially restrictive, stereotyping, non- stigmatising, pessimistic attitude towards mental illness.
Kishore, Gupta, Jiloha & Bantman (2011)	Delhi, India	N= 436 (360 from urban & rural communities & 76 medical professionals)	To assess myths, beliefs & perceptions of mental disorders and health-seeking behaviour in the general population & medical professionals	Cross-sectional study	Pre- tested questionnaire. Details not reported	Myths and misconceptions are significantly more prevalent in rural areas then in urban areas and among medical professionals
Vijayalakshmi, Reddy, Math & Thimmaiah (2013)	Banglore, India	N= 268 Female undergraduate student (148 nursing students & 120 BBM students)	To compare attitudes towards mental illness among nursing students and Bachelor of Business Management (BBM) students	Cross-sectional descriptive design	The Attitude Scale for Mental Illness (ASMI) & OMICC scale	Nursing students generally hold positive attitudes towards all aspects of mental illness then BBM students.
Ganesh (2011)	South India	N= 100 Adults	To assess knowledge regarding mental illness & explore attitude towards mental illness and mentally ill people	Cross-sectional descriptive design	Pre- designed and pre-tested questionnaire. Details not reported	Knowledge about MI is poor among the participants in this study and the majority has negative attitudes towards mental illness

Reference	Location	Sample Size & Study Population	Aim of Study	Design	Data Collection	Summary of Findings
Dixit (2005)	India	N= 35 Undergraduate engineering students representing urban middle- class youth	To study social representations of mental illness	Qualitative study	Essay question given to participants	Mental illness generally understood as some sort of social deviance.
Dogra, Vostanis, Abuateya & Jewson (2005)	Leicester, UK	N= 30 (15 parents and 15 young people)	To explore Gujarati young people and their parents' understanding of the terms mental health and mental illness	Qualitative study	Semi-structured interview schedule	Neither young people nor their parents had a consistent understanding of the terms mental health and mental illness.
Mehrotra, Tripath & Elias (2013)	South India	N= 536 College students in an urban community	To explore lay meanings of mental health	Qualitative study	Open- ended question asking 'being mentally health and fit what does that mean to you?'	Lay meanings of mental health overlap significantly with scientific conceptualisation of mental health as more than an absence of illness
Thara, Islam & Padmavati (1998)	Tamil Nadu, South India	N= 72, adults from a rural community	To explore how the rural community perceive mental disorders, to study explanatory models attributed to them & describe how the community manage mental disorders	Cross-sectional study	Interviews using a questionnaire	An impoverished and illiterate community is able to describe behavioural components of mental illness

Reference	Location	Sample Size & Study Population	Aim of Study	Design	Data Collection	Summary of Findings
Singh, Shukla, Verma, Kumar & Srivastava (1992)	Jhansi, India	N= 238 Adults in an urban community	To study attitudes of Indian urban adults towards mental illness	Cross-sectional study	50 pre- framed statements in Hindi on different aspects of mental illness	Findings highlighted a progressive attitude towards mentally ill patients, most answered in a socially acceptable way
Bhana & Bhana (1985)	South Africa	N= 320 (80 Hindu male & 80 Hindu female psychology students and their mothers)	To identify perception of mental illness held by Indian South Africans and to determine if there are any generational and sex differences in perceptions	Cross-sectional study design	A eastern-western mental illness scale (Likert scale)	Adolescents differed significantly from their mothers in their perception of mental illness
Gupta & Bonnell (1993)	Delhi, India	N= 140 University students	To examine the effects of sex, course of study, religious preference and occupational background on opinions about mental illness	Cross-sectional study	Opinion about Mental Illness Scale (OMI)	Difference between males & females on medical health ideology & interpersonal aetiology. Psychology & non-psychology students differed on factors of authoritarianism & mental health ideology
Mahto, Verma, Verma, Singh, Chaudhury & Shantna (2009)	Ranchi, Eastern India	N= 100 (50 males & 50 females). Postgraduate students	Aimed to find out students' opinion on mental illness	Cross-sectional study	OMI scale	No significant difference between male and female opinion

Reference	Location	Sample Size & Study Population	Aim of Study	Design	Data Collection	Summary of Findings
Vimala, Rajan, Siva & Braganza (2003)	Vellore, India	Number not specified. Participants were family members of clients psychotic illness	1. To assess knowledge, attitudes and practices of family members of clients regarding mental illness, 2. To identify a pathway to care for clients with mental illness 3. To assess the relationship between knowledge and attitude and practice and selected socio-demographic characteristics	Cross-sectional study	Interviews using a structured questionnaire	High attitude scores were associated with those who had secondary level of education and with those from urban areas. Educational interventions are necessary to improve the general knowledge of family members regarding mental illness

Overview of the Research & Critique

Overview of Studies

Ten of the papers employed a cross- sectional study design to answer their research questions. Salve, Goswami, Sagar, Nongkynirih & Sreenivas (2013) studied the perception and attitudes of Indian people towards mental illness in an urban community in India. Participants were randomly selected from a block in an urban area of Delhi. In total 100 adults living there for over six months took part in the study. Kishore, Gupta, Jiloha & Bantman (2011) compared urban, rural and professional communities in India. They assessed myths, beliefs and perceptions about mental disorders and health- seeking behaviour in the general adult population in Delhi India. In total 436 (360 from urban & rural communities & 76 medical professionals) participants took part in this study.

Similarly Vijayalakshmi, Reddy, Math & Thimmaiah (2013), investigated undergraduate students' attitudes towards mental illness in Bangalore, India. The authors examined the differences in attitudes towards mental illness between students enrolled on nursing courses and students on Bachelor of Business Management (BBM) courses. Participants were recruited through convenience sampling from colleges of nursing and graduate women's colleges. In total 268 undergraduate students (148 nursing students and 120 BBM students) took part in this study. Ganesh (2011) conducted research which aimed to assess knowledge and attitude to mental illness among the general public in South India. A total of 100 participants were recruited through convenience sampling.

Thara, Islam & Padmavati (1998) explored how people within a rural community of Tamil Nadu in South India perceived mental disorders, what explanations they attributed to them and how this community managed mental disorders. In total 72 participants were interviewed regarding signs of mental disorders, the causes they attributed to mental disorders, people's reactions to symptoms and behaviours of mental illness in others and help- seeking behaviours. Singh, Shukla, Verma, Kumar

& Srivastava (1992) assessed views about mental illness within an urban community in Jhansi, India, presenting results on adult attitudes. In total 238 adults responded to the attitude survey and were included in this study. To determine whether there were any sex or generational differences Bhana & Bhana (1985) conducted research in the Indian population outside India, to identify perceptions of mental illness held by South African Indians. A total of 320 participants (80 Hindu male & 80 Hindu female psychology students and their mothers) took part in this study.

Gupta & Bonnel (1993) examined the effects of sex, course of study (psychology and non- psychology), religious preference and occupational background on opinions about mental illness. A sample of 140 students were randomly selected from either non-psychology or psychology courses at a University in Delhi. Mahto, Verma, Verma, Singh, Chaudhury & Shantna (2009), aimed to find out students' opinions on mental illness. The study was conducted in Ranchi, Eastern India, within the postgraduate population in departments of Ranchi University and St Xaviers College. A sample of 100 students were purposively recruited; 50 male participants and 50 female participants aged between 25 to 35 years. Those who had psychiatric illness, physical illness or family history of mental illness were excluded from this study.

Finally Vimala, Rajan, Siva & Braganza (2003) conducted a study with three objectives; to assess knowledge, attitudes and practices of family members of clients regarding mental illness, to identify a pathway of care for clients with mental illness and to assess the relationship between knowledge, attitude, practice and selected socio- demographic characteristics. This study took place in The Christian Medical College and Hospital in Vellore, India. Families of clients who had psychotic illness were chosen randomly from a register of those attending the outpatient department for the first time. The number of participants in this study was not mentioned. To explore attitudes towards mental illness in a country as large as India, using a cross- sectional design was appropriate to allow researchers to gain information about this population at a single point in time. Alternatively, a longitudinal study design could have been used by researchers to observe changes over time, however, this would be timely and costly.

In contrast to the above studies, three papers used qualitative methodology to shed light on their research questions. Dixit (2005) completed a qualitative study to explore social representations of mental illness in a student population representing urban middle- class youth in India. A sample of 35 undergraduate engineering students, assumed to represent urban middle class youth, were included. Dogra, Vostanis, Abuatenya & Jewson (2005) interviewed Gujarati young people and their parents to explore their understanding of the terms 'mental health' and 'mental illness.' A final study sample of 30 participants (15 parents and 15 young people) were recruited in Leicester, UK. Similarly, Mehrotra, Tripath & Elias (2013) did not specify their study design however, they analysed data from an open- ended questionnaire which asked students 'being mentally healthy and fit- what does that mean to you?' with the aim of promoting mental health within Indian college youth. They explored lay meanings of mental health in an urban population. The use of qualitative methods can provide much in depth information regarding the attitudes of the Indian population. Using the qualitative data was appropriate in answering the research questions which aimed to explore meanings of mental health in the Indian population.

Methodology

Participants and Recruitment

Five of the reviewed studies used over 200 participants in their sample (Singh et al., 1992; Mehrotra et al., 2013; Kishore et al., 2011; Bhana & Bhana, 1985 & Vijayalakshmi et al., 2013). The researchers used creative and opportunistic methods of recruitment to gain maximum numbers for their studies. Bhana & Bhana (1985), administered questionnaires to students during class who were then asked to take the same questionnaire home for their mothers to complete. In total 320 participants were recruited, highlighting the benefits of recruiting in this way to gain large numbers of participants using minimal resources. Kishore et al., (2011), recruited 436 participants by visiting people from urban and rural communities door to door which proved to be a successful method in recruiting such large numbers. Similarly, Singh et al., (1992), also employed a door to door survey strategy to recruit for their study with a final sample of 238 participants. Door to door visits were a resourceful way of getting a larger sample and reduced potential barriers for participants such as travel and access to study sites. However, confidentiality was not guaranteed as neighbours, family members and children may have been around and listening to discussions which may have influenced participants' responses leading to response bias.

Mehrotra et al., (2013), recruited students from 10 colleges in South India. Questionnaires were administered to groups of 20 to 40 students which again is a quick and effective method at gaining large numbers of responses from the target population by using minimal amount of resources. Finally, Vijayalakshmi et al., (2013), used convenience sampling to get an overall sample of 268 students. They administered questionnaires to groups of students in common places such as lecture halls. Although a creative method of recruitment, collecting data in group settings may have meant that students were conforming to rather than being actively interested in providing meaningful responses.

Similarly Thara et al., (1998), Salve et al., (2013), Gupta & Bonnel (1993), Mahto et al., (2009) & Ganesh (2011) recruited a large number of participants through

approaching students or members of the public in different areas of India. Thara et al., (1998) selected 72 participants from villages in a rural community in India. Similarly Salve et al., (2013) recruited 100 participants through random sampling from a block in an urban area of Delhi. Gupta & Bonnel (1993) also used random sampling to recruit students from either non- psychology or psychology courses at a University in Delhi, a total of 140 students participated. Random sampling reduces selection bias ensuring those that could be included in the study would have been. On the other hand, Ganesh (2011) used convenience sampling to recruit 100 members of the public for their study.

Furthermore, Mahto et al., (2009) purposively recruited 100 participants (50 males and 50 females) from the postgraduate population in departments of Ranchi University and St Xaviers College. Such sampling techniques could have meant that certain people who would have been suitable to participate may have been excluded. Such large sample numbers gives greater confidence in the findings of these studies and their generalisability to the wider population, than those from smaller studies. Furthermore, large samples increase the statistical power of the studies.

In contrast Dixit (2005) recruited 35 students representing urban middle- class youth to explore social representations of mental illness. This was a qualitative study which generally tend to have fewer participants. The author highlighted why the findings of this study could be generalised to educated urban middle- class youth in India which further validates the sample size. Dogra et al., (2005) had a sample of 30 Gujarati children and their parents. It could be argued that recruitment of Indian people to studies may be difficult in the UK due to language barriers. For instance, participants for whom English was not their first language were excluded (Dogra et al., 2005). However, the authors state respondents suggested further potential participants which is another creative way of recruiting from a population that may be hard to reach.

Unfortunately Vimala et al., (2003) did not specify the number of participants included in their study. They did however exclude family members who were mentally ill which may have affected the sample characteristics. Not knowing the

sample size impacts the significance of the findings and raises questions about generalisability and validity of the study.

Data Collection

The reviewed studies used a variety of measures to elicit information and answer their research questions. Seven studies used either pre- designed questionnaires or measures that were constructed as part of the research (Salve et al., 2013; Kishore et al., 2011; Bhana & Bhana, 1985; Gupta & Bonnel, 1993; Mahto et al., 2009; Vijayalakshmi et al., 2013 & Ganesh 2011). Both methods come with advantages and disadvantages. In their study investigating undergraduate students' attitudes towards mental illness Vijayalakshmi et al., (2013) used both the Attitude Scale for Mental Illness (ASMI) and the Opinions about Mental Illness in the Chinese Community (OMICC) questionnaire. The OMICC was administered in English whereas, Salve et al., (2013) used the OMICC translated to Hindi to study participants' attitudes towards mental illness in an urban community. Alongside the OMICC Salve et al., (2013) developed a semi- structured interview schedule using two focus groups (with males and females separately), to collect information about mental illness (causative factors, preventative measures, identifying features, treatment seeking places and related practices in the community). The interview schedule was translated to Hindi and pretested and modified before use. The use of focus groups to create an interview schedule demonstrates the usefulness of involving the public in the research process.

The OMICC was an appropriate measure used to elicit opinions about mental illness however, it is questionable whether it was applicable to the Indian community. As the title of the scale states, it is for the Chinese community therefore its domains may be more focused on cultural beliefs of that community only and may not be relevant for Indian people. Therefore, this could have potentially impacted on the validity of the studies.

Gupta & Bonnell (1993) used the OMI scale to explore differences in opinions on mental illness among students. Similarly Mahto et al., (2009) used the OMI scale with students to explore their opinions on mental illness, the OMI seemed an

appropriate scale to use for these studies. The OMI is a Likert- type scale consisting of 5 factors; authoritarianism, benevolence, mental hygiene, social restrictiveness and interpersonal aetiology. Gupta & Bonnel (1993) present the validity of the OMI which ranged from .56 to .89 and reliability which ranged from .60 to .82 highlighting it to be a suitable measure to explore opinions about mental illness. Although the OMI was appropriate to use it would have been useful to know whether the questionnaires were administered individually or in groups as this could have impacted on the participants' responses. Pre- tested questionnaires were used by Kishore et al., (2011) to explore myths, misconceptions and perceptions of mental illness and by Ganesh (2011) to assess knowledge and attitudes towards mental illness. This method of data collection was appropriate for their studies and although the questionnaires were not made explicit to the reader, both authors included tables which highlighted the questions when reporting results.

In contrast in their study of South African Indians Bhana & Bhana (1985) developed a Likert scale questionnaire over several years which consisted of items representing both the eastern and western frameworks of mental illness. Developing a scale was an appropriate way for the researchers to ensure validity of the measure however there could have been possible bias in constructing measures for one's own study.

Participants, in the studies using qualitative methodology were interviewed using either semi- structured interview or structured interview schedules to collect data (Thara et al., 1998; Dogra et al., 2005 & Vimala et al., 2003). This method provided rich qualitative data useful in answering the research questions. To gain the trust of participants in a rural community Thara et al., (1998) conducted interviews outside the villages to avoid on- lookers in order to ensure confidentiality and encourage participation. Furthermore, the authors report that the research itself increased the number of people seeking treatment. This demonstrates the benefits of conducting research within this community. However, this research was carried out by the Schizophrenia Research Foundation (SCARF), which is a non- profit voluntary organisation involved both in research and rehabilitation of severely mentally ill people in Madras. This could have created publication bias due to a vested interest of SCARF in the research outcomes.

Alternatively Singh et al., (1992) employed a creative method of using statements regarding different aspects of mental illness presented in Hindi. These statements were read out and participants rated them as strong agreement, agreement, undecided, disagreement and strong disagreement. Presenting statements rather than an open- ended questions may have encouraged participants to respond autonomously and arguably gathering a truer representation of their attitudes. Dogra et al., (2005) conducted interviews with Gujarati parents and their children separately reducing either responses being influenced by the other and encouraging freedom of expression. Unfortunately they did not make the role of the researcher explicit. It would have been helpful to know whether the researchers were from the same cultural background and how this may have influenced interpretation of their findings. Furthermore, Mehrotra et al., (2013) used qualitative information from open- ended questions in a student population. Dixit (2005) used essay questions in a student population giving participants 25 minutes to write an essay on the 'meaning of mental illness.' The use of these methods ensured freedom of expression generating insight into Indian people's views about mental illness without putting them on the spot.

Accounting for language barriers when conducting research in the Indian population is vital to encourage participation. Salve et al., (2013) used the OMICC and their interview schedule translated to Hindi and similarly Singh et al., (1992) presented their statements in Hindi. Kishore et al., (2011) translated the questionnaire used in their study from English to Hindi and then back from Hindi to English. Translated materials to Hindi and then potentially interpreting them in either English or Hindi could bring in a double hermeneutic between the translated material and the original data. However, using language familiar to participants during data collection can encourage participation, increasing access to people who may not readily participate in research.

Ethical Considerations

Ethical approval ensures research is thoroughly scrutinised in order to protect the dignity and safety of its participants. Nine papers did not provide information about whether ethical approval was sought for the studies and if informed consent was gathered from the participants. Three of the papers highlighted where approvals were sought and that informed consent was gathered from the participants (Salve et al., 2013; Mehrotra et al., 2013) & Vijayalakshmi et al., 2013). Ganesh (2011), did not provide information about ethical approvals for the study however did highlight that consent was sought from participants.

Study Findings

A summary of the study findings can be found in table 1. Overall the reviewed research showed that there were varied attitudes within the Indian community towards mental illness. Indian people were able to identify various signs of mental illness (Thara et al., 1998; Salve et al., 2013 & Singh et al., 1992). Violence was the most frequently reported sign of mental illness and factors such as family conflict, financial problems, role performance problems and difficulties with neighbours were identified as causes of mental disorders within a rural community (Thara et al., 1998). This study also highlighted that an impoverished and illiterate community was able to describe behavioural components of mental illness. Sudden change in behaviour such as remaining quiet, over- talkativeness and abusing and fighting with others were described as common signs of mental illness (Salve et al., 2013). The authors concluded that there was a lack of awareness of bio- medical components of mental illness in this urban community. The authors have identified specific implications for practice including, increasing awareness of bio- medical concepts, effective treatments for mental illness, the identification of mental illness and better care in the community.

Early signs of mental illness included difficulties sleeping, changes in facial expression, aloofness, pre- occupation with ghosts and feeling of impending mental imbalance among participants in an urban area of India (Singh et al., 1992). Attitudes towards mentally ill people varied. Salve et al., (2013) found 80% of the participants felt that mentally ill patients and their families were ignored by the

community, concluding a socially restrictive and stereotyping attitude towards metal illness in an urban community. However, they also found a non- stigmatising, pessimistic attitude towards the future of people with mental illness. Singh et al., (1992) reported 73% of their sample considered mentally ill people as dangerous and hard to understand and 79% saw mentally ill patients in the neighbourhood as a bother in an urban community. The authors concluded their study and similar studies are beneficial in highlighting gaps in knowledge regarding mental illness.

Religious concepts provided explanations for mental illness and its cause and adopting religious practices and consulting faith healers was seen as useful for treating mental illness (Thara et al., 1998; Salve et al., 2013; Singh et al., 1992 & Kishore et al., 2011). Within a rural community 70% to 80% of the participants would use religious treatment as the first port of call (Thara et al., 1998). In a rural community one fourth of the participants identified the role of evil spirits in the development of mental illness (Salve et al., 2013). In their study comparing urban, rural and medical communities Kishore et al., (2011) used Chi- square tests to compare the three groups and found that myths and misconceptions were significantly more prevalent in rural communities. A higher proportion of the rural sample (34.7%) believed mental disorders were caused by semen/vaginal secretion and 52% of the rural sample believed air pollution was a cause of mental illness. A higher proportion of the rural sample (39.4%) believed mental illness was a punishment by God for past sins. Interestingly 40% of the urban sample and 8% of medical professionals believed mental illness was untreatable. In contrast Singh et al., (1992) who studied an urban community in India reported 72% of their sample did not believe mental illness was caused by misfortune or God's wrath, however the authors point out this result was in conflict with the behaviour of the general public who would primarily consult with faith healers.

Bhana & Bhana (1985) uncovered a significant difference between South African Indian adolescents and their mothers in their perception of mental illness. Adolescents compared to their mothers showed greater acceptance of western conceptualisation of mental illness. Gender differences in conceptualisation of mental illness was found between males and their mothers and females and their mothers. Similarly, Dogra et al., (2005) found that neither Guajarati young people

nor their parents had a consistent understanding of the terms ‘mental health’ and ‘mental illness’ in the UK. Adults identified isolation related to immigration and loneliness exacerbated by a culture of silence within the Gujarati community, whereas young people identified low self- esteem, school related stresses and pressures as a cause of mental illness. Half of the participants stated they preferred to keep mental health problems to themselves because of a fear of being labelled or stigmatised. These studies were conducted outside of India and add weight to the field of clinical psychology. They provide insight into how generational differences can explain attitudes held by Indian people regarding mental illness. These findings also raise questions about whether they can be generalised to Indian people in other areas of the world such as America or Africa.

Gender, age, educational and professional differences in attitudes were identified in this population. Gupta & Bonnell (1993) found that males had a greater tendency to view mentally ill people as more like normal people and believed in the efficacy of treatment. In this study more males were found to believe mental illness arises from interpersonal experiences than females. Non- psychology students compared to psychology students took a less authoritarian view about mental illness. Non-psychology students saw mentally ill people as less inferior (Gupta & Bonnel 1993). Religious preference and occupational background did not influence opinion towards mental illness in this study.

Mahto et al., (2009) found that overall there was no significant difference between males and females in their perception of mental illness. However, they did find that in general, males were more assertive in expressing their opinions of mental illness whereas females were more neutral or ambivalent in their opinions. For example, 52% of female participants in this study were neutral in their response to an item asking whether mentally ill people let their emotions control them. 54% of female participants compared to 44% of male participants had neutral attitudes to an item that stated ‘many people who have never been patients in a mental hospital are more mentally ill than hospitalised mentally ill patients.’

Vimala et al., (2003) found that 97% of their participants thought mental illness was curable with medication. 40% expressed misconceptions regarding mental illness

however these were not highlighted. A third of the participants stated they used physical restraint to keep the mentally ill client under control. High attitude scores were associated with those who had secondary level education and above and with those from urban areas, demonstrating the influence of education on attitudes. The researchers aimed to contribute to care pathways for people with mental illness. Based on the findings the authors make a valid suggestion to provide educational interventions for relatives of mentally ill clients and identified the role that mental health nurse practitioners and primary care settings can play in this.

Vijayalakshmi et al., (2013) concluded that nursing students held positive attitudes towards all aspects of mental illness compared to BBM students in India. For example, 53.4% of nursing students were not afraid of treated mentally ill people, compared to 40% of BBM students. More nursing students disagreed that people with mental illness tend to be violent and dangerous. This study excludes men, which raises questions about how generalisable the findings are to the whole population. Age and gender differences were reported among the general public in South India by Ganesh (2011). It is important to note the demographics of the population studied; 67% were female and 33% male, 68% were non- professionals and over half the sample was over 30 years of age (54%). Such demographic characteristics could have had an impact on the level of knowledge they had about mental illness. In terms of attitudes, 60% were afraid of someone with a mental illness staying next door and 55% were ashamed to mention if someone in their family has a mental illness. The author also analysed associations between knowledge and attitude and found that participants under the age of 30 years had more knowledge than those aged over 30 years ($p= 0.0001$). Male participants had more knowledge than female participants ($p= 0.001$). However, the findings add weight to the argument of providing mental illness awareness to the student population of India who can further influence attitudes of society towards mental illness and reduce stigma.

Dixit (2005) explored social representations of mental illness among undergraduate students, gathering qualitative data. Through analysis the author found that mental illness was generally understood as a form of social deviance. Mentally ill people were seen as distant from society and not performing normal social activities.

Quotes used to illustrate this finding were “one who is mentally ill is almost being cut- off from society,” and “for survival in the social life, a person should be mentally balanced.” Mentally ill people were also described as dangerous to society and mental illness was linked to social deviance and criminal behaviour such as terrorists and corrupt politicians.

Mehrotra et al., (2013) collected basic demographic data including information about age, gender, education, religion, marital status, presence of a psychological problem and whether any help was sought among a student population. The age of the participants ranged from 17 to 30 years, the majority of the participants were single (98%) and Hindu by religion (69%) and 88% reported no history of psychological problems. Content analysis was completed on the responses to the open- ended question. The authors found that subjective well- being (a presence of positive feelings and life satisfaction) was the most popular definition of mental health. Environmental mastery was the second most common characteristic of being mentally healthy and fit. Managing emotions and being active and engaged were the next most common characteristics of being mentally healthy and fit. Further analysis revealed that males more frequently than females cited active engagement as a characteristic of good health ($p= 0.001$). Although findings of this study are presented clearly and method of content analysis is explained at each stage, the findings are difficult to generalise to other groups such as working adults and to those living rural settings. There is no clear information about whether the open-ended question had a word, space or time limit which could have restricted responses limiting freedom of expression.

Synthesis of findings

Using guidance from Aveyard (2014), the main findings of the research papers were examined to reveal five broad themes; signs of mental illness, socio- demographic differences, religion and spirituality, generational differences and social norms. These themes are discussed below.

Signs of Mental Illness

Overall the studies exploring attitudes of urban and rural communities in India found that the Indian population seemed to conceptualise mental illness in the view of its most extreme symptoms (Thara et al., 1998 & Salve et al., 2013). It can be argued that such symptoms are present in severe mental illness or in later stages of mental illness (Salve et al., 2013). However, more common signs of mental illness were identified in an urban community (Singh et al., 1992). Regardless of geographical location and level of literacy Indian people are able to identify signs of mental illness which highlights they have awareness of this subject. The findings demonstrate a need for better awareness of common symptoms of mental illness among Indian people this would increase their knowledge of mental illness and encourage help-seeking behaviours before symptoms become severe or unmanageable.

Socio- demographic Differences

Indian males may have more exposure to sensitive issues surrounding mental illness compared with females making it easier for them to express their opinions regarding this subject. Furthermore, females were more neutral or ambivalent in their opinions (Mahto et al., 2009). Mothers and their sons conceptualise mental illness differently from mothers and their daughters, which could be due to traditional gender roles in patriarchal societies. It could be argued that females are raised in a more protected environment spending greater time with their mothers (Bhana & Bhana, 1985). In addition, Ganesh, (2011) highlighted that male participants had more knowledge about mental illness. This highlights the impact of socialisation on attitudes held by Indian males and females regarding mental illness and how comfortable they may feel expressing these. For example, females may shy away from such sensitive issues which are not necessarily discussed openly within this community.

Age, educational level and profession have also shown to influence attitudes towards mental illness. It can be argued that having more exposure to mental illness either through profession, education or as family members of mentally ill people, positively influences attitudes held about mental illness (Gupta & Bonnel 1993;

Vimala et al., 2003 & Vijayalakshmi et al., 2013). This highlights that exposure to mental illness can help reduce stigma attached to it and further increase awareness of mental illness.

Religion & Spirituality

Four of the reviewed studies emphasised how religion and alternative explanations influenced people's attitudes of mental illness (Thara et al., 1998; Salve et al., 2013; Singh et al., 1992 & Kishore et al., 2011). Overall Indian people believed mental illness to be a punishment from God. Religious treatments and faith healers were reported to be used as treatment for mental illness. These studies recruited people from the general community in different parts of India. Interestingly, these beliefs were prevalent in both urban and rural communities. For example, in their study Kishore et al., (2011) found that a large number of people across the urban, rural and professional samples were reported to believe that keeping fasts and daily worshiping could reduce the effects of mental illness. This further emphasises the importance placed on religion within this population regardless of occupation and level of education. Furthermore, the same study had participants in the rural sample who were younger, middle class and from larger families. Being younger and from large families indicates the possibility of family values being passed through generations and maybe a larger influence of family in conceptualising mental illness. Contrary to these findings Gupta & Bonnel (1993) found that religion did not influence opinions regarding mental illness among students in Delhi. This difference may be due to the students having more knowledge and awareness of mental illness.

Generational Differences

Two of the studies reviewed revealed generational differences in attitudes towards mental illness and both were conducted with Indian people living outside India. The results from these studies are thought- provoking when considering how Indian immigrants may conceptualise mental illness across the world. Bhana & Bhana (1985), reported that adolescents were more accepting of western perspectives of mental illness in comparison to their mothers. This may be due to exposure to a

range of influences such as education. They found that the mothers who participated were able to occupy both eastern and western perspectives on mental health. Dogra et al., (2005) also showed how adaptive beliefs are about mental illness, emphasising generational differences in understanding the causes of mental illness within the Gujarati population in the UK. These findings question whether knowledge about mental illness is discussed among family members or whether it is too stigmatising to talk about such issues within the family. It seems then that Indian immigrants may hold views about mental illness without being influenced greatly by the country they have moved to in contrast to their children who may follow beliefs and attitudes of the society in which they are born, rather than parental attitudes.

Social Norms

The influence of social norms on conceptualisation of mental illness was prevalent in the Indian population. Mentally ill people were seen as dangerous by society in India regardless of geographical location and level of education (Salve et al., 2013; Singh et al., 1992 & Dixit, 2005). In contrast nursing students with exposure to mentally ill patients did not perceive them to be violent or dangerous (Viajayalakshmi et al., 2013). This highlights how knowledge and awareness of mental illness can be useful in destigmatising mental illness.

Additionally, mentally ill people were seen as distant from society, potentially dangerous to society and mental illness was closely linked to social deviance and criminal behaviour (Dixit, 2005). However, being mentally healthy was linked to subjective well- being and environmental mastery (Mehrotra et al., 2013). Achieving environmental mastery could cause potential conflict for Indian people suffering from mental illness if society classifies them as a danger to others and links mental illness to criminal behaviour (Dixit, 2005).

Discussion

Implications of Findings

The reviewed research has shown diverse perspectives into the attitudes of Indian people towards mental illness. The studies conducted in India have highlighted that this community can identify signs of mental illness. These findings emphasise that Indian people from a range of communities with varied levels of literacy can recognise aspects of mental illness which shows they have an awareness of this subject. Attitudes towards mentally ill people varied. On one hand mentally ill people were seen as socially excluded and deviant whereas the Indian community also held a non- stigmatising view towards the future of people with a mental illness highlighting the impact of social norms on conceptualisation of mental illness. Furthermore, religion and spirituality played a role in the way Indian people viewed mental illness, its cause and its treatment. This demonstrates that as well as social factors, culture also influences the way in which Indian people view mental illness and such an important finding should not be taken lightly.

Gender, age, educational and professional differences in attitudes were also identified in this population. The attitudes Indian people hold may influence how readily they seek help for more common mental health difficulties such as depression and anxiety. In addition, mentally ill people are seen as violent and dangerous which further increases stigma of mental illness within this community creating barriers to admitting one may be suffering from a mental illness and seeking help. Furthermore, two of the studies were conducted outside of India with only one in the UK (Bhana & Bhana, 1985 & Dogra et al., 2005). These studies identified generational differences in attitudes. This creates a more complex picture of the attitudes held by Indian people towards mental illness. It highlights the intricate relationship between the individual, society, culture, religion, gender, education and profession in influencing attitudes.

Gaps in Research

As immigration continues to rise it is vital that the many voices of this population are studied further in different parts of the world. Mental health awareness initiatives also need to be evaluated. Unfortunately, there is limited research conducted in the UK with the Indian population. It would be beneficial for the field of clinical psychology to become more aware of Indian people's views about different aspects of mental illness in order to tailor mental health services to meet their needs. For instance, services such as IAPT in the UK are working to increase access to mental health services for people from BME backgrounds. If Indian people are indeed entering services in the UK then studies of their experience of mental health services, professionals and recovery would provide vital information about how Indian people utilise such services. Furthermore, studies to compare views of Indian adults and children who were born in different countries, would help develop an enhanced understanding of differences in conceptualisation of mental illness in this population.

Conclusion

Taken as a whole the evidence reviewed demonstrates how diverse the attitudes of Indian people are towards mental illness. Indian people were able to identify signs of mental illness however lacked knowledge of certain aspects of mental illness and its causes. The studies conducted outside of India identified generational differences in attitudes which provide stimulating ideas regarding the influence of culture and immigration on attitudes. In conclusion, further research outside of India to provide insight into the help- seeking behaviours of this community and their experiences of mental health services and professionals would be beneficial in evaluating the appropriateness of services for the Indian population.

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Appendix A: Author Guidelines for Journal of Cross- Cultural Psychology

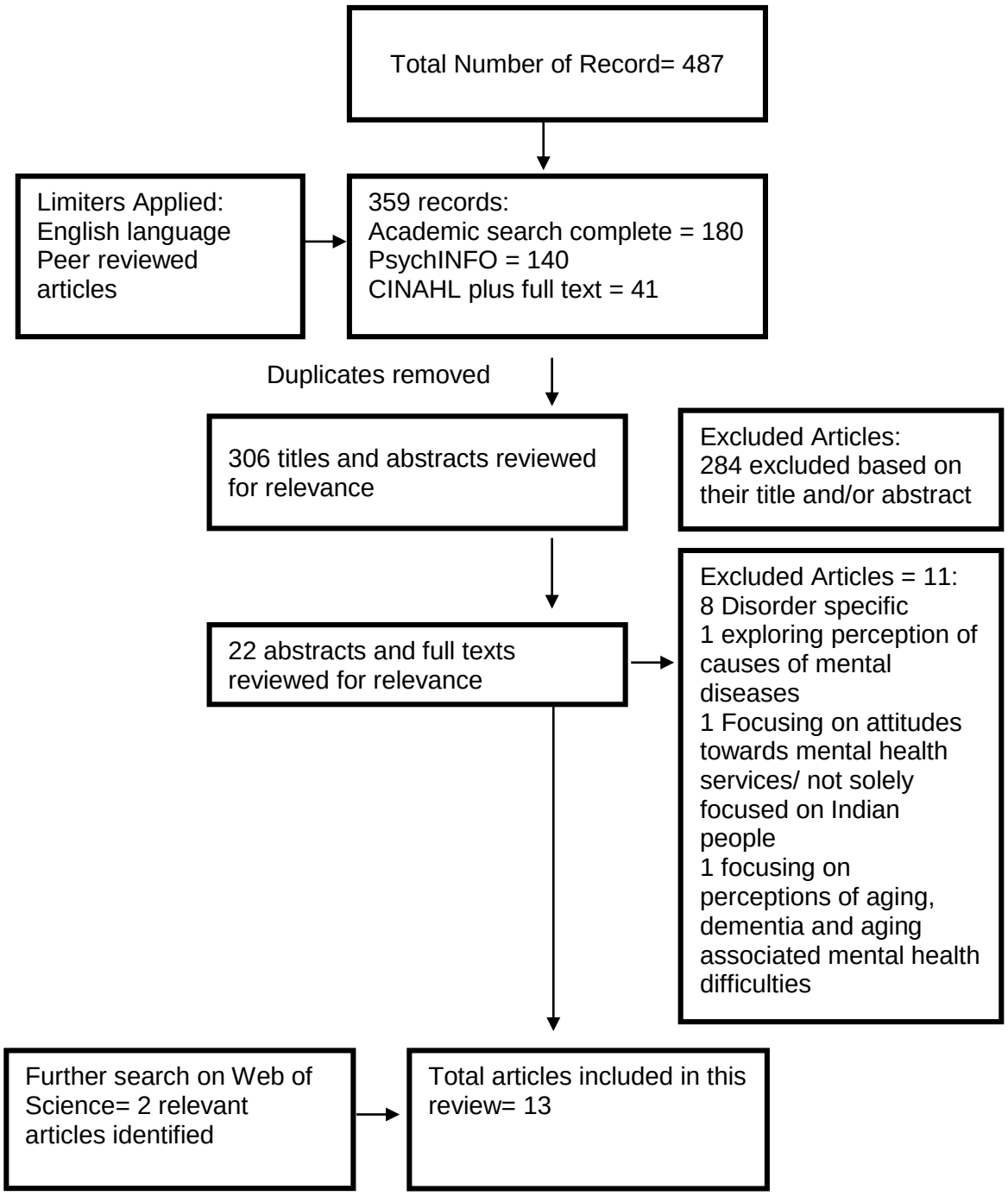
Aims and Scope

Journal of Cross-Cultural Psychology publishes papers that focus on the interrelations between culture and psychological processes. Submitted manuscripts may report results from either cross-cultural comparative research or from other types of research concerning the ways in which culture (and related concepts such as ethnicity) affect the thinking and behaviour of individuals as well as how individual thought and behaviours define and reflect aspects of culture. Integrative reviews that synthesize empirical studies and innovative reformulations of cross-cultural theory will also be considered. Studies reporting data from within a single nation should focus on cultural factors and explore the theoretical or applied relevance of the findings from a broad cross-cultural perspective.

Manuscript Guidelines

Manuscript length should normally be 15 to 35, typewritten pages inclusive of tables and figures. Longer papers will be considered and published if they meet the above criteria. Manuscripts should be prepared according to the most recent edition of the American Psychological Association Publication Manual.

Appendix B: A Flow Chart Describing the Study Selection Process.



Paper Two: Research Report
A Q Methodological Study of British Indian People's Views of Recovery in Mental Illness

For submission to Journal of Cross- Cultural Psychology (Please see Appendix A, paper one for author guidelines to this journal)

Milli Dave

Abstract

Recovery orientated services are becoming more prevalent in the United Kingdom (UK). Mental health services and Government initiatives have provided guidelines to improve outcomes for people suffering from mental illness. There is a danger that these guidelines do not match the needs of individuals who experience mental illness. Individual accounts of recovery have revealed it to be a personal and unique journey. Despite research regarding recovery there is very little information about the prevalence of mental illness among Indian people in the UK. With such limited research it is impossible for services and professionals to ensure recovery orientated practice that is culturally appropriate. The views of British Indians have somewhat been neglected in this field. This study therefore, aimed to reveal the viewpoints held by British Indians regarding necessary factors for recovery in mental illness. Q methodology was used to obtain the views of British Indian people from the Gujarati and Punjabi subgroups. A sample of 20 participants were asked to Q sort 52 statements pertaining to recovery based on their personal beliefs. Factor analysis of the 20 Q sorts revealed four factors interpreted as 'recovery as a Personal Journey: Alongside help from Mental Health Services as well as feeling in control and environmental stability,' **'**Barriers to Help- Seeking Still Exist: However Acceptance and Understanding Can Aid Recovery,' 'A Professional Intervention vs Dealing with Difficulties Alone: The Danger of Shame and Stigma,' Factor four was a bipolar factor and therefore interpreted twice as 'recovery as the responsibility of the whole family: family members, carers and friends as key factors in recovery' and 'recovery as a personal process: the need for control and spirituality.' These factors are discussed in relation to their significance to British Indians and clinical practice.

Introduction

At present there is no universally accepted definition for recovery however, in relation to mental health problems, the term recovery is commonly used with a range of definitions and descriptions. "Recovery is described as a deeply personal, unique process of changing one's attitudes, values, feelings, goals, skills and/or roles. It is a way of living a satisfying, hopeful and contributing life, even with the limitations caused

by illness" (Anthony, 1993, p. 527). The notion of recovery has become increasingly prevalent in mental health services. In 2011, 'No Health without Mental Health,' published Government objectives which aimed to improve mental health outcomes and one of these objectives was to have more people recover from mental health problems (Department of Health (DOH), 2011).

There are many determinants and consequences of mental health problems including psychological and social factors. Therefore, addressing these has been seen as beneficial in improving outcomes (DOH, 2011). Key components of the Government aims include ensuring people who have mental health problems have a good quality of life, the ability to manage their own lives, strong social relationships, a sense of purpose, living and working skills, improved opportunities in education and employment and a suitable and stable place to live (DOH, 2011).

Many National Health Service (NHS) mental health services within England such as South London & Maudsley NHS Foundation Trust and St Georges Mental Health NHS Trust, are starting to incorporate recovery ideas into their services (Shepherd, Boardman & Slade, 2008). Although recovery orientated services aim to achieve symptomatic improvements, the quality of life as judged by the individual is fundamental in recovery rather than changes in symptoms and their severity (Shepherd et al., 2008). Furthermore, employment and education opportunities facilitate social inclusion providing a sense of purpose and increasing self- esteem (Shepherd et al., 2008). Independent living and stability are seen as a key factors in recovery, promoting control and autonomy (DOH, 2011). Therefore the aim for mental health professionals is to empower individuals by providing them with skills essential to help manage their difficulties (Shepherd et al., 2008).

Whilst the commitment of the Government and mental health services is encouraging, there is a danger that their aims may not tailor to individual needs. In terms of services, success in recovery is assessed by adherence to treatment plans and long term use of medication whereas service users define success as hope for the future, autonomy, choice and personal growth (Pilgrim, 2008). The latter coincides with a recovery model

which identifies the process of gaining control over one's life, appreciating one's self, contributing within a community and exploring hopes and dreams (Brown, 2001).

Exploring individual ideas about recovery can provide a great deal of insight into important factors for people with mental health difficulties in gaining the best quality of care from mental health services. In a study exploring mental health service users' views of recovery, themes of 'giving up,' and 'fighting to get better' were identified. 'Giving up' occurred when service users were faced with the long- term involvement of professionals and medication, causing them to adopt a passive identity by handing over responsibility to others. 'Fighting to get better' was a day- to- day process requiring significant effort to find motivation and learn new ways of coping (Kartalova- O'Doherty & Doherty, 2010).

Deegan (2001), described recovery as a transformative process in which strategies such as finding tolerant relationships, spirituality, meaning in own suffering, routines and taking responsibility for recovery aided the service user. She recommended that mental health professionals should explore individual gifts and resources to help aid recovery from mental health difficulties. The meaning an individual assigns to the experience of mental health difficulties determines their illness identity and impacts upon aspects of hope and self- esteem in recovery (Yanos, Roe & Lysaker, 2010). This model argues that defining oneself as inadequate or incompetent due to mental illness damages hope and self- esteem. Furthermore, Wisdom, Bruce, Saedi, Weis & Green (2008), found individuals with mental illness described the challenges of losing their identity and the need for hope in moving forward. These studies highlight the importance of hope in recovery, without which it could be a struggle.

Cultural variables such as ethnicity, race, gender and social status impact on responses to mental health treatment (Comas-Diaz, Griffith, Pinderhughes & Wyche, 1995). With the rapid increase of Black and Minority Ethnic (BME) communities within Britain (Patel & Shaw, 2009), it is important that mental health services tailor to their needs. This will ensure they provide sufficient culturally relevant mental health care within Britain. There are various policies that provide guidelines to improving access for people from a BME

background. The Improving Access to Psychological Therapies (IAPT) positive practice guide (IAPT, 2009) recommends collaborative working with local community organisations to help engage BME communities with mental health services. It emphasises the importance of engaging with communities and faith groups who may have specific knowledge about the needs of people from BME backgrounds. Furthermore, the Mental Health Network Briefing paper (MHN), (2012) recommends that hard evidence should be gathered regarding the outcomes for BME service users. This information can provide insight into whether initiatives to improve access are actually effective. They are also vital in creating culturally sensitive practitioners, interventions and services.

Improving access to mental health services for people from a BME background has been high on many political agendas for some time. However, people from a BME background face various barriers when accessing mental health services including stigma, ethnicity, culture, language or faith (IAPT, 2009). People with mental health difficulties from BME groups face shame and stigma from communities with their family members facing associated stigma. Knifton (2012), identified that shame and stigma associated with mental illness reduced help-seeking behaviours in many BME groups. The participants in this study suggested improved contact and dialogue with families, faith leaders and youth groups to combat stigma (Knifton, 2012). Despite these efforts stigma still remains a major barrier for people from BME groups. Additionally, in their study of Gujarati adults and young people Dogra, Vostanis, Abuatenya & Jewson (2005) found that participants preferred to keep mental health difficulties to themselves due to a fear of being labelled and stigmatised. Furthermore, non- English speaking people find it difficult to communicate their needs causing future reduction in help-seeking behaviours (IAPT, 2009).

There have been various studies that have explored the mental health needs of particular BME populations. Mental health services still lack an understanding of cultural differences of their service users, often failing to tailor to their needs. In a study exploring Asian in-patients' and carers' experiences of mental health services, it was found that issues of accommodating to religious practices and cultural differences were

areas of concern for the in-patients (Greenwood, Hussain, Burns & Raphael, 2000). In this study, participants highlighted the need for staff to have cultural awareness training to reduce assumptions they make about the Asian community such as assuming they are all the same. Furthermore, religious concepts such as prayer and meditation were described as helpful however, practicing such strategies was faced with obstacles such as no room in which to pray or meditate. A survey carried out with South Asian women found that they preferred confidential talking therapies provided by South Asian staff and health promotion materials to be provided in their ethnic language (Kumari, 2004). Such studies have helped create a body of knowledge regarding various BME communities within the UK and help guide practitioners to provide culturally appropriate support to these communities.

Indian People and Mental Illness

Previous research exploring Indian people's attitudes towards mental illness have been conducted primarily in India. Indian people have been found to identify various signs of mental illness including violence or a sudden change in behaviour however, it is important to note that these could be argued to be present in severe mental illness or later stages of mental illness (Salve, Goswami, Sagar, Nongkynirih & Sreenivas (2013). Religion and spirituality have also been used to conceptualise and treat mental illness in India, for example, mental illness was seen as a punishment from God and religious treatment for mental illness was used in rural communities within India (Kishore, Gupta, Jiloha & Bantman 2011 & Thara, Islam & Padmavati, 1998). Such studies provide an awareness of Indian people's beliefs regarding mental illness however, it can be difficult to generalise their results to the Indian population within the UK.

In comparison, generational differences in the conceptualisation of mental illness have been identified in studies conducted outside of India, highlighting the impact of migration on individual attitudes. Dogra et al (2005) conducted a study of Guajarati young people and their parents in the UK and found they had an inconsistent understanding of the terms 'mental health' and 'mental illness.' Adults identified

isolation related to immigration and loneliness exacerbated by a culture of silence within the Gujarati community, whereas young people identified low self- esteem, school related stresses and pressures as a cause of mental illness. In their study Bhana & Bhana (1985) found that South African Indian mothers compared to their children were able to hold both eastern and western concepts of mental illness. Those who are migrants of the United Kingdom (UK) have to deal with the process of adapting to a new culture. This process of acculturation has been described by Berry (1997) and leads to psychological changes and adaptation through a number of struggles. Understanding such experiences is essential as they play a role in shaping the views of people from BME groups and can influence their vision of recovery in mental illness.

Despite research with Indian communities very little is still known about the prevalence of mental illness in people of Indian origin (Patel & Shaw, 2009). Indian people are also under-represented in mental health services and mental health statistics (Patel & Shaw, 2009). Statistics infer that in general the rates of mental health problems are higher within the BME population in the UK than the White British population (Mental Health Foundation (MHF), 2007). However, people from BME groups are less likely than the White British population to have their problems detected by a General Practitioner (GP), (MHF, 2007).

Indian people make up 2.5% of the population in England and Wales, making them the next largest ethnic group after White British (Office for National Statistics (ONS), 2012). The West Midlands is the second most diverse area in England (ONS, 2012). In terms of prevalence of mental illness among Indian people, higher rates of common mental health difficulties (non- psychotic psychiatric symptoms) have been reported in Pakistani and Indian women aged 55- 74 years compared with White British women in the same age group (Weich et al., 2004). It has also been noted that African Caribbean people are more likely to wait until crisis to seek help and may display more serious symptoms of mental illness (Kenyejad, 2008). However, Indian, Bangladeshi and Chinese groups have lower rates of referral to mental health crisis services compared with White British groups (Mind, 2013).

Data taken from South Staffordshire and Shropshire NHS Foundation Trust (SSSFT) between April 2011 and March 2013 highlighted that out of a total of 2374 BME service users, only 292 Indian people attended mental health services for one appointment. In total, 101 Indian people had an appointment with mental health services but failed to attend (SSSFT Health Informatics Service, personal communication, June 19, 2013). In comparison with this data, members of the African Caribbean community are over-represented in mental health services and statistics and research predominantly focuses on Asian and African Caribbean service users (Patel & Shaw, 2009). These statistics demonstrate that although Indian people do suffer from mental health difficulties they have been neglected in research which provides very little insight into their experiences.

Although limited, there is some literature focusing on coping strategies used by Indian people when faced with mental health difficulties. Many people have used spirituality and religion as a way of understanding who they are when suffering from mental health difficulties (Kang, 2010). The influence of Hinduism has been explored amongst British Hindus and certain practices and philosophies of Hinduism such as meditation and understanding the concept of trying to control the mind have been reported as useful for Indian service users (Kang, 2010).

As recovery is an individual concept it is difficult to identify one single definition universal to all regardless of age, gender, race, ethnicity and faith. Unfortunately, with very little research involving British Indian people, it is difficult to understand their views related to recovery when faced with mental illness. Although there is evidence to suggest Indian people are under- represented in mental health services in the UK, understanding their views can provide insight into what the necessary conditions are for recovery. This would then enable services and professionals to better meet their needs and help to increase access to mental health services for people of Indian origin.

The main aim of this study therefore, is to explore the views British Indian people (specifically from a Guajarati or Punjabi subgroup) hold of recovery in mental illness. British Indian is defined as those individuals who identify themselves as citizens of the

UK of Indian descent, who are either Gujarati or Punjabi. Q methodology is used to explore views of the British Indian population which will focus on factors necessary for recovery in mental illness. The findings of this study will be used to inform the practice of mental health professionals in how to provide culturally appropriate support for British Indians.

Q Methodology & Epistemological Position

Q methodology is the systematic study of subjectivity. It permits the study of an individual's viewpoint, opinions, beliefs and attitudes (Exel & Graaf, 2005). Q methodology is used to identify social viewpoints and knowledge structures in relation to a specific subject matter (Watts & Stenner 2012). In Q methodology participants are presented with statements related to the research topic. This set of statements is called the Q set which is developed by the researcher. Participants are asked to read and rank- sort these statements from their individual point of view according to some preference, judgement or feeling about them (Exel & Graaf, 2005). This is called the Q sorting process. These individual Q sorts are then subject to factor analysis, which provides information about both similarities and differences in perspectives on a particular subject (Exel & Graaf).

The researcher adopts a social constructionist position which places emphasis on how subjective meaning becomes a social fact through interaction, which leads to shared meaning- making. Q methodology is capable of identifying predominant social viewpoints in relation to a subject matter (Watts & Stenner, 2012). The Q sorts in this study were an expression of subjective meaning and the interpretation of collective Q sorts resulted in the dominant social beliefs of the British Indian population.

Method

Ethical Approval

This study was approved by both the Independent Peer Review (IPR) board at Staffordshire University and the Nottingham National Research Ethics Service (NRES) committee. To enable recruitment of participants from NHS sites, approvals were gained from the Research and Development departments at SSSFT and the Black Country Partnership NHS Foundation Trust. Please see Appendix A for the approval letters.

Participants

Purposive sampling was employed in order to recruit participants whose viewpoints related to the subject matter (Watts & Stenner, 2012). This study was promoted through various means including; personal visits to recruitment sites, speaking at team meetings, emailing recruitment leaflets to a range of services, distributing recruitment leaflets at the University of Staffordshire, promoting the study through the SSSFT intranet and attending faith groups. Recruitment leaflets which included the inclusion and exclusion criteria, were distributed to all sites that agreed to their service users and staff being approached for this study. (Please see Appendix B for the recruitment leaflet).

Information sheets detailing the study and procedures (please see Appendix C) were provided to individuals who expressed interest in taking part. If they then agreed to take part informed consent was taken in the presence of the researcher (please see Appendix D). In total, 20 participants were recruited through NHS primary care psychological therapy services, NHS Community Mental Health Teams (CMHT), community groups and local faith groups within Staffordshire and Shropshire, Wolverhampton and Leicestershire.

Inclusion and Exclusion Criteria

Participants were invited to take part; if they identified themselves as British Indian, were of Indian descent with British citizenship, were from the British Gujarati and British Punjabi subgroups, were aged 18 years and over, were fluent in English, had accessed mental health services, were current mental health service users or had knowledge of mental illness (specifically knowledge through personal experience of mental health difficulties, exposure to people with mental health difficulties or through caring for someone with mental health difficulties). Both males and females were invited to take part. Participants were excluded if; they identified with ethnicities other than Indian and if they could not speak fluent English. Demographic information regarding the participants is presented below in table 1.

Table 1: Demographic information of participants.

Participant ID	***Gender***	***Religion***	***Country of birth***	***Experience of MI***	***Accessed help for MI***	***Know someone with MI***	***Carer for someone with MI***
1	*Male*	*Hindu*	*India*	*Yes*	*Yes*	*No*	*No*
2	*Male*	*Sikh*	*UK*	*No*	*No*	*Yes*	*No*
3	*Female*	*None*	*UK*	*No*	*No*	*Yes*	*No*
4	*Female*	*Sikh*	*UK*	*No*	*No*	*No*	*No*
5	*Female*	*Sikh*	*UK*	*No*	*No*	*Yes*	*No*
6	*Female*	*Buddhist*	*UK*	*Yes*	*Yes*	*Yes*	*Yes*
7	*Male*	*Hindu*	*India*	*No*	*No*	*No*	*No*
8	*Male*	*Sikh*	*UK*	*No*	*No*	*Yes*	*No*
9	*Male*	*Hindu*	*UK*	*Yes*	*Yes*	*No*	*No*
10	*Female*	*Hindu*	*UK*	*Yes*	*No*	*No*	*No*
11	*Female*	*Sikh*	*Africa*	*No*	*No*	*Yes*	*No*
12	*Male*	*Sikh*	*UK*	*No*	*No*	*No*	*No*
13	*Female*	*Sikh*	*UK*	*No*	*No*	*Yes*	*Yes*
14	*Male*	*Hindu*	*India*	*No*	*No*	*No*	*No*
15	*Female*	*Hindu*	*Kenya*	*Yes*	*No*	*Yes*	*No*
16	*Female*	*Hindu*	*UK*	*No*	*No*	*Yes*	*No*
17	*Female*	*Hindu*	*Uganda*	*No*	*No*	*Yes*	*No*
18	*Male*	*Hindu*	*Dares-Salam*	*No*	*No*	*Yes*	*No*
19	*Female*	*Hindu*	*India*	*No*	*No*	*Yes*	*Yes*
20	*Female*	*None*	*UK*	*No*	*No*	*Yes*	*Yes*

Note. MI= Mental Illness

Design and Procedure

Q methodology consists of three main stages; collection of participant data through Q sorting of a provided Q set, inter correlation and factor analysis of the Q sorts and the interpretation of the factors (Watts & Stenner, 2012). The aim of this study was to obtain completed Q sorts from each participant representing their viewpoints regarding recovery. A Q set consists of items that provide a broad coverage in relation to the research question (Watts & Stenner, 2012). The Q set was developed through searching academic literature and popular texts including documentaries, articles, forums, blogs and magazines all related to recovery, Indian people and mental illness. This produced an initial set of 68 statements which were then carefully examined to ensure they did not include complicated terminology and that they were understandable. Any similar statements were removed. A Q set containing between 40 and 60 items is recommended (Watts and Stenner, 2012), a final Q set of 52 statements was used in this study, please see Appendix E.

Each participant met with the researcher individually in a location convenient for them such as local community centres and NHS consultation rooms. Basic demographic data was gathered using the pre- sorting information sheet which can be found in Appendix F. The 52 statements were presented on equal sized individual cards. Participants were asked to read each statement and sort them into 3 piles, strongly agree, strongly disagree and unsure, in relation to their personal views of what they felt was important in recovery. Once this was completed participants were asked to return to each pile, individually re-read them and sort them using a scale from -5 strongly disagree, through 0 neutral to +5 strongly agree. Participants were told that all items of the Q set would have to be allocated a ranking on the distribution grid shown in figure 1. Following this, participants were finally interviewed to ascertain reasons for their decisions. Please see Appendix G for instructions and examples of post- sort interview questions.

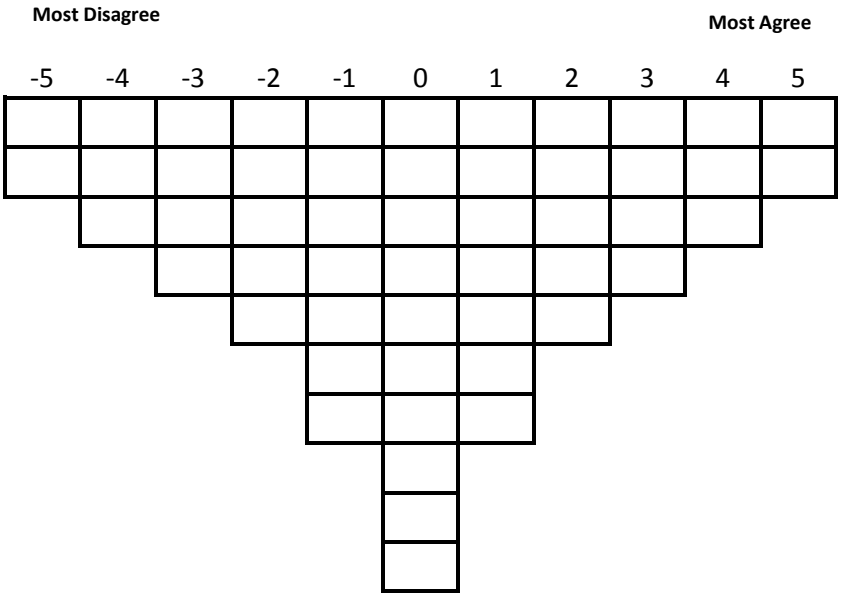


Figure 1. Q distribution grid. Illustrates the distribution grid and the scale used during the Q sorting process

Statistical Analysis

All 20 Q sorts were entered into PQmethod software (Schmolk, 2014) and subjected to a by- person factor analysis. A correlation matrix was generated, highlighting the nature and strength of the relationship between any two Q sorts (please see Appendix H for the correlation matrix). Four factors were extracted from the data and subject to varimax rotation, this solution explained 47% of the study variance. The Q sorts of 16 participants were significantly associated with one or other of these factors (significantly associated Q sorts had a factor loading of ≤0.40 indicating significance as $p < 0.01$).

In Q methodology a factor solution is chosen based on both statistical and theoretical reasons (Brown, 1980). Therefore, this four factor solution was chosen as each factor offers a range of meaningful views related to recovery. This four factor solution also satisfies the Kaiser- Guttman criterion (Guttman, 1954; Kaiser, 1960, 1970) which suggests retaining only those factors that have an eigenvalue of 1.00 or above. It is also recommended that the factor model should explain at least 35% to 40% of the study variance (Watts & Stenner, 2012), indicating the suitability of a four factor model. Table 2 shows the rotated factor matrix identifying the factor loadings for each Q sort

on factors one, two, three and four. The factor eigenvalues and the percentage of variance explained by each factor is also shown in this table.

Table 2: Rotated factor matrix with an X indicating a defining sort.

Q Sort	Factor 1	Factor 2	Factor 3	Factor 4
1	34	40**X**	11	14
2	54	30	51	5
3	33	56**X**	22	-17
4	27	76**X**	16	28
5	23	68**X**	11	-1
6	26	40**X**	39	-11
7	52**X**	20	23	19
8	75**X**	32	0	-2
9	63**X**	28	11	-2
10	55	8	56	-10
11	0	23	40**X**	28
12	67**X**	19	-8	25
13	38	67**X**	-1	5
14	0	8	70**X**	-4
15	4	16	7	-2
16	60	40	8	-5
17	0	-8	19	-47**X**
18	25	1	13	46**X**
19	11	5	11	46**X**
20	72**X**	22	11	23
Eigen Value	**3.82**	**2.84**	**1.67**	**1.11**
% Variance	**19**	**14**	**8**	**6**

Note. Factor loadings for each factor are shown in table 2. Defining Q sorts are indicated via a significant factor loading which was ≥ 0.40 (Brown, 1980). Defining sorts are indicated with an 'X' and emboldened. The eigenvalue and percentage of variance explained by each factor is included.

Q sorts that load significantly onto a factor highlight similar viewpoints in relation to the research question (Watts & Stenner, 2012). Table 2 shows Q sorts from participants 7, 8, 9, 12 and 20 loaded significantly onto factor one. The Q sorts from participants 1, 3, 4, 5, 6 and 13 loaded significantly onto factor two and Q sorts from participants 11 and 14 loaded significantly onto factor three. Q sorts from participants 17, 18 and 19 loaded significantly onto factor four. The Q sorts of participant 15 did not significantly load onto

any of the factors. There were three confounding Q sorts; 2, 10 and 16 which loaded significantly onto more than one factor.

A factor array represents the overall viewpoint of a particular factor (Watts & Stenner, 2012). PQmethod creates factor arrays through a weighted averaging procedure and the Q sorts that significantly loaded onto each factor are merged to create a factor array. Factor arrays were produced for all four factors and are presented in table 3 in Appendix I.

Factor Interpretation

Factor interpretation involved careful attention to the item rankings in each factor array, encouraging engagement with every item, making it easier to understand the factor's overall viewpoint (Watts & Stenner, 2012). The highest and lowest items in each factor were noted along with the items that ranked higher and lower in relation to the other factors. Additionally, demographic data was studied in relation to each factor. Finally, qualitative data collected during the post- sort interview, was examined in relation to the participants that loaded significantly onto each factor. This was to ensure a holistic view of each factor was captured. A description of each factor is presented including the demographic details of significantly loading participants. Ranking of relevant items are stated in the interpretation, for example, in factor one the inclusion of (42: -3) in the first bracket indicates item 42 was ranked -3. Participant comments have also been considered and included where they shed light to the interpretation.

Factor four is a bipolar factor as it had both positively and negatively loading Q sorts which are positioned near to both their poles (Watts & Stenner, 2012). Q sort 17 has captured a viewpoint that is the polar opposite of the shared viewpoints represented in Q sorts 18 and 19. Taking this into consideration, factor four has been interpreted twice. Firstly, through examining the viewpoints associated with its positive pole (4+) and secondly, with the examination of the viewpoint of the negative pole (4-) which is a reversed (direct opposite) factor array. For example, table 3 in Appendix I shows item 16 in factor four (4+) has been ranked -5 therefore, in its reversed array (4-) item 16 is

ranked +5. Factor four presented two distinct but connected viewpoints (4+ and 4-) regarding recovery which have been interpreted below.

Factor One: Recovery as a Personal Journey: Alongside help from Mental Health Services as well as Feeling in Control and Environmental stability

Factor one has an eigenvalue of 3.82 and explains 19% of the study variance. Five participants (7, 8, 9, 12 and 20) are significantly associated with this factor. Four are male and one participant is female. Four out of five participants were born in the UK and one male participant was born in India. One participant had experienced mental illness and accessed help. Two out of five participants knew someone with a mental illness, one of which was a carer for someone with mental illness.

Interpretation

A positive and confident relationship with mental health services is demonstrated in factor one. They support Indian people with mental health problems to get back into the community (18: -3), they believe they will benefit from counselling (17: -4), they recognise cultural differences in the experience of mental health (22: -3), they do not assume that Indian people will look after their own (27: -4) and they have knowledge about their patients' culture and understand it (33: -2). Indian people are therefore comparatively confident in the mental health services provided (29: -2).

Recovery does not prioritise the need for medication (42: -3). On the contrary, recovery is a deeply personal process (37: +2) and a journey of self-discovery which demands admitting there is a problem and accepting that help is needed (31: +3). This is important because it demonstrates control of the illness and life (45: +3) and engagement in positive thinking about the situation, which is a very important aspect of recovery (36: +4). The process involves receiving explanations about the causes of illness and coming to understand it and the experiences far better (19: +3; 52: +4). Participant 9 who is currently engaged in mental health services stated, *“Now I’m doing psycho-dynamic therapy and that’s more instead of tackling your problem it’s*

understanding why you've got these problems. I think that helps a lot to understand how and why I have these problems." Being listened to and understood by other people is also a necessity (12: +3).

Participant 20 who was a carer for a family member with a mental illness stated:

> *First of all I didn't know about his illness. When I had this professional help and the doctor came to me and he was talking to me he explained about the illness and very nicely he did and I was so shocked when he did that.*

Despite this being a personal process, having stability and support (34: +5) and an appropriate and stable environment in which to live (28: +2; 24: +4) are important. If those elements are in place, recovery will occur gradually, incrementally and in many different stages (48: +5). Ultimately, it will probably result in changing personal attitudes and values about life (32: +2) and it may never mean a complete absence of symptoms (25: -5). Participant 9 stated, *"I have seen myself in stages getting better but there has never been a stage where all symptoms have gone away. It's learning how to control them more than getting rid of them."*

Factor Two: Barriers to Help- Seeking Still Exist: However Acceptance and Understanding Can Aid Recovery

Factor two has an eigenvalue of 2.84 and explains 14% of the study variance. Six participants are significantly associated with this factor (1, 3, 4, 5, 6 and 13). Five are females born in the UK and one participant is a male born in India. Two out of six participants have experienced mental illness and accessed help and three out of six participants know someone with a mental illness, one of which is a carer for someone with a mental illness.

Interpretation

Shame and stigma in other people knowing of ones' experiences of mental illness is present resulting in avoidance of support groups (3: +2). Mental illness does not run in the family (21: -3) and the family reputation is not damaged due to caring for someone with a mental illness (16: -3). Despite this, aiding recovery is not the responsibility of

the whole family (9: -3). Racism, stigma and language barriers impact on help- seeking behaviours (20: +2; 41: +1). Although mental health services are important in recovery (5: +2) and do not make assumptions about Indian people (2: -2; 17: -2), they need to be culturally appropriate (8: +4; 49: +3) and raise awareness of their usefulness (50: +3).

Recovery is a deeply personal process with many different stages (37: +4; 48: +2) with the importance of admitting that a problem is present and help is needed (31: +5). This results in coping with the illness (43: +2) but not forming a new identity (7: -3). Being listened to and understood is important in recovery alongside a support network and living in the right environment (12: +5; 34:+3; 24: +3) without the need for all symptoms to disappear (25: -5). Participant 4 stated, *"I think for good recovery from mental health services and from other people what you need is for someone to sit there and say well what are you thinking and be really completely person centred."*

Participant 3 stated:

> *Although it's an individual process there is something about being heard and the value that brings, so I'm imaging having a mental illness would be quite chaotic in my mind and having to express some of that chaos to somebody and me making sense of that. But a part of that process would have to be someone listening to me and valuing me as well in that process. If somebody isn't listening to me or I don't feel understood that could lead to me feeling rejected and wouldn't aid my recovery.*

There is no need for medication, positive thinking, employment or a belief in God for recovery to occur (42: -4; 36: -4, 47: -2; 1: -4). Furthermore, a curse cannot cause mental illness (14: -5).

Factor Three: A Professional Intervention vs Dealing with Difficulties Alone: The Danger of Shame and Stigma

Factor three has an eigenvalue of 1.67 and explains 6% of the study variance. Two participants are significantly associated with this factor (11 and 14). One female born in Africa who knows someone with a mental illness and one male born in India, neither of whom have experience of mental illness.

Interpretation

Recovery is a deeply personal process with the importance of medication (37: +4; 42: +3). Disappearance of all symptoms is not expected and neither is forming a new identity (25: -3; 7: -3). Financial security, stability and choice of treatment are not needed for recovery to occur (24: -2; 47: -4; 28: -3, 51: -2). Although a professional intervention is needed for recovery (38: -4) alongside an awareness of available services (50: +2), there are some reservations in seeking help from mental health services. Services are seen as unhelpful and unable to meet the needs of Indian people (11: +3; 10: +2) however, they can support people back into the community (18: -2). Support groups are avoided due to a fear of being seen by members of the Indian community and admitting to caring for someone in the family with a mental illness, brings shame to the family (3: +5; 44: +3). A curse does not explain mental illness (14: -5) and mental illness does not run in the family (21: -5).

With reference to Indian people avoiding support groups participant 14 stated:

> *This is some sort of taboo subject back at home (India) and it's a cultural thing within the Asian community, South- East Asian community altogether not just Indians. They think it's some sort of curse on us by God because of their belief in their religion or faith or sect, they think well it's a God given curse, nobody can help us it's God who has done it.*

Mental health professionals have little understanding and knowledge of their patients' culture and the impact of racism and cultural differences in mental illness (33: +2; 22: +4; 35: -2; 8: +2). Participant 11 stated, "*Doing your homework before you actually go and see someone especially the language the dialogues are so different especially from different religions or different areas or education level."* Therefore, working with someone from the same background is helpful to develop an understanding of personal experiences and receive appropriate support (39: +3; 46: +5) as assumptions about Indian people are prevalent among mental health professionals (17: +4; 27: +4). When discussing the usefulness of having a mental health professional from one's own background, participant 14 stated, "*They understand about the language, they*

understand about the eye contact and everything when they are talking to the person, but western body language is very different from us."

Further on participant 14 stated:

> *Western professionals treating Asians they can't because our mind set about illness is different from how the western world thinks about illness, we don't think the same way, that's why professionals are failing in recognising the difference of opinion because of cultural backgrounds.*

Factor Four (4+): Recovery as the Responsibility of the Whole Family: Family Members, Carers and Friends as Key Factors in Recovery

Factor four has an eigenvalue of 1.11 explaining 6% of the study variance. Three participants are significantly associated with this factor (17, 18 and 19). Two females, one born in Uganda and one born in India and one male, born in Dares- Salam. All participants are Hindu aged between 55- 64 years. No participants have experienced a mental illness but all know someone with a mental illness. One participant was a carer for her family member who had a mental illness.

Interpretation

The positive role of a support network incorporating family members, who are responsible for helping someone with mental illness (9: +3) and close friends is demonstrated in this factor. If someone in the family is suffering from a mental illness the family reputation is not effected (16: -5). Having a close support network of family, carers and friends is more important in recovery (40: +3; 34: +4) alongside help from professionals from the same cultural background (46: +3). Although mental health services can aid recovery, a professional intervention is not needed (5: +4; 38: +3), they are largely rejected to protect against judgement which will reflect badly not only on the individual but on the family as a whole (44: +5). Keeping things within the family is therefore preferred even though mental health professionals have knowledge about their patients' culture and do not make assumptions about the benefit of services for Indian people (33: -4; 17: -3). It would be useful for services to help people with a mental

illness engage with the community and share information about their services with people from different ethnic backgrounds (18: +2; 50: +5).

When talking about keeping things in the family the participant 19 stated:

> *As the years went on and we all grew up we found they (extended family) weren't telling anyone from the community that he (father) was suffering from this mental illness and we had to keep it a secret as well, we felt like it was something to be ashamed of when it wasn't.*

Although it is important, the presence of family support does not ensure a better recovery (2: -4) and mental health services assume Indian people will look after their own (27: -5). Participant 19 stated, *"When my father was ill they were always saying how we were really supportive around my father maybe that's why he wasn't offered anything because they felt he didn't need it like for example the counselling."* Recovery is not a deeply personal process and one does not need to gain control over the mental illness and life or admit they have a problem and need help (37: -2; 45: -4; 31: -3). A combination of positive thinking, medication and understanding personal experiences (36: +2; 42: +4; 52: +2) is needed for recovery. This can result in living a satisfying and hopeful life (26: +4). There is no journey through different stages and all symptoms are not required to disappear (48: -2; 25: -2). A belief in God and religion is not needed in recovery (1: -2; 15: -3) neither is stability or financial security (28: -3; 6: -2).

Factor Four Reversed Interpretation (4-): Recovery as a Personal Process: The Need for Control and Spirituality.

Recovery is a deeply personal process involving different stages with the importance of admitting there is a problem and help is needed (37: +2; 4: +2; 31: +3). Financial security and stability are needed to gain control over ones' life resulting in all symptoms of mental illness disappearing (6: +2; 28: +3; 45: +4; 25: +2). However a satisfying and hopeful life cannot be achieved through recovery (26: -4). The need for understanding personal experiences is not present (52: -2). Medication and positive thinking is not required for recovery (42: -4; 36: -2) which can occur without the aid of a professional intervention, family, carers and friends (38: -3; 40: -3; 34: -2). However, taking a more

spiritual approach is beneficial, placing an emphasis on religion and a belief in God as important for recovery to occur (1: +2; 15: +3). Participant 17 stated, *"Our people are very religious daily life depends on religion and when they are in difficulty they always turn to God."*

Taking care of someone with a mental illness is not the responsibility of the whole family and there is no shame in caring for someone suffering from mental illness (9: -3; 44: -5). Indian people do recover better due to the amount of family support available (2: +4). However, there is a danger that the family reputation is damaged if a family member is suffering from a mental illness which could bring shame to the family (16: +5).

Mental health services do not aid recovery (5: -4) and there is very little understating among mental health professionals about a patients' culture (33: +4). They assume Indian people will not benefit from their help due to having family support and communication difficulties (27: +5; 17: +3). They do however, help people back into the community (18: -2). Simply learning about cultural needs, sharing information about services with BME groups and working with a professional from the same background will not encourage Indian people to seek help from services (49: -2; 50: -5; 46: -3).

Discussion

The aim of this study was to explore the views British Indian people hold of recovery in mental illness which has been successfully met. Q methodology revealed four factors, each presenting a range of shared viewpoints related to recovery among the British Indian population. Similarities and differences between the viewpoints in all factors were also present.

The viewpoints in factors one and two emphasised recovery as a personal journey of self- discovery unique to the individual (akin to Anthony 1993; Pilgrim 2008 & Brown 2001). Elements required for this journey in factor one included insight and positive thinking to empower individuals and provide hope. These findings indicate the positive

role of hope in recovery, through which developing an understanding of experiences related to mental illness, can provide a sense of control and motivation. This supports findings of previous literature that suggests strength is needed for motivation and determination to move forward when faced with a mental illness (Kartalava- O'Doherty & Doherty, 2010). This allows individuals to explore their hopes for the future (Brown, 2001).

Stability and support were also necessary for recovery to occur, demonstrating the importance of independence, control and autonomy alongside external support. The importance of such factors have been highlighted in Government guidelines (DOH, 2011). The viewpoints in factor one demonstrated British Indian people had confidence in mental health services which were perceived to be knowledgeable about cultural differences. This supports the guidelines provided by IAPT (2009), which recommend collaborative working with BME communities to encourage engagement. Factor two highlighted that barriers such as shame, stigma, racism and language still remain and impact on help- seeking behaviours. However, this factor demonstrated a fundamental need to be listened to and understood in order to develop acceptance of experiences and potentially overcome some of the barriers. Truly understanding ones' experiences can help instil hope and motivation which are essential in recovery. This supports previous accounts of recovery that have emphasised the need for meaning- making in recovery (Deegan, 2001).

Taken together, the viewpoints in factors one and two highlight the individual nature of recovery, with a profound need to understand personal experiences and accept there is a problem and help is needed. These similarities demonstrate that the quest for meaning- making in recovery is essential in determining ones' identity in relation to the illness. The meaning attached to ones' identity can provide hope and strength for recovery, increasing ones' self- esteem similar to the model described by Yanos et al., (2010). Therefore, positive thinking and acceptance can provide hope for an individual suffering from mental illness, assisting their journey to recovery.

Considering the demographics of participants associated with factors one and two, these similarities could represent the views of Indian people born in the UK and those who have experienced mental illness and accessed help. The openness to mental health services and professionals in these factors demonstrates the key role they can play in supporting people develop insight into their difficulties. Through such support from professionals, British Indians can feel empowered and explore the skills they feel they may need to cope with their difficulties (akin to Shepherd et al., 2008). These findings are encouraging and suggest that Indian people have confidence in mental health services and will utilise them if needed.

Shame and stigma have been reported as barriers in seeking help within the BME community (Mind, 2013).The impact of shame and stigma related to mental illness was highlighted in factor three. Particular emphasis was placed on a fear of being judged by the wider Indian community, resulting in stigmatisation. This supports previous research which highlights that people from BME groups do face stigmatisation from communities reducing their help- seeking behaviours (Knifton, 2012) and they prefer to keep mental health difficulties hidden due to a fear of stigmatisation (Dogra et al., 2005). This can create a real dilemma for British Indians as this factor also highlights the need for medication and professional interventions in recovery.

As a result of stigma, British Indian people may isolate themselves and avoid seeking help from external support. This can create an incredibly lonely place for British Indians who may be enduring mental health difficulties alone. Factors such as stability and autonomy were not important within this factor indicating experiences of isolation and a lack of engagement with mental health services and society. These findings demonstrate that although there is a need for professional input to aid recovery, the fear of stigma and shame from the wider community can result in services being rejected.

Factor four (4+ and 4-) demonstrated two very different viewpoints in relation to recovery. Firstly, the viewpoints in factor 4+ highlighted the importance of support from family, carers and friends for recovery. Mental health services were rejected to protect

against judgement from the wider community which would reflect badly not only for the individual, but also the family as a whole. In order to protect family and individual reputation, mental health difficulties are kept hidden from others (akin to Dogra et al., 2005). Additionally, previous literature has emphasised the need for control in recovery (Brown, 2001). However, if family members are involved in the care of Indian people suffering from mental health difficulties, this may lead to Indian people passing responsibility of their care to family members adopting a passive identity (Kartalova-O'Doherty & Doherty, 2010).

Secondly, factor 4- revealed the complete opposite viewpoint from factor 4+ highlighting need for spirituality and religion in recovery (akin to Kang, 2010 & Greenwood et al., 2000). Although, control is needed for recovery, factors such as medication and positive thinking are replaced by a belief that God will provide a complete cure for individuals suffering from mental illness. This is similar to the findings of previous studies in India that have revealed the preference in religious treatment for mental illness (Thara et al., 1998). Furthermore, if spirituality is needed in recovery, strategies such as prayer and meditation related to religious practices may be useful for some British Indians to help cope with mental illness. This is similar to research conducted by Kumari, (2004) who found such practices commonly used in the South Asian community.

A commonality between factors one, two and three was the view that curses did not cause mental illness. Previous research conducted in India has found a belief among Indian people that evil spirits can cause mental illness, leading to a preference for religious treatments such as consulting faith healers or daily worshipping (Thara et al., 1998 & Kishore et al., 2001). Personal accounts from participants in this study highlighted that such beliefs were still prevalent among the wider Indian community in Britain. Although not indicated in the findings of this study, if such views regarding spirituality are still prevalent, it demonstrates how culture can influence attitudes towards mental illness and the treatments currently available in the UK. This may result in British Indians not consulting medical professionals as a first port of call and may not view mental health services as beneficial for recovery.

The need for a disappearance of all symptoms related to mental illness was not evident in all four factors with the exception of the reversed interpretation of factor four (4-). This reflects the aims of recovery orientated services in their quest for improving the quality of life rather than concentrating on symptomatic improvements (Shepherd et al., 2008). Taken together, these viewpoints provide further support to the notion of recovery as a personal process unique to the individual, with success only really measurable by the service user. Taking into consideration the demographics of all factors, such views are present in those who both have and have not experienced mental illness. This is significant as it highlights that the aims of mental health services are in fact in sync with those of the Indian community.

Considered together, the differences between the factors have revealed contrasting views among British Indians born in the UK and those born either in India or Africa. Factors one and two emphasised the need for individual motivation and strength to aid recovery. In contrast, factors three and four (4+) highlighted British Indians were reluctant to share mental health difficulties and reject help from services to protect their reputation among their community. Taken together the viewpoints in factors three and four could represent those of second- generation Indians who were born in India or Africa and have settled here in the UK.

The impact of migrating to a new country can influence individuals in many different ways. Berry (1997), described the strategies used to acculturate when faced with adapting to new cultures. These strategies involve integration, assimilation, separation and marginalisation depending on the value given to maintaining relationships with the larger society. Acculturation can lead to psychological changes in personal identity, values, attitudes and behaviour (Esses, Medianu, Hamilton & Lapshina 2015). The current findings highlight the significance of acculturation in influencing the views of British Indians regarding recovery, which may result in some cultural conflict. Previous research has also highlighted generational differences in attitudes towards mental illness (Bhana & Bhana, 1985). Understanding experiences of acculturation, can provide great insight into essential elements required for recovery among second-

generation British Indians. A connection with cultural beliefs regarding mental illness may influence the way in which second- generation British Indians view the essential elements for recovery.

Clinical Implications

The findings of this study highlight that British Indians value the role of mental health services and professionals in recovery, which is promising. In order to empower British Indians, it is essential that services and professionals truly understand their cultural experiences including racism, shame, stigma, the role of religion and spirituality and the impact of migration. Only through a holistic understanding of individual experiences can professionals play a key role in aiding recovery. Furthermore, stigma related to mental illness is still prevalent within the British Indian community. This impacts on their help- seeking behaviours creating a culture of isolation. It is imperative that services work collaboratively with Indian people to ensure they are aware of the interventions available to them. Through an awareness of the usefulness of mental health services, Indian people who are fearful of stigmatisation can gain further confidence in seeking help.

Limitations

It is worth noting that the findings of this study are difficult to generalise to the wider Indian population. This is because Q methodology has identified a snapshot of viewpoints which may not be similar among all British Indians. However, this study has successfully met its aims of gaining an understanding of views regarding recovery among a sample of British Indian people. Additionally, people whose were not fluent in the English language were excluded from this study resulting in valuable views being neglected.

Finally, the inclusion criteria specified that people who had knowledge of mental illness could participate, resulting in those who had no experience of mental illness taking part in this study. The concept of recovery may have been challenging for people who had no experience of mental illness or mental health services. Evidence suggests Indian

people are under- represented in services therefore, even though participants may not have experienced mental illness or accessed services, they still hold valuable opinions regarding the essential factors for recovery to occur.

There is great scope for future research in the field of recovery and Indian people. Future studies should definitely concentrate on the views of non- English speaking Indians to allow their voices to be heard. This can provide essential information regarding the role of language in meaning- making and how interpreters may help to reduce the barriers of accessing services. What should also be considered in the future is how experiences of racism and migration among British Indians impact on help-seeking behaviours. This could provide a much greater insight into why these factors make it difficult for Indian people to seek help in the UK.

Conclusion

The aim of this study was to explore the views held by British Indian people regarding recovery in mental illness. The present study has added to the limited amount of research available exploring British Indians and recovery in mental illness. Q methodology revealed four factors highlighting the key aspects necessary for recovery within the British Indian population. Recovery was seen as a journey of self- discovery requiring insight and positivity. The importance of being listened to and understood by others was identified in order to accept and fully understand personal experiences of mental illness.

Some British Indians also prefer to keep mental health difficulties hidden due to a fear of stigmatisation from the wider community. This can lead British Indians to avoid professional support to protect themselves from shame and stigma, leading to family members playing a key role in aiding recovery. The role of spiritualty was represented in the viewpoints highlighting the need for a belief in God and religion. Finally, the differences in viewpoints of British Indians born in the UK and those born in India and Africa are significant in understanding the impact of acculturation in help- seeking

behaviours. Such experiences should be taken into account when considering the key aspects necessary for recovery among British Indians.

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Appendix A: IPR and Ethical Approval Letters

STAFFORDSHIRE UNIVERSITY

Faculty of Health Sciences

INDEPENDENT PEER REVIEW APPROVAL FEEDBACK

Researcher Name	**Milli Dave**
Title of Study	**Exploring the Views of the British Indian Community on Mental Health Recovery.**
Award Pathway	**DClinPsy**
Status of approval:	**Approved**

Action now needed:

You must now apply to the Local Research Ethics Committee (which serves the Trust within which you intend to complete your study) for approval to conduct your study. You must not commence the study without this second approval. To seek approval you will need to complete the application form for the committee and forward copies of your proposal.

Please forward a copy of the letter you receive from the L.R.E.C. to Helen Sutton at Blackheath Lane as soon as possible after you have received approval. Once you have received L.R.E.C. approval you can commence the implementation phase of your study. You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal.

It is now possible to begin writing your dissertation and you may wish to consult with your supervisor on this matter.

Comments for your consideration:

Thank you for forwarding the amendments requested by the Independent Peer Review Panel (IPR)

Signed: Prof V Unnithan **Date**: 26 February 2014
Vice-Chair of the Faculty of Health Sciences IPR Panel

NRES Committee East Midlands - Nottingham 1
Royal Standard Place Nottingham NG1 6FS

Telephone: 0115 8839695

01 July 2014

Miss Milli Dave
Trainee Clinical Psychologist
South Staffordshire and Shropshire NHS Foundation Trust
Leek Road
Stoke on Trent
ST4 2DF

Dear Miss Dave

Study title:	**Exploring the Views of the British Indian Community on Mental**
REC reference:	**14/EM/0219**
IRAS project ID:	**148555**

Thank you for your email of 25 June 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 20
June 2014.

Documents received

The documents received were as follows:

Document	*Version*	*Date*
Covering letter on headed paper		24 June 2014
Participant information sheet (PIS)	9	24 June 2014
Research protocol or project proposal	8	24 June 2014

Approved documents

The final list of approved documentation for the study is therefore as follows:

Document	*Version*	*Date*
Covering letter on headed paper		22 April 2014

Covering letter on headed paper		24 June
Evidence of Sponsor insurance or indemnity (non NHS Sponsors only)		23 April 2014
Letters of invitation to participant	5	22 April
Other [IPR Approval Feedback]		26
Other [IPR Approval letter]		04 March
Participant consent form	4	22 April
Participant information sheet (PIS)	9	24 June
REC Application Form		23 April
Research protocol or project proposal	8	24 June
Summary CV for Chief Investigator (CI)		03 April

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor's responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

14/EM/0219 **Please quote this number on all correspondence**

Yours sincerely

Ms Helen Wakefield
REC Manager

E-mail: NRESCommittee.EastMidlands-Nottingham1@nhs.net

Copy to: Audrey Bright, South Staffordshire & Shropshire NHS Foundation Trust

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust
R&D Department
Block 7
St George's Hospital
Corporation Street
STAFFORD ST16 3AG

Telephone: 01785 221168

Our Ref: AB/R279

Date: 8 October 2014

Ms Milli Dave
Trainee Clinical Psychologist
South Staffordshire and Shropshire Healthcare NHS Foundation Trust
Trust HQ
St George's Hospital
Corporation Street
Stafford ST16 3AG

Dear Milli

Study title

We have considered your application for access to patients and staff from within this Trust in connection with the above study.

On behalf of the Trust and the Responsible Care Professionals within the Psychology Directorate have now satisfied themselves that the requirements for Research Governance, both Nationally and Locally, have been met and are happy to give approval for this study to take place in the Trust, with the following provisos:

- That all researchers coming into the Trust have been issued with either a letter of access or honorary contract by ourselves
- That you conform to the requirements laid out in the letters from the REC dated 25th June 2014 and 1st July 2014, which prohibits any changes to the agreed protocol
- That you keep the Trust informed about the progress of the project at 6 monthly intervals
- If at any time details relating to the research project or researcher change, the R&D department must be informed.

Your research has been entered into the Trust database and will appear on the Trust website.

As part of the Research Governance framework it is important that the Trust are notified as to the outcome of your research and as such we will request feedback once the research has finished along with details of dissemination of your findings. You will be asked to provide a copy of the final report and receive an invitation to present final feedback via our research seminar series. To aid dissemination of findings, copies of final reports are placed on our Trust Website. To this end, please contact me towards the completion of the project to discuss the dissemination of findings across the Trust and a possible implementation plan.

If I can help in any other way please do not hesitate to contact me.

Yours sincerely

Ruth Lambley-Burke
R&D Manager
Cc Dr Rachel Lucas, Director of Psychology, Trust HQ, Stafford

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Miss Milli Dave
Trainee Clinical Psychologist
South Staffordshire and Shropshire NHS Foundataion Trust
R207 Faculty of Health Sciences
Staffordshire University, Science Centre
Leek Road, Stoke on Trent

25th November 2014

Dear Millie

Name of project - Exploring the Views of the British Indian Community on Mental Health Recovery.

REC Ref. No. 14/EM/0219

I am writing to inform you that the Black Country Partnership NHS Foundation Trust's Research and Innovation Group has approved your study and hereby gives local R&D approval for your research to begin, on the basis of your research application and proposal approved by NRES Committee NRES Committee East Midlands - Nottingham 1

Approval is subject to adherence to the conditions set out by the ethics committee in their letter to you dated 20 June 2014. Should you fail to adhere to these conditions or deviate from the protocol reviewed by the ethics committee, then local approval for this study will be withdrawn. Permission to conduct research is also conditional on the research being conducted in accordance with the Department of Health's Research Governance Framework for Health and Social Care.

I would like to wish you every success with your research and look forward to receiving a copy of your completed report in the future.

Yours sincerely

Joanne Tomkins, Research & Innovation Manager
On behalf of
Dr Stephen Edwards, Medical Director for BCPFT

Appendix B: Recruitment Leaflet

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

Recruitment leaflet for research participants

British Indian men and women required for Doctorate research project.

Trainee Clinical Psychologist Milli Dave is interested in exploring the views British Indian people hold of mental health recovery.

Do you identify with the following?

- British Indian- specifically from the Gujarati or Punjabi subgroup
- Fluent in English
- Aged 18 or over
- Have previously accessed a mental health service or are currently engaged with a mental health service.
- Have knowledge of mental illness

If you answer yes to these points and are interested in taking part in the research then contact Milli Dave for more information!

At: email address: xx
Tel: xx

Appendix C: Participant Information Sheet

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

Information Sheet for Research Participants

The Research Project: Exploring the Views of the British Indian Community on Mental Health Recovery.
Researcher: Milli Dave

I would like to invite you to participate in this doctoral research project. Before you decide whether or not to take part in this study, I would like you to understand why the research is being done and what it would involve for you.

I am a Trainee Clinical Psychologist and hope to explore the views of British Indians on recovery within mental health. Recovery is the journey taken by people with mental health difficulties and focuses on life beyond mental illness. As Black and Minority Ethnic (BME) communities are increasing in Britain it is essential that mental health services tailor to their needs. By exploring people's views on recovery we can gain a great deal of insight into what factors are important for people in dealing with their difficulties.

There is limited research into the views of British Indian adults on recovery from mental health difficulties. Therefore, I would like to explore the views held by British Indians on recovery as this will help influence and shape mental health services to tailor support to the needs of this group. It is really important that your views are explored in order to provide psychologists with information about what is important to you when dealing with mental health difficulties.

Please read this information sheet carefully as it will inform you of what taking part in this study will involve.

Why have I been invited?

This study aims to explore the views of British Indian adults; therefore it is felt you are ideal participants for this project.

Do I have to take part?

It is up to you whether you decide to take part in this study. If you agree to take part you will be asked to read and sign a consent form. You are free to withdraw from this study at any time and this would not affect the standard of care you receive.

What will happen if I agree to take part?

Once you decide to take part in the study I will contact you to discuss your participation and agree a suitable time and date to meet in a convenient location.

During our meeting you will be asked to sort a range of statements related to recovery into order of preference. Sorting these statements will enable you to provide me with your views of recovery and will allow me to explore what factors are important to you. I will guide you through this process and we will discuss why you chose to sort statements in the way you did. You will also be given the opportunity to share your thoughts on why you chose to sort statements in a particular order. This meeting will last for approximately an hour however, can be shorter or longer than this. I will also audio record our meeting in order to keep information about the process and our discussions for interpretation of the results. We will only need to meet once to complete the sorting process unless we have to terminate for any reason and arrange another date.

What are the possible advantages of taking part?

This research will help gain insight into the factors that are important for people from a British Indian background in recovery from mental illness. As there is limited research in this area, it will enable mental health practitioners and services to become more aware of the needs of this community. It is also hoped that the findings of this research will add to existing knowledge about the British Indian community and help increase their access to appropriate mental health services.

What are the possible drawbacks of taking part?

It is possible that taking part in this research may evoke negative thoughts and feelings within you. If this becomes a concern for you and you wish to seek additional support, I will provide you with contact details of services from which you can seek support within your area.

Confidentiality

All data collected will be kept strictly confidential and stored on a password protected database. Our meeting will also be audio recorded and stored on a password protected recorder and this password will only be known by myself. The data will only be available to those included in the research team. No names or personal information will be linked to the data in any way. Keeping in line with Staffordshire University policy all the data gathered will be kept for 5 years.

If during the research you express thoughts of harming yourself or others, this will be shared with your GP or mental health worker to help provide you with any support you may need.

What will happen to the results of this study?

All information provided by you will be stored anonymously and in line with Staffordshire University policy the data will be kept for 5 years.

All of the information collected from participants will be analysed using Q methodology. Q methodology is a research method that permits the study of individual viewpoints, opinions, beliefs and attitudes. This methodology will allow me to explore the views British Indian people have about recovery and whether there are similarities or differences in viewpoints. It is hoped that this study will provide a range of viewpoints of the British Indian community regarding recovery. Differences in views within this community will also be explored and discussed.

The final results of this study will be available in one or more of the following sources; scientific papers in peer reviewed academic journals, presentations at local meetings or conferences and if you wish I will be happy to provide you with a short summary of the findings.

What if there is a problem?

If you have concerns about any aspect of the study, you should ask to speak to the researcher the first instance who will do their best to answer your questions. Please contact the researcher at xx or on xx.

However if you still remain unhappy and wish to complain formally, you can do this by contacting Patient Advice and Liaison Service (PALS) who provide information and support to service users and carers. You can contact them on 01785783028 or pals@sssft.nhs.uk

What happens now?

Once you have read this information sheet and wish to take part in the study, I will take down your contact details in the first instance. I will then contact you individually to arrange a convenient time to meet and complete the consent form. Alternatively if you have any concerns or questions related to this research please do not hesitate to contact me at xx

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION SHEET.

Appendix D: Participant Consent Form

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust

A Keele University Teaching Trust

Participant Consent Form

Centre Number:

Study Number:

Patient Identification Number for this trial:

CONSENT FORM

Title of Project: Exploring the Views of the British Indian Community on Mental Health Recovery.

Name of Researcher: Milli Dave

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated (date), version 4 for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. If I am currently engaged in a mental health service I agree to my mental health worker being informed of my participation in the study. ☐
4. I am aware that if the researcher has concerns about my or anybody else's safety that information will be shared will my GP/relevant professionals involved in my care. ☐
5. I agree to take part in the above study. ☐

Name of Participant	Date	Signature
Name of Person taking consent.	Date	Signature

Appendix E: The 52 Statement Q- set used in this Study.

1. Good recovery requires a belief in God
2. Indian people recover from mental illness better than other ethnic groups because they have a lot of family support
3. Indian people avoid attending support groups because they worry about seeing someone they know
4. The cultural background of mental health professionals does not matter as long as they listen and are flexible
5. Mental health services play a role in supporting people with mental illness recover
6. Recovery from mental illness requires financial security
7. Recovery from mental illness is forming a new identity
8. Mental health services should meet the cultural and religious needs of Indian people
9. Helping someone with a mental illness is that responsibility of the whole family
10. Current approaches to treating mental illness do not meet the needs of Indian people
11. Indian people do not seek help from mental health services because they think it would not help them
12. For good recovery you need to be listened to and understood
13. Being actively involved in the community can help recovery
14. Having a mental illness means someone has put a curse on you
15. Religion can help someone recover from mental illness
16. If a family member is suffering from mental illness the family reputation is damaged
17. Mental health professionals assume that Indian people will not benefit from services such as counselling because of communication problems
18. Mental health services fail to support those with a mental health illness to get back into the community
19. Recovery from mental illness requires getting explanations for your mental illness
20. People from ethnic minorities are not just recovering from mental illness but also from racism and stigma
21. Mental illness runs in the family
22. Professionals do not recognise there are cultural differences in the experience of mental illness
23. Mental health services have to go beyond normal care to help people recover from mental illness
24. Recovery from mental illness requires living in the right environment
25. Recovery from mental illness means all symptoms have disappeared
26. Recovery from mental illness is finding a way of living a satisfying and hopeful life
27. Mental health services and professionals assume that Indian people will look after their own and that they do not want help from services
28. Recovery from mental illness requires having a stable place to live
29. Indian people lack confidence in mental health services
30. Recovery from mental illness requires meeting other people who have recovered from mental illness
31. Recovery from mental illness requires admitting that you have a mental illness and need help
32. Recovering from mental illness changes personal attitudes and values about life
33. Mental health professionals have very little understanding and knowledge about their patients culture
34. Recovery from mental illness requires having people who stand by you
35. Mental health professionals do not know about how racism can affect someone's mental health
36. Recovery from mental illness requires positive thinking

37. Recovery from mental illness is a deeply personal process
38. Recovery from mental illness can occur without professional intervention
39. Interpreters can aid recovery by helping someone with a mental health problem to better understand what is happening to them
40. Carers relatives and friends provide most of the support in the recovery process
41. Language barriers prevent people from seeking help from mental health services
42. Recovery from mental illness requires medication
43. Recovery from mental illness is about coping with your illness
44. Indian people would be ashamed to say they were caring for a mentally ill person at home because of what people in their community would think about them and their family
45. Recovery from mental illness requires you to take control of your illness and your life
46. Having a mental health professional from your own cultural background helps because they know what kind of support you need
47. Recovery from mental illness requires gaining employment
48. Recovery from mental illness has many different stages
49. Mental health services should learn more about what people in different communities need
50. Information about mental health services should be shared with everyone from different ethnicities
51. Recovery from mental illness requires being able to choose a treatment for mental illness
52. Recovery from mental illness requires an understanding of what has happened to you

Appendix F: Pre- Sorting Information Sheet

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust
A Keele University Teaching Trust

Pre- Sorting Information Sheet

1. What is your age? (please tick)

18- 24 years old ☐
25- 34 years old ☐
35- 44 years old ☐
45- 54 years old ☐
55- 64 years old ☐
65- 74 years old ☐
Over 74 years old ☐

2. What is your gender? (please tick)

Male ☐
Female ☐
Other ☐

3. How would you describe your ethnicity? (please state)
   _____
4.
5. What is your religious preference? (please state)
   _____

6. What is your country of birth? (please state)
   _____

7. If you were not born in the United Kingdom please state how long you have been living in the United Kingdom? (please state)

_____

8. Have you ever experienced mental illness? (please tick)

Yes ☐

No ☐

9. If you ticked yes to question 7, please state whether you have accessed help for the mental illness?

Yes ☐

No ☐

10. If you ticked yes to question 8 please stated below what time of help you have accessed.

---

11. Do you know someone who has a mental illness?

Yes ☐

No ☐

12. Are you are carer for someone with a mental illness?

Yes ☐

No ☐

Appendix G: Instructions and Post- Sorting Interview Questions

South Staffordshire and Shropshire Healthcare NHS
NHS Foundation Trust
A Keele University Teaching Trust

Instructions

I am interested in your views about recovery from mental illness as an Indian person. Recovery is the journey taken by people with mental health difficulties and focuses on life beyond mental illness.

There are 52 cards with different statements related to recovery, each offers a different response to the research questions. I would like you to take each card and read each statement carefully.

Step 1:

After reading each of the cards I would like you to make 3 piles

Pile 1: Statements you most agree with
Pile 2: statements you most disagree with
Pile 3: Statements you neither agree nor disagree with (neutral)

Please note: I am interested in your point of view therefore, there is no right or wrong answer.

Step 2:

- Take the cards from the agree pile and read them again. Select the two statements you most agree with and place them in the two last boxes on the right of the score sheet below 5. Next, from the remaining cards in the deck, select the three statements you most agree with and place them in the three boxes below the 4. Follow this procedure for all cards from the agree pile.

- Now take the cards from the disagree pile and read them again. Just like before, select the two statements you most disagree with and place them in the two last boxes on the left of the score sheet below -5. Follow this procedure for all cards from the most disagree pile.

- Finally, take the remaining cards from the neutral pile and read them again. Arrange the cards in the remaining open boxes of the score sheet.

- Once you have completed this please look over the score sheet again and move any cards around you may wish to.

Post- sort interview guide

- Please explain why you most agree with the two statements you placed below 5. Why is that important to you? Do your experiences effect your reasons? Does this affect your recovery?

- Please explain why you most disagree with the two statements you placed under -5. Why do you feel so strongly about this? What is the personal meaning for you? Have you experienced any of this? How does it shape your view of recovery?

- Feedback on the process, where there any statements you didn't understand?

Appendix H: Correlation Matrix between Q Sorts

Sort	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
1	0	27	36	56	45	45	44	38	35	33	22	42	42	-2	-8	28	-17	2	2	50
2	27	0	45	44	47	44	42	53	46	60	30	41	42	40	14	56	0	23	23	56
3	36	45	0	56	54	46	35	42	45	46	11	34	55	20	13	34	10	11	-4	38
4	56	44	56	0	61	42	36	46	35	36	35	44	67	25	8	51	-16	17	28	44
5	45	47	54	61	0	25	22	41	40	28	27	25	55	28	10	45	0	4	11	36
6	45	44	46	42	25	0	27	34	28	50	29	25	33	34	17	33	2	2	0	28
7	44	42	35	36	22	27	0	52	34	55	25	54	39	20	-2	29	-11	23	10	51
8	38	53	42	46	41	34	52	0	68	39	14	52	52	-2	13	61	-2	11	13	67
9	35	46	45	35	40	28	34	68	0	45	17	35	40	13	11	56	5	16	14	65
10	33	60	46	36	28	50	55	39	45	0	27	29	27	42	2	39	14	1	14	52
11	22	30	11	35	27	29	25	14	17	27	0	-2	20	30	1	11	-2	20	19	17
12	42	41	34	44	25	25	54	52	35	29	-2	0	40	2	-2	56	-17	42	13	45
13	42	42	55	67	55	33	39	52	40	27	20	40	0	5	20	47	-5	17	13	45
14	-2	40	20	25	28	34	20	-2	13	42	30	2	5	0	8	16	17	25	-1	14
15	-8	14	13	8	10	17	-2	13	11	2	1	-2	20	8	0	26	2	-2	-10	-5
16	28	56	34	51	45	33	29	61	56	39	11	56	47	16	26	0	5	23	22	54
17	-17	0	10	-16	0	2	-11	-2	5	14	-2	-17	-5	17	2	5	0	-35	-20	-7
18	2	23	11	17	4	2	23	11	16	1	20	42	17	25	-2	23	-35	0	38	22
19	2	23	-4	28	11	0	10	13	14	14	19	13	13	-1	-10	22	-20	38	0	34
20	50	56	38	44	36	28	51	67	65	52	17	45	45	14	-5	54	-7	22	34	0

Appendix I: Factor Arrays

Table 3: Factor arrays for all four factors

Statement & Number	Factor Arrays			
	1	2	3	4
1.Good recovery requires a belief in God	-1	-4	-3	-2
2. Indian people recover from mental illness better than other ethnic groups because they have a lot of family support.	-2	-2	0	-4
3. Indian people avoid attending support groups because they worry about seeing someone they know.	1	2	5	0
4. The cultural background of mental health professionals does not matter as long as they listen and are flexible.	0	1	0	1
5. Mental health services play a role in supporting people with mental illness recover.	1	2	0	4
6. Recovery from mental illness requires financial security	-1	-1	-4	-2
7. Recovery from mental illness is forming a new identity.	-1	-3	-3	1
8.Mental health services should meet the cultural and religious needs of Indian people	0	4	2	-1
9. Helping someone with a mental illness is that responsibility of the whole family.	0	-3	1	3
10. Current approaches to treating mental illness do not meet the needs of Indian people.	-1	0	2	0
11.Indian people do not seek help from mental health services because they think it would not help them	-1	1	3	-1
12. For good recovery you need to be listened to and understood.	3	5	1	0
13. Being actively involved in the community can help recovery.	1	-1	1	0
14. Having a mental illness means someone has put a curse on you.	-5	-5	-5	-1
15. Religion can help someone recover from mental illness.	1	-1	0	-3
16.If a family member is suffering from mental illness the family reputation is damaged	-4	-3	-1	-5
17. Mental health professionals assume that Indian people will not benefit from services such as counselling because of communication problems.	-4	-2	2	-3

Note: Factor arrays for each factor are presented. Reading this table by column reveals the factor arrays for each factor, for example factor one has ranked item 1 as -1 and item 2 as -2 and so on. Reading this table by row reveals the cross factor rankings for each item. For example, item 3 has been ranked by factor one as +1, by factor two as +2, by factor three as +5 and by factor four as 0.

Table 3: Factor arrays continued

Statement & Number	Factor Arrays			
	1	2	3	4
18. Mental health services fail to support those with a mental health illness to get back into the community.	-3	-1	-2	2
19.Recovery from mental illness requires getting explanations for your mental illness	3	0	0	-1
20. People from ethnic minorities are not just recovering from mental illness but also from racism and stigma.	-1	2	0	0
21.Mental illness runs in the family	-2	-3	-5	0
22. Professionals do not recognise there are cultural differences in the experience of mental illness.	-3	-2	4	-1
23. Mental health services have to go beyond normal care to help people recover from mental illness.	0	0	-1	1
24.Recovery from mental illness requires living in the right environment	4	3	-2	1
25.Recovery from mental illness means all symptoms have disappeared	-5	-5	-3	-2
26. Recovery from mental illness is finding a way of living a satisfying and hopeful life.	0	4	1	4
27. Mental health services and professionals assume that Indian people will look after their own and that they do not want help from services.	-4	-1	4	-5
28.Recovery from mental illness requires having a stable place to live	2	0	-3	-3
29. Indian people lack confidence in mental health services.	-2	0	1	1
30. Recovery from mental illness requires meeting other people who have recovered from mental illness.	-1	-2	-1	1
31. Recovery from mental illness requires admitting that you have a mental illness and need help.	3	5	-1	-3
32. Recovering from mental illness changes personal attitudes and values about life.	2	0	-1	-1
33.Mental health professionals have very little understanding and knowledge about their patients culture	-2	0	2	-4
34. Recovery from mental illness requires having people who stand by you.	5	3	-2	2

Note: Factor arrays for each factor are presented. Reading this table by column reveals the factor arrays for each factor, for example factor one has ranked item 18 as -3 and item 19 as +3 and so on. Reading this table by row reveals the cross factor rankings for each item. For example, item 20 has been ranked by factor one as -1, by factor two as +2, by factor three as 0 and by factor four as 0.

Table 3: Factor arrays continued

Statement & Number	Factor Arrays			
	1	2	3	4
35.Mental health professionals do not know about how racism can affect someone's mental health	-2	0	-2	0
36. Recovery from mental illness requires positive thinking.	4	-4	1	2
37. Recovery from mental illness is a deeply personal process.	2	4	4	-2
38.Recovery from mental illness can occur without professional intervention	0	-1	-4	3
39. Interpreters can aid recovery by helping someone with a mental health problem to better understand what is happening to them.	2	1	3	0
40. Carers relatives and friends provide most of the support in the recovery process.	0	0	0	3
41. Language barriers prevent people from seeking help from mental health services.	0	1	0	0
42. Recovery from mental illness requires medication.	-3	-4	3	4
43. Recovery from mental illness is about coping with your illness.	1	2	-1	1
44.Indian people would be ashamed to say they were caring for a mentally ill person at home because of what people in their community would think about them and their family	2	0	3	5
45.Recovery from mental illness requires you to take control of your illness and your life	3	1	0	-4
46. Having a mental health professional from your own cultural background helps because they know what kind of support you need.	0	-1	5	3
47.Recovery from mental illness requires gaining employment	-3	-2	-4	0
48. Recovery from mental illness has many different stages.	5	2	0	-2
49.Mental health services should learn more about what people in different communities need	0	3	1	2
50. Information about mental health services should be shared with everyone from different ethnicities.	1	3	2	5
51. Recovery from mental illness requires being able to choose a treatment for mental illness.	1	1	-2	-1
52. Recovery from mental illness requires an understanding of what has happened to you.	4	1	-1	2

Note: Factor arrays for each factor are presented. Reading this table by column reveals the factor arrays for each factor, for example factor one has ranked item 35 as -2 and item 36 as +4 and so on. Reading this table by row reveals the cross factor rankings for each item. For example, item 37 has been ranked by factor one as +2, by factor two as +4, by factor three as +4 and by factor four as -2.

Paper Three: Reflective Commentary

Milli Dave

Introduction

This paper provides critical reflections on the process of conducting this doctoral thesis project which explored the views British Indian people hold of recovery in mental illness. Ethical considerations including; the position of the researcher, the influence of researcher characteristics and the researcher's Q sort will be shared and discussed. A reflexive analysis will explore the researcher's personal responses in relation to participants. This paper will conclude by discussing implications for future clinical and research practice. This paper is written in the first- person as it provides a personal account of experiences.

Literature Review

My desire to explore literature related to Indian people was influenced by previous clinical experience. A key part of these roles had been to improve staff knowledge and awareness of cultural differences, as well as increasing access to psychological therapies for Black and Minority Ethnic (BME) groups. Through this experience and literature pertaining to BME groups, I was aware some communities were under-represented in mental health services in the United Kingdom (UK).

Based on this, my initial thoughts about a literature review question were to explore why BME groups were under- represented. This yielded many studies however, it was difficult to find research solely conducted in the UK. It felt appropriate to narrow my focus to review research pertaining to the Indian population, as they are a specific BME group that have been under- represented in mental health statistics. Again, I wished to limit the literature to that conducted in the UK due to its relevance for current practice, however, my initial search found a very small number of studies that met this criteria. Terms such as 'ethnic minorities' and 'British Indian,' were not helpful in yielding more results. This led to reviewing literature from around the world, mainly in India. When searching for literature, I had to be mindful of various terminology used to describe this ethnic group. For example, the term 'Indian' resulted in studies of 'American Indians', therefore searching for 'Indian' and 'India' yielded in more appropriate literature.

The reviewed studies provided a great deal of information through their findings, making synthesis a challenging but interesting task. I felt the most suitable method of synthesising the findings would be to explore themes within the results akin to Aveyard (2014). Through this method I was able to build a deeper understanding of the attitudes held by Indian people regarding mental illness.

The process of conducting a literature review has demonstrated that research completed outside of the UK, is a valuable resource in providing information related to different cultures and I will not overlook this in future practice. Furthermore, this process also made me aware of gaps in knowledge regarding Indian people's views of aspects of mental illness. It also highlighted the lack of research conducted within the Indian community in the UK. This, for me, provided further inspiration to complete my thesis project exploring the views of British Indian people regarding recovery.

Reflections of Methodology

Terminology

From the onset the term 'British Indian' was contested, causing what I felt was unnecessary confusion during the initial stages of applying for Independent Peer Review (IPR) from Staffordshire University. Being British Indian myself, I felt this was the most appropriate classification to use when recruiting participants. However, feedback from the IPR panel suggested further expansion of this term. This meant going back to the drawing board in specifying British Indian. This was a difficult task as throughout life I have defined my ethnic origin as British Indian and know the distinction between Indian and other ethnic groups such as British Pakistani or British Bangladeshi. In order to clarify the term British Indian I had to explore what subgroups I wanted to include in this study and why. Through my literature review it appeared little research had been conducted with Punjabi and Gujarati groups which are part of the Indian community. I therefore changed my criteria to include British Indians specifically from the Gujarati or Punjabi subgroups.

On reflection, by limiting the criteria to include Guajarati and Punjabi British Indians, I may have excluded potential participants who may have described themselves as Indian but not met the inclusion criteria such as South Indian/Asian and mixed ethnic groups such as White and Asian. I am now aware that terminology related to BME groups can cause misunderstanding. A key learning point has been not to assume other people have the same knowledge as I do when it comes to using terms to identify BME groups. Furthermore, using specific classifications when attempting to study a particular ethnic groups can immediately exclude potential participants. Keeping the term British Indian may have enabled me to include all potential participants for this study without much exclusion.

The term 'mental illness' has been used in all of the papers, although I personally prefer alternative terms such as 'mental health difficulties' or 'mental health problems.' I am mindful that using the term 'mental illness,' can be perceived as a medical term often used to describe or diagnose mental health difficulties. However, mental health difficulties were described as mental illness in most of the previous literature in paper one and in the literature used to create my Q set in paper two. Using alternative terms may have caused confusion for participants during the research process. Therefore, it would not have been appropriate for me to alter a definition that has been used consistently.

Q Methodology

My choice of using Q methodology was primarily based on my epistemological position. This approach was new to me and I had some reservations of using it due to potential for misunderstanding when trying to describe it to professionals and participants. I had not encountered previous research with the Indian community employing this methodology. Understandably, I felt anxious throughout the research process in relation to this methodology and its use within the Indian community. When constructing the Q set I had to thoroughly examine each statement, ensuring its readability and relevance to the Indian population akin to Watts & Stenner (2012).

During the post- sorting interview I made a conscious effort to elicit participant feedback on the Q sorting process. I received positive comments about the process as a whole. None of the participants had come across this methodology which created curiosity and a desire to learn more about it. A common theme from the feedback was that participants did not feel put on the spot as they might have done in an interview setting. On reflection, it appears Q methodology was a culturally appropriate method for this population and helped in easing their anxieties as much as mine.

Confidentiality & Anonymity

All participant data was kept strictly confidential on a password protected database. Participant data was coded to ensure anonymity during data analysis and interpretation. Ensuring anonymity was key in recruiting people from the Indian community. Several potential participants withdrew after discovering the findings of this study would be disseminated due to a fear of other people such as, their General Practitioners (GPs) or care- coordinators knowing they had taken part.

This is a thought- provoking message about the dilemma Indian people may face in sharing their views even when anonymity is ensured and how they feel they may be judged by others in their support network. The repercussions of stigma from sharing experiences discussed in paper one, may extend to taking part in research. This may have been one of the factors that made recruitment to this study challenging. Indian people may not readily have the opportunity to openly share their experiences or may in fact shy away from such actions. A number of participants who did take part, stated they were pleased that such research was being done as they had not come across this previously. Raising awareness of the benefits of research is necessary in encouraging participation.

Minimising Risk

Protection from harm was ensured within this project. It was acknowledged that exploring issues around recovery may evoke negative thoughts and feelings for the

participants- particularly if they had very negative experiences of mental health services. In order to address this, details of emergency services were provided if needed. Participants were also informed that should they express thoughts of harming themselves or others, information would have to be shared with relevant professionals involved in their care. Measures to manage immediate risk of harm were also taken with details of emergency services such as the local crisis team, emergency departments and the Samaritans were made available if needed. None of the participants expressed thoughts of wanting to harm themselves or others.

Recruitment Journey

Recruitment was challenging from the beginning of the research process. Initially I started by contacting mental health services in Staffordshire to enquire whether they would be happy for me to promote my study to their service users and aid in recruitment. The response I received was disheartening at the initial stage. Most National Health Service (NHS) sites such as primary care psychological therapies services and Community Mental Health Teams (CMHTs) did not wish to be a part of this study due to having only a handful of Indian service users. However, as I persevered with recruitment I gathered support from voluntary organisations and community development workers in Staffordshire. These professionals acknowledged that Indian people were under- represented in their services and felt research within this population would be beneficial in helping them engage this community. I also decided to broaden my recruitment area including, Wolverhampton and Leicestershire to increase potential for participants. On reflection I feel securing recruitment sites at a much earlier stage would have been advantageous and less time consuming.

In the early stages of my research journey, I quickly began to feel discouraged with the recruitment process. The experience of recruiting participants from the community has highlighted the importance of being proactive and creative. Discussions with professionals working to engage BME groups identified how difficult they were finding it to reach out to Indian people especially in Staffordshire. Through experience, they had found that directly communicating with Indian people,

for example, attending faith groups or religious festivals was most beneficial rather than expecting them to come to services or professionals. I soon recognised that I had failed to consider the creative and opportunistic approaches to recruitment highlighted in my literature review which I had praised (Singh, Shukla, Verma, Kumar & Srivastava 1992; Methrotra, Tripath & Elias 2013; Kishore, Gupta, Jiloha, & Bantman 2011; Bhana & Bhana 1985 & Vijayalakshmi, Reddy, Math & Thimmaiah 2013).

Taking the above into consideration I visited local temples, attended team meetings to promote my study and spoke to staff who knew of service users whom may meet the inclusion criteria. An interesting observation was the reluctance of mental health staff in asking their services users of their ethnic background. In this situation I had to provide information about the characteristics that would constitute someone identifying as Indian. I also gave staff reassurance that their service users would not be offended if approached with my recruitment leaflet as recruitment relied on self-identification of individuals as British Indian.

Working with professionals has been an essential part of recruitment and their knowledge of engaging BME communities has been critical in aiding recruitment. Furthermore, it has highlighted how difficult it is to reach out to the Indian community. The effectiveness of engaging with the community has been identified and I will take this forward when considering future research and clinical practice.

Ethical Considerations

Position of the Self in Research

Throughout this process I struggled to find a balance between the various roles to which I am assigned. Through actively engaging and reaching out to members of the Indian community I felt I was shifting between the role of a researcher and a community engagement worker. The experience of attending a Sikh temple to promote my research demonstrated the need for more link workers to engage with BME communities. This experience was thought- provoking as the audience

enquired about mental health difficulties and medication and seemed to lack awareness of how to access support if faced with mental health difficulties. Experiencing first- hand the lack of awareness in some Indian communities, further emphasised the difficult task of engaging such groups in services. It was difficult to separate these two roles: in order to actively promote my research it was inevitable that I would need to reach out to Indian communities to encourage participation in research.

Personal Characteristics

I describe myself as a British Indian Hindu female from the Gujarati subgroup. I am also a Trainee Clinical Psychologist as well as a researcher. I was mindful of the dynamics and dilemmas this research created and the impact of my cultural and professional identity. The disadvantages of self- disclosure have been written about in psychodynamic literature. When clients are explicitly curious about their therapist, it highlights unconscious motivations and if questions are answered the client is deprived of the opportunity to understand themselves (Lemma, 2003). Participant curiosity was present during discussions about the research and the post- sort interviews. Participants would ask about my age, marital status and caste. In clinical practice, self- disclosure is discouraged which created a dilemma for me when conducting research. I struggled to maintain my professional boundaries due to a fear of being offensive and disrespectful.

Working therapeutically, I had become good at keeping my personal and professional worlds apart. Being explicitly asked about personal information brought my anxieties into conscious awareness. I was anxious about being judged by fellow members of the Indian community on the basis of being an unmarried female, living alone and the meaning this holds within the Indian community. At the same time I often found myself answering some questions out of respect. I am mindful of the way in which my responses may have influenced the dynamic between myself and the participants. I may have experienced a possible lack of respect and participants may have struggled to see beyond my age, race, culture, gender and caste.

According to Hindu scriptures, one's caste or role in society is shaped by their qualification and nature (Kang, 2010). Being asked about my caste is something I encounter regularly in my community. It is a way of evaluating a persons' standing in society which is a concept I am critical of. Identification of caste in the researcher-participant relationship may have caused an immediate power imbalance creating superior- inferior role positions. Having revealed my caste to one participant who was insistent on finding out, created doubts in my mind about whether my caste was more important than my role as a researcher. I was also mindful of how someone from a different caste may feel about sharing their personal stories with me, making them reluctant to take part in the research. Furthermore, participants may not have been truly honest in their responses if they were in doubt about my background.

My Views Regarding Recovery

Researching a group of people from the same ethnicity as myself could lead to bias when interpreting the findings of this research. To minimise the potential for bias I completed the Q sort to encourage self- awareness of personal views towards recovery in mental illness. Awareness of my own views allowed me to objectively study the data and findings rather than being guided by my personal beliefs. My completed Q sort can be found in Appendix A, figure 1.

My personal beliefs regarding autonomy influenced me in rating related statements highly (+5). Being given a choice is important when faced with difficulties, as is establishing a sense of control without which I feel recovery from a mental illness can be challenging. I also value the role of family, friends and religion in recovery (+4) as well as developing an understanding of personal experiences (+3). I have always valued the role of alternative therapies when experiencing physical and psychological difficulties. Growing up, the use of yoga and Ayurveda (Indian herbal medication) were encouraged within my family for physical and emotional difficulties such as stress and low mood. Therefore, I feel medication is not required for recovery and that mental illness does not run in the family (-5). I did value the role of mental health services, however felt that often they did not understand how cultural differences and racism can impact upon experiences of mental illness (+1).

Reflexivity: Minimising Bias

Reflexivity involves being aware of personal responses as well as social and cultural contexts in which we live (Etherington, 2004). Conducting research with a community in which I am a part of, produced a range of emotions within me.

My religious beliefs have always been important and provided me with strength in difficult times. My beliefs led to the preconceived impression that participants would also value religion in recovery. Hearing participants devalue religious beliefs was challenging. They would often describe loss of hope in religious practices and God. The role of hope has been highlighted in recovery experiences which may be likely to fade during difficult times. On reflection, I am mindful of how a protective factor such as faith may diminish during the journey of recovery.

In a therapeutic context, transference is the redirection of a client's feelings from a significant person towards the therapist. The process of counter transference is the redirection of the therapist's feelings towards a client (Lemma, 2003). These processes between myself and the participants were apparent during discussions regarding feelings of unfair treatment and cultural conflict. Hearing participants' accounts of feeling mistreated by mental health services triggered feelings of anger within me and evoked personal memories of feeling mistreated by services in the past. Additionally, many participants spoke about their struggles of moving to England and their experiences of racism. I became conscious of my own experiences of cultural- conflict, evoking strong feelings of sadness and anger at the unjust these people had experienced. I was aware that the impact of my responses based on personal feelings during these discussions, could influenced participants' responses in the post- sort interview. Therefore, having an awareness of my personal feelings was critical in order for me to monitor my reactions and regulate my emotions.

Implications

Conducting research with the British Indian population has highlighted implications for clinical practice and future research. The challenges in promoting this study and

in recruitment have been evident however, this should not deter future researchers in continuing to study this population. A number of lessons have been learnt from conducting this doctoral thesis project. The importance of anonymity and being actively involved in recruitment is crucial in ensuring Indian people feel comfortable enough to share deeply personal experiences with researchers. Without research we will be none the wiser as to how Indian people experience mental illness and mental health services. Although there are government guidelines as to what is expected from recovery orientated services, it is essential to listen to personal experiences of mental health difficulties and services in order meet different needs.

The impact of my cultural identity in the research process highlights the strengths and weaknesses of conducting research within a community to which I belong. I have become aware of how my personal characteristics and background may influence participant engagement and responses. Insight into personal responses is critical in reducing bias in research and interpretation. The dynamic processes that occurred between myself and the participants increased self- awareness and I was mindful I would struggle to keep my personal and professional worlds apart. Although these processes were challenging, allowing participants to have their voices heard felt worthwhile and gave me confidence in conducting this thesis project. Additionally, embarking on a journey which included using a methodology I was not familiar with has developed my research skills, increasing my confidence in using this methodology and highlighted its benefits for future research especially with the Indian population.

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Appendix A: My Q Sort

Most Disagree With										Most Agree With
-5	-4	-3	-2	-1	0	1	2	3	4	5
Mental illness runs in the family	Recovery from mental illness means all symptoms have disappeared	Having a mental health professional from your own cultural background helps because they know what kind of support you need	Recovery from mental illness is forming a new identity.	The cultural background of mental health professionals does not matter as long as they listen and are flexible	Mental health services and professionals assume that Indian people will look after their own and that they do not want help from services	Mental health professionals do not know about how racism can affect someone's mental health	Being actively involved in the community can help recovery.	People from ethnic minorities are not just recovering from mental illness but also from racism and stigma.	Recovery from mental illness requires having people who stand by you.	Recovery from mental illness requires you to take control of your illness and your life
Recovery from mental illness requires medication	Recovery from mental illness requires financial security	Interpreters can aid recovery by helping someone with a mental health problem to better understand what is happening to them	Indian people recover from mental illness better than other ethnic groups because they have a lot of family support	Carers relatives and friends provide most of the support in the recovery process	Indian people would be ashamed to say they were caring for a mentally ill person at home because of what people in their community would think about them and their family	Mental health professionals have very little understanding and knowledge about their patients culture	Recovery from mental illness has many different stages.	Recovery from mental illness is finding a way of living a satisfying and hopeful life.	Religion can help someone recover from mental illness	Recovery from mental illness requires being able to choose a treatment for mental illness.
	Having a mental illness means someone has put a curse on you	If a family member is suffering from mental illness the family reputation is damaged	Recovering from mental illness changes personal attitudes and values about life	Recovery from mental illness requires positive thinking	Mental health services should meet the cultural and religious needs of Indian people	Good recovery requires a belief in God	Recovery from mental illness is a deeply personal process	For good recovery you need to be listened to and understood	Helping someone with a mental illness is that responsibility of the whole family	
		Mental health services fail to support those with a mental health illness to get back into the community	Mental health professionals assume that Indian people will not benefit from services such as counselling because of communication problems	Recovery from mental illness requires gaining employment	Recovery from mental illness requires meeting other people who have recovered from mental illness	Professionals do not recognise there are cultural differences in the experience of mental illness	Indian people lack confidence in mental health services	Recovery from mental illness requires an understanding of what has happened to you		
			Mental health services have to go beyond normal care to help people recover from mental illness	Indian people do not seek help from mental health services because they think it would not help them	Recovery from mental illness requires getting explanations for your mental illness	Current approaches to treating mental illness do not meet the needs of Indian people.	Recovery from mental illness requires admitting that you have a mental illness and need help			
				Recovery from mental illness can occur without professional intervention	Language barriers prevent people from seeking help from mental health services	Mental health services should learn more about what people in different communities need				
				Recovery from mental illness is about coping with your illness	Information about mental health services should be shared with everyone from different ethnicities	Mental health services play a role in supporting people with mental illness recover.				
					Indian people avoid attending support groups because they worry about seeing someone they know					
					Recovery from mental illness requires having a stable place to live					
					Recovery from mental illness requires living in the right environment					

Figure 1. My Q Sort