The Cultural Conceptualisations of Psychological Distress and Help-Seeking among South Asian Immigrants in the UK and Canada

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Thesis submitted in accordance with the requirements for the degree of Doctor of Philosophy

of the

University of London

MAY 2025

Department of Population Health

Faculty of Epidemiology & Population Health

LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE

No funding received

Research group affiliation: Centre for Global Mental Health

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ACKNOWLEDGEMENTS

I would like to thank my primary and secondary supervisors, Dr. Abhijit Nadkarni and Dr. Ritsuko Kakuma for their guidance, patience, and expertise throughout the course of my PhD. I have learned so much from both of you about scoping studies, academic writing, and critical thinking. I am truly inspired by your relentless commitment to equity and Global Mental Health and hope to bring this level of passion to my own work in the field.

My sincerest thanks also go to my tertiary supervisor, Dr. Daisy Singla. Data collection in Canada would not have been possible without you advocating for me and my research at your institution and beyond. I appreciate your careful review of my work, which was always constructive and supportive.

I would also like to thank the London School of Hygiene and Tropical Medicine for awarding me two doctoral grants which allowed me to compensate participants.

Thank you to Professor Subodh Dave and Mudassara Anwar, who sat on my advisory committee, for providing their input throughout the duration of the research! Thank you for bringing your clinical and community mental health expertise to our team and for connecting me with your existing network, allowing me to reach more people.

This study relied on the input from many community organizations and leaders who championed the work in the South Asian community and beyond. I always felt that the research was worthwhile after speaking to these individuals who shared their professional and personal experiences with mental health. This is not an extensive list, but some of these individuals include Dr. Akm Alamgir (Access Alliance), Professor Farooq Naeem (CAMH), Kripa Sekhar and Debonita Mukhopadhyay (South Asian Women's Centre) as well as Jamila's Legacy, the British Association for South Asian Studies, the Black, African and Asian Therapy Network, ForwardCulture and Brown Therapy.

I would also like to thank all the individuals who gave me the opportunity to work alongside my PhD. I learned so many skills that helped me complete this PhD and prepare me for my career post-graduation. Thank you Aaminah and Seetal (ForwardCulture), Agnes and Caitjan (King's College London), Subodh and Vas (Royal College of Psychiatrists), and Laura and Lise (HealthLumen).

I could not have finished this PhD without my family's grace, humour, and unconditional love. Thank you, Ma, Papa, Didi, Tim, Remie, Ari, Nani and Dan plus all of my friends who I consider family across North America and Europe - you are my whole world. Thank you especially to Dan, Dora and Sydney, my faithful editors. My parents have always instilled the importance of an education and making a difference in the world for myself and others. I hope I have made you proud!

Finally, a massive thank you to all the participants in this study who chose to share their stories with me. This thesis is for you – I hope this work can play a small role in creating change for our community!

ABSTRACT

The South Asian diaspora is the largest diaspora in the world. In both the UK and Canada, South Asians make up a significant portion of the population. South Asians in these countries experience higher levels of Common Mental Disorders (CMDs) than other ethnic groups but tend to underutilise mental health services. My study aims to explore the cultural factors that influence how first- and second-generation South Asian immigrants in the UK and Canada experience, understand and seek help for psychological distress.

I did a systematic review on the explanatory models of, and help-seeking for, CMDs among South Asians in high-income countries to examine the existing evidence base on my topic. I conducted semi-structured interviews (n=38) in London, UK and Toronto, Canada. Participants were first- and second-generation South Asian immigrants with self-reported experience of psychological distress within the past 5 years. I analysed the data using a reflexive thematic approach. I also hosted six public consultations (n=40) across the two study sites, where members of the South Asian community were invited to comment on the initial and final research findings.

I found distinct generational differences in how first- and second-generation immigrants perceived the cause of their distress as well as their help-seeking behaviours and coping strategies across both study sites. My analysis suggests that participants attribute their distress to familial factors, but the factors themselves differ. First-generation participants cited post-migration stresses and the loss of their support system, while second-generation participants cited identity struggles, intergenerational trauma and pressure and expectations. Many participants preferred doing self-help activities and speaking to friends and/or family over professional help from General Practitioners and therapists, particularly for participants who are first-generation immigrants. Cultural factors such as collectivism, religion, and stigma were barriers to help-seeking across both generations.

This research demonstrates that there is a lack of culturally appropriate mental health care for South Asians and other ethnically diverse populations. To address this problem, we must invest in

community resources, run culturally sensitive anti-stigma and awareness campaigns, address the social determinants of mental health, and employ person-centered and structurally competent care. Finally, further research led by and in engagement with the South Asian community is required.

TABLE OF CONTENTS

RESEARCH INSPIRATION & POSITIONALITY STATEMENT

To begin, I would like to introduce myself and my history with this topic.

I would describe myself as a young, non-disabled, straight, cisgender female Canadian of Indian origin who has always wanted to pursue a career in public health. I am both a second-generation Indian immigrant in Canada and a first-generation immigrant to the United Kingdom. I come from a well-educated, middle-class family, though my father was amongst the first in his family to attend university in India and my mother was never given the opportunity to go, only due to her gender. I understand that being able to pursue a PhD is a privilege, and one that my parents sacrificed to make happen.

I believe my worldview is succinctly summarized by Ursula Le Guin: "For we each of us deserve everything, every luxury that was ever piled in the tombs of the dead kings, and we each of us deserve nothing, not a mouthful of bread in hunger…No man earns punishment, no man earns reward. Free your mind of the idea of deserving, the idea of earning and you will begin to be able to think" (The Dispossessed, 1974). My take on this quote, which I repeat often to my family and friends – of course we should enjoy all the pleasures and luxuries that life has to offer, but we should want this for **everybody.** No one deserves or earns anything more than the other.

This study is deeply personal to me. I grew up surrounded by my parents' and uncles' and aunties' stories of how they migrated to Canada with only a few hundred dollars in their pockets (though as many South Asian individuals know the exact amount of money always changes every time the story is told!). They spoke about how difficult it was to navigate the English-speaking world, how they would walk kilometers with kilograms of 'atta' (flour in Hindi) just to save bus fare, and how hopeful they were for their children's futures. I knew from a young age that immigrant families were exceptional and strong, despite the many challenges that came their way. It was only with time that I began to understand that along with resiliency, these challenges would often lead to mental health problems and struggling to thrive for first-generation parents, and their second-generation children struggling to know their bi/multi-cultural self and attempt to support their parents.

In previous iterations of my research inspiration, I distanced myself, choosing to focus on my observations about the South Asian family and community that I grew up amongst in Ontario, Canada. I spoke about how I noticed that the people around me were suffering from mental health problems, yet were unwilling or unable to access timely, effective care.

In truth I am not only a witness to these experiences but an active participant myself. As I am writing I am having flashes of the moments that I now know ultimately led me to pursue this work: losing a close family friend, a first generation immigrant from India, to suicide; shame and embarrassment at being unable to hang out with friends because I had to go to Hindi school (a Saturday morning class for children of native Hindi speakers to learn the language); navigating school and life as one of the only Brown students; having a family doctor insinuate that I should not trust my mom’s views on medication.

The subtle and non-subtle racism and discrimination I experienced prior to and since moving to the UK also fueled me to take on this research. I remember sitting in a pub in South London with some white friends when an older lady approached me to ask if I was Suella Braverman. This instance led to distress and greatly impacted my wellbeing. It made me feel “othered” and “different” and like I didn’t really belong anywhere— a common occurrence for second-generation immigrants like myself.

In parallel, I began to grow tired of Eurocentric, individualistic, and pharmacological approaches to mental healthcare. It was a very common occurrence to hear from the South Asian individuals in my life that a doctor was of no use to abate sadness, loneliness, and anxiety. People believed a doctor would only prescribe them medication (a temporary solution with unknown side effects) or a therapist would tell them to leave their marriages, without understanding the gravity of such an action. I knew that these approaches were not working for members of my community, and I knew they were not working for me.

One day, in late 2020, as the pandemic intensified, I spoke to my older sister about how mental health problems were seemingly becoming more common among our friends, family, and wider South Asian community. I then decided to conduct a rapid literature review to ascertain what existed on the topic of mental health in the South Asian diaspora. Though interest was burgeoning (especially since the COVID-19 pandemic highlighted inequalities in the prevalence of mental health problems by ethnic group), I noticed that there were only a limited number of studies that could be translated into practice.

I set out to try and answer some questions. How did my grandmother deal with the trauma of being a child during partition of India and Pakistan? Why did my mother refuse to share her sorrows with her many close friends? How could we, the healthcare community, empower individuals and communities and strategically invest in resources using community capital?

Although the pursuit of answers to these questions has only generated more questions, I hope that some of the findings from the study will help my community continue to thrive. Mental health problems affect everyone, either directly or indirectly, and everyone has a fundamental right to access culturally sensitive care.

THESIS STRUCTURE

Chapter 1 (Introduction): I begin by introducing key topics relevant to my study including the fast-growing mental health care crisis, culture and mental health, mental health in immigrant and ethnically diverse populations, and an overview of the South Asian diaspora. I end this chapter by introducing my research question and objectives as well as why I think this work is important.

Chapter 2 (Paper #1: Systematic Review): In this chapter, I present a systematic review *(Published- Transcultural Psychiatry)* on explanatory models and help-seeking among South Asians residing in high-income countries (objective 1). I address how the results from this systematic review influenced the qualitative portion of my study.

Chapter 3 (Methods): This chapter focuses on the methods I employed to collect interview data. It also outlines how I conducted public consultations to support the analysis and dissemination of my research.

Chapter 4 (Reflexivity): In this short chapter, I reflect on my position as a researcher and present excerpts and observations from my reflexive practices.

Chapter 5 (Papers #2-5: Qualitative Results): This chapter includes four papers *(Prepared for Submission)* pertaining to the interview results (objectives 2 and 3). They are grouped by immigrant generation and topic.

Chapter 6 (Additional Results): In Chapter 6, I include additional results, which are the interview participants' recommendations for policy and practice. I also summarise the findings from my six public consultations.

Chapter 7 (Discussion and Conclusion): This chapter is a critical discussion of the results from my systematic review, interviews, and public consultations. I discuss the connection between explanatory models and help-seeking and the similarities and differences between the results in the UK and Canada and between generations. I also address the strengths and limitations of the study and perhaps most importantly, introduce ways that mental health care can be improved for my study population. Finally, I end with a concluding statement and my hopes for the future of this research.

LIST OF ACRYNOMS

ABFT=Attachment-Based Family Therapy
CaCBT=Culturally Adapted Cognitive Behavioural Therapy
CBT= Cognitive Behavioural Therapy
CDHS= Cultural Determinants of Help-Seeking
CFI= Cultural Formulation Interview
CIMH= The Cultural Influences on Mental Health Model
CMD= Common Mental Disorder
DALY= Disability-Adjusted Life Year
DBT=Dialectical Behavioural Therapy
DSM= Diagnostic and Statistical Manual
GP= General Practitioner
IAPT= Improving Access to Psychological Therapies
IPT=Interpersonal Psychotherapy
MINI= McGill Illness Narrative Interview
NHS= National Health Service
PHP=Positive Health Programme
SDG= Sustainable Development Goals
WHO=World Health Organization

KEY TERMINOLOGY

Mental Health: Terminology in mental health is broad and covers significant ground. Unless stated otherwise, I refer to mental illness, mental ill-health, and mental disorder as ‘mental health conditions’ or ‘mental health problems.’ I recently worked on a scoping review on terminology used in the field of Public Mental Health with colleagues at the Royal College of Psychiatrists. We included the perspectives of individuals with lived experience who preferred these terms to others, which is why I made this decision.

Public Mental Health: Public mental health is a population-level approach to prevent, diagnose, and treat mental health conditions and promote overall wellbeing (Wahlbeck, 2015). In public mental health, social, economic, and political characteristics are acknowledged as determinants of mental health that must be accounted for in the mental health continuum (Eriksson et al., 2018). It acknowledges that “mental health is best promoted through respectful, participatory means where culture and cultural heritage and diversity are acknowledged and valued” (Wahlbeck, 2015).

Global Mental Health: Global mental health is a multi-disciplinary research field which “aims to alleviate mental suffering through the prevention, care and treatment of mental and substance use disorders, and to promote and sustain the mental health of individuals and communities around the world” (Collins, 2020). Vitally, research in this field is meant to address inequality in mental health prevention, diagnosis, and treatment.

Immigrant: An immigrant is “a person or their ancestors who have left a country to come to another, of which they are not a native to take up permanent residence. We [can] extend this term beyond citizenship or nationality where an individual, regardless of how long they have lived in the new country or which generation they might be, remains an immigrant with family histories, and therefore identities, that go beyond that country” (Dhillon and Ubhi, 2003). For the purposes of this research, I include first- and second-generation South Asian immigrants.

First-generation Immigrant: An individual who is born outside of the UK or Canada, has parents born outside of the UK or Canada and moved to the UK or Canada (as their first country of settlement) as an adult less than 10 years ago (recent) or more than 10 years ago (established).

Second-generation Immigrant: An individual born in the UK or Canada with at least one parent born outside of the UK or Canada.

Ethnically Diverse Populations: I considered what language to use when discussing ethnicity and race in this research. In Edward Said's seminal work, *Orientalism* (1978), he describes how the primary outcome of the West's "style of dominating, restructuring and having authority over the 'Orient' is representation" (Aspinall, 2020) . He states that "any and all representations, because they are representations, are embedded first in the language and then in the culture, institutions, and political ambience of the representer" (Aspinall, 2020; Said, 1978; p. 272). Stemming from this analysis of representation, I chose to follow the guidance of Race Equality Matters, an anti-racist organization in the UK. After wide consultations with people with lived experience, they determined that the term "ethnically diverse" was the most favoured term to use when referencing individuals formerly referred to as Black, Asian, and Minority Ethnic (BAME) individuals (Race Equality Matters, n.d.). Though I have chosen this term, I acknowledge that there is likely never going to be a term that represents the complex experiences of ethnically diverse people in the UK and beyond.

Ethnic Identity: The definition of ethnic identity is poorly agreed upon in research due to a lack of consistent approaches (Clarke et al., 2008; Liebkind, 2016). Additionally, perspectives on personhood and identity differ across cultures (Liebkind, 2016). However, across all definitions of ethnic identity is the concept that it is related to one's country of origin and culture. According to Liebkind (2009), ethnic identity "is generally seen as embracing various aspects, including self-determination, feelings of belongingness and commitment to a group, a sense of shared values, and attitudes towards one's own ethnic group." Further, Jean Phinney (1992) created a well-known model of ethnic identity, consisting of four key constituents: self-identification (the "label" an individual uses when talking about themselves), affirmation and belonging (the sense of pride an individual feel because they belong to a group), behaviours and practices (linguistic, religious, and cultural customs practiced by the ethnic group), and ethnic identity achievement (an individual's dedication and understanding to their ethnic identity) (Phinney, 1992; Balidemaj and Small, 2019).

West/Western: The term "West" or "Western" has been imagined in different ways historically and in modern times. For this study's purposes, "West" refers to "civilization that developed in the continent of Europe and was carried to…areas in other parts of the globe that were colonized by people from Europe" (Willis, 1973; Birken, 1992). More specifically, when I discuss Western medicine, I am fundamentally referring to *biomedicine* because as stated by Arthur Kleinman in his book chapter "What is Specific to Western Medicine?" biomedicine "emphasizes the established institutional structure of the dominant profession of medicine in the West" (Kleinman, 1993).

Culture: Culture is dynamic and can shift over time, as can the way it is defined and understood in the literature. I prefer anthropologist Robert Redfield's description of culture as "conventional understandings, manifest in act and artefact," a definition also endorsed by the Lancet and University College London Commission on Culture and Health (Napier et al., 2014). This description is perhaps superior to other descriptions because it highlights a key component of culture – 'shared understandings.' Positively, it does not tie culture to ethnic or racial identity, nor does it insinuate that "all members of a group share a given value" or that "local ideas can be readily translated across or even within groups that share languages, practices and overt expressions of belief" (Napier et al., 2014). However, for the purpose of this study, I am assuming that many core cultural understandings are shared across members belonging in the South Asian ethnic group, a decision that was validated by evidence in the literature and close communication with community leaders and organizations.

Psychological Distress: Generally, 'psychological distress' refers to "non-specific symptoms of stress, anxiety and depression… [and is] indicative of impaired mental health and may reflect common mental disorders (CMDs)" (Viertio et al., 2021). For the purposes of this research, this term includes a) CMDs and b) emotional distress. As defined by NICE Clinical Guidance, CMDs are depression and anxiety disorders such as post-traumatic stress disorder, panic disorder, generalised anxiety disorder, obsessive-compulsive disorder, and phobias (Kendrick and Pilling, 2012). Emotional distress is defined as “upset and negative emotions which do not fit diagnostic criteria for mental illness” (Awan et al., 2022).

Help-Seeking: I defined help-seeking as “attempts to maximise wellness or to ameliorate, mitigate, or eliminate distress” (Arnault, 2009). I also included coping strategies, such as rumination or active coping strategies, which precede help-seeking, as part of this definition (Hussain and Cochrane, 2010). Help-seeking services included were broad in scope: informal (personal networks such as friends and family), formal (including professionals such as General Practitioners (GPs), nurses, psychiatrists, and non-health professionals such as teachers, spiritual and religious leaders, and community workers) and self-help (such as online resources) (Kim and Lee, 2021). Additionally, help-seeking may be influenced by an individual’s culturally informed conceptualisation of personal recovery, which is “the continuing experience of living with, managing, or overcoming mental health difficulties” and was therefore also examined (O’Keeffe et al., 2021).

South Asian: I define South Asian as a person who self-identifies as being of South Asian origin (born in India, Pakistan, Bangladesh, and Sri Lanka or has one or both parents born in one of these countries) (Anand and Cochrane, 2005; Moller et al., 2016). It should be noted that these South Asian sub-groups are not homogenous and have religious, language, economic and political nuances (Prajabati and Liebling, 2022).

CHAPTER 1: INTRODUCTION

1.0 Introduction

I begin by introducing global mental health and the emerging field of public mental health in which I situate my research. I then focus on three key areas that are fundamental to understanding my study: the current mental health crisis, the influence of culture on mental health and care, and the South Asian diaspora. Next, I explain how my study contributes to filling a significant research gap on the topic of immigrant and ethnically diverse mental health and outline my aims and objectives.

1.1 Research Discipline

My study is firmly rooted in two prominent fields: global mental health and public mental health. Throughout my thesis, I advocate for the incorporation of culture in all forms of mental health service delivery to tackle health inequalities, an aim that aligns with the core principles of these fields.

Despite a growing recognition of the social, physical, and economic impact of mental health conditions, there are very few interventions aimed at reducing their prevalence even in high-income countries. Healthcare systems and providers must address this gap to both reduce the burden of mental health conditions and guarantee every individual’s right to positive mental health (Campion, 2018; Bhugra et al., 2015). An important step in addressing this gap is to generate knowledge on unmet need at different geographical locations.

1.2 Mental Health and Mental Health Care

1.2.1 What is Mental Health?

Mental health is “a combination of feeling good and functioning effectively,” while mental disorder relates to “mental states associated with significant distress, impairment in functioning, or risk of self-harm" (Papageorgiou et al., 2023). The Lancet Commission on Global Mental Health (2018) highlighted how mental health is a global public good and the world population has a right to positive mental health and mental health care (Moitra et al., 2023), whereby the United Nations recognised the importance of mental health by adding it to the universal health coverage section of the Sustainable Development Goals (SDG-3) (Lund et al., 2018).

1.2.2 The Impact of Mental Health Conditions

Mental health conditions can negatively impact individuals and their families, communities, and entire societies in three important areas:

> **Productivity:** The economic losses associated with mental health burden are massive. Mental health conditions can contribute to individuals missing educational and work opportunities, increasing their healthcare use, and unemployment (Ngui et al., 2011). Productivity losses and related physical health issues due to mental health problems led to a global loss of 2.5 trillion US dollars in 2010, a number that is expected to rise to 6 trillion US dollars by 2030 (The Lancet Global Health, 2020).
>
> **Quality of Life:** Individuals with mental health conditions usually have a poorer quality of life that is significant beyond such a "productivity-centred, 'human capital,' valuation approach" (Cardoso and McHayle, 2024). A secondary analysis of quality-of-life factors such as safety, leisure, and socialising demonstrated that quality of life was statistically significantly lower in groups with a CMD or severe mental illness than the healthy population group (Evans et al., 2006). Mental health conditions can also hinder creative and/or critical thinking, risk-taking and the ability to overcome life challenges (Centre for Mental Health, 2024).
>
> **Excess Mortality, Morbidity, and Disability:** Excess mortality, morbidity and disability is also associated with mental health conditions (Jenkins et al., 2011). A frequently reported cause of death for those living with mental health conditions is cardiovascular disease. In fact, the heightened risk of mortality for depression and smoking are comparable (Jenkins et al., 2011). An analysis of the Adult Psychiatric Morbidity Survey in England from 2000-2007 confirmed the negative relationships between mental health conditions and physical health; the authors found that most mental health conditions had statistically significant detrimental effects on health utility scores (Roberts et al., 2014).

I wish to emphasise that the true costs of mental health conditions are unquantifiable, and we must address these issues from a moral standpoint, rather than an economic one. The number of individuals with mental health conditions is growing and as a result, suffering is also growing. Green (2000) argues that as a society, we must take a rights-based approach to mental health care that goes beyond economic losses or cost-effectiveness to address this suffering. Though they base their argument on many ideas, I believe two are most crucial. First, they use Beauchamp and Childress' theory that moral rights live separate to law but must be used to critically appraise legal rights (e.g., the right to mental health care). Second, they highlight Buchanan's claim that upholding individual rights encourages the common good, not just individual self-sufficiency and health (i.e., the negatives created by mental health conditions can diminish the common good and should therefore be addressed by universal mental health care). To summarise, Green astutely points out "the harms that are conveyed to family members, friends, occupational colleagues, and even strangers by the mentally ill supports a claim that mental health care can advance the common good by alleviating at least some of those effects" (Green, 2000).

1.2.3 The Mental Health Crisis

Despite the global recognition of a right to mental health and mental health care and the adverse consequences of mental health conditions, we are in a rapidly escalating mental health crisis. This crisis refers to a growing number of mental health conditions combined with a significant treatment gap (Patel et al., 2023). Reasons for increasing prevalence of mental health conditions and a treatment coverage gap are a) an increase in economic and social risk factors such as poverty, education, and employment inequality as well as interpersonal and community-based violence (Lund et al., 2018), b) reduced protective factors such as social relationships and equality, and c) deteriorating healthcare systems (Patel et al., 2023). The COVID-19 pandemic (Santomauro et al., 2021) and climate-related disasters, including heat, fires, and flooding, have exacerbated these factors (Charlson et al., 2021).

1.2.3.1 Rising Prevalence of Mental Health Conditions

This crisis is of global concern considering that mental health conditions are a significant reason for disability. In 2019, depressive and anxiety disorders were responsible for over 970 million medical cases (Moitra et al., 2023), and 418 million disability adjusted life years (DALYs), which account for 16% of DALYS globally (Arias et al., 2022). A population survey of 29 low, middle, and high-income countries found that by the age of 75 years, about one in two individuals will develop a mental health condition (McGrath et al., 2023). Major depressive order was the most prevalent condition for both men and women (McGrath et al., 2023). We must consider that the availability of current and accurate global epidemiological data is limited due to insufficient surveying in low- and middle-income countries; most data is based on information emerging from high-income countries.

1.2.3.2 The Treatment Gap

While information on treatment gaps (i.e., the prevalence of mental health conditions in a given country compared to the number of people receiving adequate treatment) is not gathered frequently, evidence suggests that treatment coverage remains low even in high-income countries. We can approximate from data in 84 countries that treatment coverage for major depressive order is 33% for high-income countries and 8% in low-income countries (Moitra et al., 2023). Similarly, World Health Organization (WHO) community surveys in 25 countries found that treatment coverage for individuals with a Diagnostic and Statistical Manual of Mental Disorder- IV (DSM-IV) mental health condition was 36.8% in high-income countries and 13.7% in low- and middle-income countries (Evans-Lacko et al., 2017).

Economically speaking, high-income countries should be able to maintain health systems that provide high quality mental healthcare. These countries spend 3.8% of their total national expenditure on mental healthcare, compared to an average of 2.1% globally (Dumke et al., 2024). Further, these countries boast 62 mental health specialists for every 100,000 individuals, compared to 13 globally (Dumke et al., 2024). Despite the high expenditure and specialist workforce in these settings, the crisis is ongoing (Patel et al., 2023).

These statistics beg the question: why are these mental health systems failing? Leading global mental health scholars argue that the biomedical model and diagnostic categories that are foundational to mental health care in high-income settings have led to “excessive reliance on interventions that are delivered by specialists; a scarcity of widespread promotive, preventive, and recovery-oriented strategies; and failure to leverage diverse resources within communities" (Patel et al., 2023).

Patel et al. (2023) outline five actions that must be taken to address these issues and halt the mental health care crisis:

1. Prioritise the prevention of mental health conditions by reducing the negative impact of social environments (i.e., address the social determinants of health)
2. Move away from basing treatment plans on an individual's diagnosis, instead focusing on their needs and preferences (i.e., deliver person-centred care)
3. Task-share (i.e., reduce reliance on specialists and specialist services)
4. Employ a rights-based approach to mental health services to combat discrimination
5. Centre people with lived experience of mental health conditions in all aspects of care from prevention to accountability

I further discuss the failings of the biomedical model and suggest approaches to transform these systems, particularly focusing on the incorporation of culture in mental health care in the next section.

1.3 Culture and Mental Health

"The need…to understand the relationship between culture and health, and especially the cultural factors that influence why health enhancing behaviours are or are not embraced is critical."

(Napier et al. in the Lancet and University College London Commission on Culture and Health, 2014)

1.3.1 Background of Culture in Mental Health

Investigations into the cultural influences on illness are rooted in the disciplines of medical anthropology and cross-cultural psychiatry (Kirmayer and Swartz, 2014). The field of cross-cultural psychiatry has evolved over time (Kaiser and Weaver, 2019). At first, it was a method of applying Western ideologies regarding psychiatric treatment to non-Western locations. By the mid 1900s, a deeper understanding of the influence of culture on illness was garnered. In fact, the field "shifted away from treating culture as merely a confounding factor and toward recognizing it as constitutive of different world-views with impact on illness experience" (Kaiser and Weaver, 2019; Kirmayer, 2006).

There are four key constructs imperative for understanding the intersection of culture and mental health (Kohrt et al., 2014); first, e*xplanatory models,* theorised by Arthur Kleinman (1980), elucidate that individuals or groups can have different beliefs on health and disease based on their social, cultural and political environments (Kleinman, 1980); second, *idioms of distress*, coined by Mark Nichter (1981), illustrate how culture influences the ways in which people can experience and deal with distress (Nichter, 1981); third, *popular categories of distress,* described by Rubel (1964) as symptoms which correspond to a particular population and "to which members of that population respond in similarly patterned ways" (Guarnaccia, 1993) and fourth, *culture-bound syndromes* highlight the symptoms and explanations of an illness that are confined to individuals of a certain culture (Ventriglio et al., 2016). These overlapping constructs all attempt to encapsulate the same idea: an individual's culture shapes how they experience (i.e., symptoms), understand (i.e, definitions, and perceived causes) and seek help for illness (i.e., from pharmacological or social interventions). Together, we can refer to them as the *cultural conceptualisations of distress* (Kohrt, 2014).

Five cultural factors are thought to play a significant role in mental health: emotional expression, shame, collectivism, spirituality/religion, and power distance (between healthcare provider and patient) (Soorkia et al., 2011, Gopalkrishnan, 2018) as well as acculturation and traditionalism (Soorkia et al., 2011). In turn, these cultural factors impact illness experience, definition, and management (Gopalkrishnan, 2018). While systemic factors (such as lack of awareness of available services) also influence help-seeking behaviours for psychological distress (Soorkia et al., 2011), cultural factors influence whether people want help, where people turn to for help (themselves, formal mental health services, family, or communities, for example) and how successful the help is (Gopalkrishnan, 2018).

There is an extensive evidence base that highlights how different cultural groups may think about mental health differently. Comprehensive reviews have found significant cultural variations in the symptomology of mental health problems (such as depression and post-traumatic stress disorder) (Kirmayer et al., 2017; Haroz et al. 2017; Hinton and Lewis-Fernandez, 2011). For example, loneliness, anger and ‘thinking too much’ have been identified as idioms of distress in different local contexts. For instance, O’Nell (1996) conducted an ethnography about distress among war veterans in a Native American community and found loneliness to be linked to both trauma and depression and Rogler et al. (1994) discussed anger as an idiom of distress for Puerto Rican men in America facing disenfranchisement (Kirmayer et al. 2017). Similarly, ‘thinking too much,’ known as *Kufungisisa* is a noted symptom (and cause) of CMDs in Zimbabwe (Kohrt et al., 2014).

Further, some cultural groups’ idioms of distress may mean they present with somatic, rather than psychological symptoms. In a Pakistani community in the UK, patients were found to present with a condition that could be depression according to Western diagnostic criteria, reporting their main symptom as “heat in the head” (a description also noted in primary care clinics in Pakistan) (Mumford et al., 1991). Other somatic symptoms relating to CMDs include “crawling sensation of worms, and heaviness in the head, heart distress or nerves, headache, joint and gastrointestinal pains” (Cohen, 2001). The presentation of somatic complaints may be linked to culturally informed stigmatized beliefs about mental health; for example, using the Explanatory Model Interview Catalogue, Raguram and colleagues (1996) demonstrated that individuals with higher stigma scores were more likely to present with somatic symptoms of distress than those with lower stigma scores.

1.3.2 Accounting for Difference in Mental Health Service Delivery

As societies become more diverse, it is obvious that mental healthcare services must respond to difference in cultural values, but how to achieve this is controversial.

1.3.2.1 The Biopsychosocial Model

The failure of mental health systems in high-income countries can be partly attributed to the dependence on a biomedical and diagnostic model of care, where diagnosis is based on a likely inaccurate group of signs and symptoms determined by specialists in high-income country clinics.

For example, Fried (2022) illustrates how the classification of major depressive disorder in the DSM-III was based on one article by Cassidy et al. (1957). When the lead author was asked how these symptoms were determined, they said it “sounded about right.” Most of these symptoms are still used to describe major depressive order in the DSM-V today, though research conducted since the 1950s to examine its reliability and validity indicates that the listed symptoms for depression are present across regions and cultures (Kirmayer et al., 2017; Fried, 2022). Ultimately, this dependence has influenced priority research areas and the prevention, diagnosis, and treatment of mental health conditions as well as conceptions about recovery.

This biomedical approach to mental health emerged centuries ago in the Global North. There were three prominent phases in the quest to find the causes of illness. First, until the 1800s, the perceived causes for illness were noted on an individual basis, meaning that there was a wide-ranging list of causes. Then, in the second phase, in the latter half of the 1800s, the use of microbiology to determine a single cause of each illness began in earnest, leading to a shift from “multicausal to monocausal theories of etiology” (Kendler, 2019). In the third and final phase, the chronic disease phase, multi-causal theories became prominent. It was believed that non-communicable chronic diseases such as diabetes and hypertension were attributable to many lifestyle factors. Thus, “the goal of epidemiology was to determine the magnitude and causal nature of the associations between a wide range of putative risk factors and these chronic non-communicable diseases” (Kendler, 2019). Despite this shift in Western medicine and epidemiology, at the same time, American psychiatrists fought to highlight the neuro and genetic causes of mental illness; they wished to validate and grow support for the field of psychiatry that matched other medical fields by advancing the idea that “real” illnesses are monocausal (Kendler, 2019). Since the 1980s, this form of ‘explanatory reductionism,’ (“the idea that lower levels [i.e., biology] offer explanatory power inherently superior to that of higher levels [i.e., psychology, environment]”) has been a popular idea in research and has influenced clinical practice and policy (Fried, 2022). Despite criticism of monocausal theory and overreliance on diagnostic models in Western healthcare systems beginning years ago and culminating at the World Health Forum in 1995, these ideas persist in psychiatry today (Kendler, 2019; Patel et al., 2023). However, in recent years debates around the success of explanatory reductionism have become more prominent (Herman et al., 2022).

First introduced as a concept to challenge biomedical theory by Engel in 1997, biopsychosocial approaches “offer new opportunities to work with people in a more holistic way” (Gopalkrishnan, 2018). Decades of research in the fields of Transcultural Psychiatry and Public Health since then underscore how a biopsychosocial approach that “embraces the interaction of biological, psychological, and social factors in the shaping of a continuum of mental health across the life course and improve mental health care,” is superior to a biomedical approach when designing culturally responsive services (Patel et al., 2023).

The biopsychosocial model has been criticized for its limited practical application in healthcare settings thus far, partly due to its “vagueness” (Ghaemi, 2009, Tramonti et al., 2020), but proper use of this model has the potential to address the burgeoning mental health crisis (Patel et al., 2023). Simply put, the biopsychosocial model is valid in medicine and beyond because of the “reality that mental disorders are caused by multi-level mechanisms” (Tripathi et al., 2019).

1.3.2.2 Culturally Appropriate Care

There are many constructs in healthcare regarding culturally appropriate care. Here I discuss three prominent ones: culturally sensitive services, cultural competence, and cultural adaptation. I then go on to highlight relatively new forms of practice in mental health: structural competence and person-centered care.

Culturally Sensitive Services: A popular proposed solution to account for difference and diversity in mental healthcare is the creation of culturally sensitive services (services that are “appropriately responsive to the attitudes, feelings, or circumstances of groups of people that share a common and distinctive racial, national, religious, linguistic or cultural heritage”) (Singla et al., 2022). When designed and implemented carefully, culturally sensitive services can help alleviate the mental health disparities experienced by ethnically diverse populations (Vandecasteele et al., 2024). These services allow minoritized cultures to be taken seriously, contrasting the usual “one-size-fits all” approach in Western models of care (Prajabati and Liebling, 2022). A systematic review on mental health service use among South Asians in the UK showed that culturally sensitive services were important to this population. To be culturally sensitive, participants suggested that professionals and services include “a sensitive approach involving a commitment to confidentiality, a humble appreciation of their unique ethnic and cultural identity and a genuine interest to attend to their conceptualisation of distress and faith” (Prajabati and Liebling, 2022).

On the other hand, there are arguments against the creation of culturally sensitive or specific services. First, there is no consistent definition of ‘culture,’ and healthcare professionals may conflate ethnicity with culture (Epner and Baile, 2012). Ultimately, these misunderstandings can lead to stereotyping of entire ethnic groups, which can have dangerous consequences to care (Kleinman and Benson, 2006). Additionally, focusing on the cultural aspects of service delivery may shift focus from the wider determinants that drive health inequalities such as poverty and unemployment, institutional racism, and a dwindling workforce, instead placing blame on individuals. Finally, specialised services may contribute to the “othering” of migrant and ethnically diverse populations, especially as anti-immigrant and racist rhetoric grows in countries such as the UK and Canada (Bhui and Sashidharan, 2018).

Cultural Competency: We can also question the usefulness of ‘cultural competency’ (“awareness or knowledge of a given culture and the ability...to apply this knowledge) (Singla et al., 2022). The concept of cultural competency first emerged in the 1980s to improve the consideration of culture in healthcare. More recently, however, this concept has been (rightfully) criticized for firstly using culture to justify and perpetuate stereotypes, and secondly highlighting that it is impossible to be ‘competent’ in another person’s culture (Melino, 2022). Cultural competence also does not address issues of stigma and discrimination, for example (Melino, 2022). Beyond theoretical criticism of cultural competence, a review found that cultural competence had little to no benefit to ethnically diverse populations, when delivered alongside standard treatment (Huey et al., 2014). These reflections on cultural competency then led to the development of cultural humility, where practitioners are meant to reflect on their cultural identity and the cultural identities of their clients/patients. Both cultural competence and humility, however, have limited benefits to individuals seeking care.

Cultural Adaptation: Crucially, culturally sensitive services differ from cultural adaptation. Cultural adaptation involves altering existing evidence-based treatments, which are often based on biomedical and on white, Western populations, to meet the values and needs of a specific cultural group (Bernal et al., 2009). Cultural adaptation is thought to offer improved engagement and outcomes for minoritized cultural groups (Rathod et al., 2019). Empirical evidence suggests that culturally adapted mental health treatment could be effective (Naeem et al., 2020). A 2016 meta-analysis found that culturally adapted mental health interventions had a significant effect size (0.67) (Hall et al., 2016). This result was also mirrored in another meta-analysis on interventions for CMDs for people of Chinese descent. The analysis showed no difference in efficacy between the culturally adapted and culturally specific services; both were effective in reducing clinical or self-reported CMD symptoms among participants (Li et al., 2023). A very recent example of a successful cultural adaptation intervention is Naeem et al.'s modification of Cognitive Behaviour Therapy (CBT) for South Asian individuals in Canada. Their evaluation of their pilot programme showed that this treatment was "feasible and acceptable" and should become a widespread option for South Asian Canadians (Naeem et al., 2023). Conversely, there is emerging evidence that suggests cultural adaptation may have no sustained effects. A randomised control trial with British South Asian women with postnatal depression found that a culturally adapted group CBT programme improved recovery for depression better than "treatment as usual" at the 4-month follow up mark, but not at the 12-month follow up mark (Husain et al., 2024).

Despite these limitations, *something* must be done to address the issue of 'cultural exclusion' in which healthcare services tailored to fit only the majority population, can lead to delayed or misdiagnosis, or referrals to inadequate services for ethnically diverse populations (Bowl, 2007).

Structural Competency and Person-Centered Care: Perhaps, alongside the creation of culturally sensitive and adapted services, the solution is the widespread implementation of structural competency and person-centered care in healthcare. Structural competency is meant to be an advancement on cultural competence and humility, but it is still a new concept and literature on how to operationalise it is limited (Melino, 2022). Borrowing from disciplines outside of medicine such as public health, it encourages clinicians to go beyond culture to understand how the social determinants of health can impact an individual's recovery with an overall goal of creating equitable health systems (Melino, 2022; Pinones-Rivera et al., 2024). As I will discuss, the mental health of migrant and ethnically diverse groups is largely determined by cultural, social, political, and economic factors, which cannot be discounted in healthcare.

Similarly, person-centered care also evolves from cultural competency. Rather than encouraging healthcare providers to learn about, and account for, beliefs endorsed by certain cultural groups, which leads to stereotyping, it is instead “identifying and negotiating different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism, among other factors” (Epner and Baile, 2012).

Notably, I am choosing to use the term ‘person-centered care’ rather than ‘patient-centered care’ to acknowledge that individuals are not their diagnosis and that mental health care is primarily provided in the voluntary sector, outside of formal settings such as hospitals (Ekman et al., 2011).

1.4 Mental Health among Immigrant and Ethnically Diverse Populations

1.4.1 Mental Health and Migration

Consideration of the mental health and care of immigrants and their offspring as well as ethnically diverse populations is growing. This attention is partly due to political discourse around migration and the COVID-19 pandemic (Sangaramoorthy and Carney, 2021). But perhaps most importantly, this attention is caused by the numbers highlighting the globalised increased movement of people. As of 2020, there are 281 million international migrants globally, representing 3.6% of the population. International migration to all United Nations regions is growing, but particularly rapidly in Europe and Asia (IOM, 2024). There is also a high degree of growth in migration from low- and middle-income countries to high-income countries. The proportion of migrants (including international students) locating to high-income countries has increased from 7.6% in 1990 to 13.4% in 2017 (Abubakar et al., 2018).

Migration is a process in which an individual moves from their country of origin to a host country (Moussaoui and Agoub, 2011). It typically involves three stages (premigration, migration, and postmigration), each of which comes with its own set of risk and protective factors for mental health conditions (Table 1).

Table 1. Risk and Protective Factors for Mental Health Conditions for each of the Three Migration Phases (Adapted from Moussaoui and Agoub, 2011 and Kirmayer et al., 2011).

Migration Stage	**Risk Factors**	**Protective Factors**
Premigration	Gender History of mental health condition Original country Financial situation Reasons for migrating Past traumatic experience	No prior issues with physical or mental health Skills for employment Sufficient coping strategies
Migration	Conflict and violence Difficult housing situations Fear and uncertainty regarding end of migration	Age of migration (younger ages) Extent of planning of migration Legality of migration Good financial situation in host country
Postmigration	Uncertainty about citizenship, visa, or refugee status Loss of support networks Linguistic barriers Unemployment Lowering of social or economic status Substance use Culture shock	New skills (coping, adaptation) Low rates of perceived discrimination Employment

1.4.1.1 Perceived Discrimination and Immigrant Mental Health

Alongside the usual stressors of migration, a host country's political environment can greatly affect migrants' psychosocial wellbeing. Recently migration has been described as a "moral emergency" with immigrants being tormented and 'othered' by self-interested politicians and communities aiming to promote nationalism and populism (Dahinder, 2016; Abubakar et al., 2018; Sangaramoorthy and Carney, 2021). They use terms such as "unfit" and "unwanted" to describe migrants to rationalise exclusionary policies that stop these individuals from increasing their social and economic position (Sangaramoorthy and Carney, 2021). While those who suffer the consequences of this hateful rhetoric deserve equal treatment in society on a humanitarian basis, they also bolster economic, social, and healthcare services, whether they are considered 'unskilled' or 'highly skilled' (Abubakar et al., 2018).

Consequently, immigrants are framed as vulnerable. In reality, immigrants are not "inherently vulnerable, nor do they lack resilience and agency" but are made vulnerable by hostile environments in their host countries (International Organization for Migration, n.d.). I would like to note that although problematic, advocates have used the framing of immigrants as 'vulnerable,' 'victims,' or 'deserving,' to elicit support for immigrants "to affirm the rights of those whom they try to protect" (Ambrosini, 2022). A similar sentiment is offered in Fassin and Rechtman's 2009 book *The Empire of Trauma*. They argue that the concept of trauma has been used to understand and witness various forms of suffering. This framing of trauma can be dangerous, however, because it ignores social, political, and environmental issues that inform trauma. Rather, they suggest "denaturalizing trauma and re-politicizing the victim." Despite these drawbacks, it has allowed for more "attention to the universality of human suffering, thereby making the humanity of the other more visible" (Leeming, 2010).

Unsurprisingly, exclusionary practices can have direct, significant emotional and psychological impacts on immigrants. The mental health impact on immigrants due to their imposed inferior status in society can be described as *structural vulnerability* ("how complex forces…lead to immigrants' physical and emotional suffering, including the internalization of individual and collective unworthiness") or *abjectivity* ("the feelings, thoughts, and emotions of worthlessness and precarity that accompany immigrants' experiences of non-belonging, xenophobia, and social marginalization") (Sangaramoorthy and Carney, 2021). Heightened distress resulting from racism and discrimination may also lead an individual to adopt unhealthy coping mechanisms, which have further adverse mental and physical health effects (Pascoe and Richman, 2009).

A comprehensive global meta-analysis encompassing 134 studies investigating the association between perceived discrimination and health outcomes concluded that perceived discrimination negatively impacts mental health (Pascoe and Richman, 2009). There is extensive research that confirms this association in immigrant and ethnically diverse communities. For example, a study examining the UK Household Longitudinal Study (2009-2013) to determine the longitudinal association between multiple exposures to racial discrimination and mental health found that "cumulative exposure to racial discrimination has incremental negative long-term effects on the mental health of ethnic minority people in the United Kingdom" (Wallace et al., 2016). A multiple regression analysis (with a more defined study population of first- and second-generation South Asian immigrants in Texas) demonstrated that experiences of everyday racism were correlated with higher anxiety levels and more often occurring depressive symptoms among the participants. These results are comparable to the experiences of South Asians living in other American cities as well. For instance, Tummala-Narra et al.'s 2012 analysis of the National Latino and Asian American Study also showed that perceived discrimination was positively associated with depression for South Asians, while Yoshihama et al.'s 2012 telephone interviews with Gujarati Indians in Detroit indicated that perceived discrimination was detrimental to emotional wellbeing.

1.4.1.2 Prevalence of Mental Health Conditions and Service Use among Immigrant Populations

Ascertaining the prevalence of mental health conditions among immigrants is challenging given the heterogeneity of published statistics (for example, prevalence rates differ depending on the mental health condition and migration stage in question) (Moussaoui and Agoub, 2011) and researchers prioritising refugees and asylum seekers in their studies. But, overall, we can establish that the prevalence of mental health conditions is higher in immigrant populations for CMDs such as depression, post-traumatic stress disorder, as well as severe mental health conditions (Bova and

Lusardi, 2022; Spagnoli et al., 2022; Close et al., 2016). A narrative systematic review of reviews established that 44% and 40% of included first-generation immigrants suffered with depressive and anxiety orders, respectively (Close et al., 2016).

These statistics challenge previous literature which focused on "the healthy immigrant effect" (which refers to migrants having better mental and physical health than the native population). More recently, evidence suggests that the good health status of migrants diminishes with time due to diminished social status and stress related to housing and finances (Boya and Lusardi, 2022). For example, newcomer migrants in Canada had a lower prevalence of depression than the general population, but this increased to equal levels as time progressed, a finding also echoed in US-based data (Kirmayer et al., 2011).

Evidence suggests that immigrants tend not to use formal mental healthcare services. This pattern cannot be attributed to the lack of mental health conditions prevalent in these groups or an increased use of informal or semi-formal support over formal support (Moussaoui and Agoub, 2011). Rather, it is partially explained due to the limited availability of culturally sensitive services (Kirmayer et al., 2007).

While first- generation immigrants are less likely to engage with mental health services, usage remains low for second-generation immigrants who are part of ethnically diverse groups (Soorkia et al., 2011). Some of the issues that negatively impact immigrants' mental health can also have consequences on their children (Apers et al., 2023). The children of immigrants are at higher risk of developing a mental health condition than those with non-migrant backgrounds due to their parents' sometimes low socio-economic status, their parents' experiences of racism and discrimination (e.g., intergenerational trauma) as well as their own personal experiences of racism and discrimination. Trauma can also be passed down through generations due to familial factors such as "parent-child attachment" and "intra-family communication style" (Apers et al., 2023).

Understanding the convergences and divergences in mental health between immigrants and their descendants is crucial to improving mental health outcomes for these groups and is explored in further detail in Papers 1-5 and the Discussion.

1.4.2 Mental Health in Ethnically Diverse Populations

In many high-income countries, evidence suggests that ethnically diverse individuals experience worse mental health outcomes and more limited access to mental health care than majority white individuals (Bansal et al., 2022). It is important to note that this data is primarily obtained from the UK, where ethnic differences in mental health outcomes and unequal treatment have been reported for at least the past 50 years (Bansal et al., 2022).

There is considerable overlap between some (though not all) factors affecting migrants and ethnically diverse individuals who were born in high income countries' mental health (Apers et al., 2023). For example, many health inequalities found in migrant and ethnically diverse populations persist after controlling for socioeconomic status, which signifies social exclusion and discrimination (WHO, 2010). Therefore, I believe it is acceptable for these groups to be studied together (WHO, 2010; Moore et al., 2019).

In this section, I will discuss two correlated concepts which may significantly impact mental health in ethnically diverse populations: ethnic identity and acculturation.

1.4.2.1 Acculturation and Ethnic Identity

Acculturation is "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individual members" (Berry, 2005). Acculturation can impact individuals (their behaviours) and groups (their societal, institutional, and cultural practices). The changes resulting from acculturation can take many years to occur, occasionally crossing hundreds of years and generations (Berry, 2005).

The process of merging one's culture (derived from their ethnic background) with the dominant culture in the host country is stressful. Hassles relating to acculturation, including speaking in another language, and comprehending new socioeconomic, political, and cultural systems, can negatively impact mental health (Organista, 2009). Acculturation also correlates to increased family conflict, which can cause mental health problems. Hwang (2006) describes the process of acculturative family distancing, whereby communication difficulties between immigrants and their children are apparent due to how each generation expresses and communicates differently (Hwang, 2006). Further, children who believe their parents have not acculturated to mainstream culture are less likely to communicate their mental health issues due to concerns around stigma (Bismar, 2018). However, despite being challenging, acculturation can also benefit individuals. It can result in the ability to thrive in bi- or multicultural environments (which is associated with psychological advantages), diversify perspectives, and lead to the development of new adaptation skills (Balidemaj and Small, 2019).

Another important element in the study of acculturation and mental health is ethnic identity. Phinney and their coauthors (2001) were amongst the first researchers to postulate that ethnic identity was a part of acculturation (Phinney et al., 2001). The idea is that "identity is heavily influenced by changes in values, behaviours and beliefs that occur during the process of acculturation" (Phinney et al., 2001; Balidemaj and Small, 2019). Additionally, those individuals who are forming and re-forming their ethnic identities in multicultural environments seem to use their social environment to determine which behaviours and perspectives are acceptable to various societal groups. Further, both acculturation type and ethnic identity are shaped by one's political environment (e.g., the existence and use of strategies aimed at ensuring immigrants integrate) as well as levels of ethnic diversity in their local context (Vedder et al., 2007). These processes can cause "identity conflict" which may result in depression and anxiety (Balidemaj and Small, 2019).

1.5 The South Asian Diaspora

The South Asian diaspora is the largest in the world, boasting 25 million members globally. The diaspora is vast, ever-changing, and complex, underpinned by a shared migration story driven by British Imperialism, employment opportunities, and conflict (Ullah, 2024). In this next section, I will focus on the South Asian diaspora in two prominent geographical locations: the UK and Canada.

I must note that diasporas are "often composite formations made up of many journeys to different parts of the globe, each with its own history, its own particularities." I interpret this quote as meaning that the experiences of South Asian diaspora in one location, may not necessarily be applicable to another location, and that this phenomenon is worth exploring (Brah, 1996).

1.5.1 Past and Current Migration to the UK

South Asian migration to the UK is a direct consequence of British imperialism. The first migrants to the UK were servants of British expatriates returning from South Asia, seamen who worked on British ships, and wealthy South Asian subjects who came to study or work (Ballard, 1994). Migration increased rapidly following the 1948 Nationality Act, which allowed freedom of movement for South Asian nationals to the UK (Ghuman, 1994). Individuals were looking to escape poverty or conflict and/or pursue economic opportunity and advance their social position (Ghuman, 1994). The disruption and trauma associated with the 1947 partition of India and Pakistan drove more individuals to view migration to the UK as appealing. Other 'pushes' included the forced evacuation of 100,000 people in Mirpur, Kashmir in 1962 (due to dam construction); purposeful recruitment by the British of seamen in Sylhet, Bangladesh; and lack of farming opportunities across South Asia (Ghuman, 1994; Bollard, 1994). People in South Asia also viewed migration as something that would bring honour ('izzat') to their families (Mohammad-Arif and Moliner, 2007).

Levels of South Asian migration to the UK were particularly high (especially for professionals such as doctors and engineers) in 1961 because people feared that the UK government was considering cutting off access to the country. Another immigration act in 1962 effectively halted migration from South Asia to the UK, except for the family members of those that had migrated in 1950s. Between the 1960s and 1970s there was also a spell of South Asian individuals migrating from East Africa (Uganda, Kenya, and Malawi) due to rising anti-South Asian rhetoric in these areas (e.g., President Amin's "Africanisation" policies). These individuals held British passports, were fluent in English, and were relatively affluent compared to those migrating directly from South Asia. They also wanted to separate themselves from migrants directly from South Asia, although white people in the UK tended to view them as all the same (Ghuman, 1994; Mohammad-Arif and Moliner, 2007).

Due to this long and immense migration history, South Asians are considered the "first ethnic group" of the UK (Mohammad-Arif and Moliner, 2007). Today, people of South Asian origin make up approximately 9.3% of the UK population and are growing (note: in the UK census, they use ‘Asian’ as an ethnic group, which includes Indian, Pakistani, Bangladeshi, Chinese and any other Asian background). As of July 2021, there are 896,00 individuals born in India, 223,000 individuals born in Bangladesh, 131,000 individuals born in Sri Lanka, and 37,000 individuals born in Pakistan living in the UK (Office for National Statistics, 2021). Before the pandemic, the UK granted 10,000 work visas to individuals residing in South Asia (mostly India) per quarter. Now, it is over 20,000 work visas per quarter, likely due to the increasing need to strengthen the National Health Service (NHS) workforce and a decrease in migration from the European Union due to Brexit (CIPD, 2023).

The work set out here has been undertaken against a backdrop of intense Islamophobia and anti-immigration sentiment in the UK. Recently, far right protestors rioted across the UK, spouting racist and Islamophobic ideology, making many People of Colour and Muslims, including people of South Asian origin feel unwelcome and unsafe in their country of residence (Olusoga, 2024).

1.5.2 Past and Current Migration to Canada

While the UK was seeing unprecedented immigration from South Asia, most of Canada’s immigrants in the first half of the 20th century were originating from Europe, the UK, and the US, with Canada actively encouraging migration from the UK (Ghuman, 1994).

Before the 1950s, there were only a couple thousand people from South Asia residing in Canada, primarily Sikhs coming from Punjab. By the early 1960s, the population of South Asians had barely grown. Canada had enforced a discriminatory immigration law, limiting South Asians’ access to the country. It was not until the Immigration Act of 1967, which eliminated eligibility restrictions based on race, that there was a dramatic increase in the number of immigrants moving from South Asia. Chain migration (in which migration occurs through connections with family and occasionally friends) was primarily how South Asians migrated to Canada until 1969 (Ghuman, 1994).

More recently, migration from South Asia to Canada has been concentrated to international students. Most international students to Canada come from India (Kim and Kwak, 2019). Reportedly, international students originating from India provided two billion Canadian dollars to

Ontario’s post-secondary schools, exceeding the 1.8 billion Canadian dollars provided by Ontario’s provincial government (Bhugra, 2024).

Mostly responsible is Canada’s federal government, which introduced new initiatives in 2014 to promote Canada as an ideal place to study internationally (Government of Canada, 2014). Now, Canada has recently welcomed the highest number of international students ever (close to one million individuals in 2022 and 2023), without bolstering infrastructure and social services such as access to affordable housing (Bhugra, 2024). The government used the attraction of three-year work permits for students after they completed their educational programme of choice. Students began to choose Canada as a study destination not necessarily for educational purposes, but to secure future citizenship (Ouellet and Crawley, 2024). In other cases, privately funded institutions lied to encourage international students to enrol. For example, an investigation of a Canadian college in 2022 found that it was purposefully “misleading” international students (e.g., regarding expected salaries post-graduation) into enrolling in programmes costing 20,000 Canadian dollars (Grundig et al., 2022).

The Canadian government, charity sector, and media have drawn attention to the dire situation faced by international students, the majority of whom identify as South Asian. Problems affecting these students’ mental health include culture shock, financial and housing stresses, new academic expectations, lack of understanding of the healthcare system (Khunkhun and Fournier, 2023), loss of support systems, and racism and discrimination (CASSA, 2024). Organizations aiming to help these students report receiving multiple calls per day for housing, mental health, and food crises (Bhugra, 2024).

The rise of international students in Canada has been met with rising anti-immigration sentiment. For example, students from India in Waterloo, Ontario were recently targeted in a ‘hate crime’ (Danso, 2023), while the Coalition Against Anti-Asian Racism found that 25% of individuals of South Asian origin had experiences with racism and discrimination within the past year (Canadian Race Relations Foundation, 2023).

Sadly, a consequence of the pressures faced by South Asian international students is an increase in suicide rates in this population. Because the Canadian government does not collect these statistics, this trend has had to be highlighted from funeral home employees, who have seen a rise in the death of young Indian students (Sasitharan, 2023).

To deal with the worsening crisis, as of 2024, the federal government has introduced a two-year cap to curb entry for international students.

1.5.3 Demographic Snapshot of South Asians in the UK and Canada

Here I present information on what is known about South Asians in the UK and Canada on employment, religion, and health inequalities. Details on the prevalence of mental health conditions and the treatment gap for the South Asian populations in the UK and Canada, as well as the set-up of the mental health care system in each country can be found in the Methods section.

Table 2. Employment, religion, and health inequalities in the South Asian population in the UK and Canada.

	The UK	**Canada**
Employment	Employment rates for South Asians are similar or lower than employment rates of white groups. Recent UK government data showed 76% employment for Indian groups, 56% for Pakistani or Bangladeshi groups, and 77% for white groups (UK Government, 2023).	Data from 2020 indicates that the South Asian ethnic group in Canada report some of the lowest levels of employment, after the Indigenous ethnic group (Thobani and Butt, 2022), while earlier data from 2016 demonstrated that 79.3% of people of South Asian origin (ages 25-64) participated in the labour market (Statistics Canada, 2024).
Religion	There are many religions practiced by the South Asian population in the UK such as Islam, Hinduism, Sikhism and more (Minority Rights Group, 2022). Religion is not thought to have been of motivation to those choosing to move from South Asia to the UK. After 1950 however, when South Asians were building their communities, the importance of religion began to grow for individuals post-migration, and is still important today (Knott, 2017). Symbols of religion such as clothing, celebrations, and places of worship became "strong identifying features," with many South Asians in the UK being referred to by their	Though the beginning of migration from South Asia to Canada primarily began through Sikh individuals in the 1900s, "gradually, during the 1950s and 1960s, other ethnic/religious groups began to arrive: Muslims from Punjab and Pakistan; Hindus from Punjab, Uttar Pradesh, Gujarat, Bengal and Madras; and a few Buddisht Sinhalese from Sri Lanka. They spread out across Canada…many of them settled in the Toronto area" (Coward et al., 2012; 778).

	religion rather than their country of origin. Now, places of worship for South Asian religions in the UK hold significant social and cultural power; they receive attention from local leaders, not-for-profit organizations and the police and are often recipients of local grants (Knott, 2017).	Now, Hinduism (29.9%), Sikhism (29.6%) and Islam (23.1%) are the top three religions held by South Asians in Canada (Statistics Canada, 2022). Religious buildings such as temples, mosques and Gurdwaras are an important element of cities in Canada (Coward et al., 2012).
Health Inequalities	Health inequalities between ethnic groups in the UK are apparent. Mortality rates in 2019 were lower for South Asian individuals compared to their white counterparts, but cardiovascular disease, hypertension, and diabetes were more prevalent than the white group (Commission on Race and Ethnic Disparities, 2021). Evidence also suggests that individuals of South Asian origin are more likely to experience a CMD than white individuals in the UK (Ahmad, 2022).	Medical problems such as cardiovascular disease, diabetes, hypertension, and high cholesterol which conferred increased risk of mortality are highly prevalent in South Asian individuals (partly due to genetic factors) (Thobani and Butt, 2022). Additionally, the recent COVID-19 pandemic was particularly difficult for the South Asian community in Canada. The estimated death rate was 25% higher in areas with a high proportion of South Asians than those with a smaller proportion (Thobani and Butt, 2022). The pandemic resulted in many negative outcomes for the community such

		as worse mental health, co-morbidities, and mortality.

1.6 Mental Health in the South Asian Diaspora and Research Justification, Aims and Objectives

"It is argued that wealthy countries, whether they have market-driven or state-planned systems, have created expensive and inefficient mental healthcare services, and decisions about mental healthcare do not sufficiently involve those who use services and their families."

(Sashidharan et al., 2016)

The quote above, written by leading global mental health scholars, perfectly summarises why the current research is important. Despite economic investment and a specialist workforce that far outweigh the resources in low- and middle-income countries, high-income countries are failing to deliver accessible and culturally sensitive mental health services (Moitra et al., 2023; Patel et al., 2023). One theory is that the mental health care systems in these settings rely too heavily on the biomedical approach, which inhibits them from listening to service users (Crawford et al., 2011), providing person-centered care (Patel et al., 2023), mobilising community resources (McKenzie et al., 2004), and addressing the wider determinants such as poverty and discrimination (Lund et al., 2018).

With increasingly diverse societies, it is imperative to adapt these failing mental healthcare systems, especially for individuals who may hold beliefs about health and illness that differ from the dominant Western approach, such as those with immigrant and/or ethnically diverse backgrounds. Most migrant research has been focused on the cause, diagnosis, and prevalence of mental health conditions, with little attention paid to the "voices, interests and expectations of the immigrant communities" (Farahani et al., 2021).

An important avenue to facilitate this change is to incorporate the voices of people with lived experience. Qualitative research is a critical means by which to do so because it empowers individuals to share their stories in a safe environment.

> *"The South Asian diaspora's journey is one of courage, resilience, and determination…they carry with them a unique blend of cultures, traditions, and experiences that shape their identity. Sadly, this journey is also marred with challenges, including the mental health struggles of those who find themselves caught between two worlds. The emotional toll of navigating cultural identity, dealing with discrimination, and adapting to new environments can weigh heavily on the soul."*
>
> *(Shah et al., 2023)*

Some evidence indicates that members of the South Asian diaspora, especially in the UK, US, and Canada, are more likely to suffer from a mental health condition or lower wellbeing than the general population (Karasz et al. 2019; Naeem et al., 2020).

Upon migration, first-generation South Asian immigrants lose their support systems, face financial and housing insecurity, become subject to racist and xenophobic rhetoric, and are forced to adapt to a new culture very quickly. These defining experiences can then be passed down to the subsequent generation, who then must deal with intergenerational trauma, coupled with identity struggles emerging from straddling Eastern and Western cultures (Shah et al., 2023).

These statistics make it clear that this group requires mental health support, whether it's individual, informal, or formal. Despite this group's heightened need, there is a lack of culturally responsive mental health care in these host countries, which worsens existing mental health related inequalities (Kirmayer and Swartz, 2014).

Systemic factors such as racism and discrimination are important when thinking about service utilisation. However, culture is also a significant influencer for this group's service use. As has been established for other ethnically diverse populations (Nwokoroku et al, 2022), culture plays a key role in determining who, when, how and where people seek help. Reported cultural factors that shape mental health experience and management for South Asians in the diaspora include attribution of mental health problems to non-medical circumstances, collectivism, stigma, and somatisation (Rastogi et al., 2014, Antoniades and Brijnath, 2017, Karasz, 2005, Besier et al., 2003).

While there is some indication from existing work that there may be differences in mental health experience and service use between first and second generation South Asian immigrants, this evidence is extremely limited (Prajabati and Liebling, 2022). To my knowledge, no previous work has examined the similarities and differences between generations in how culture affects their experience and help seeking for mental health conditions. If differences exist between generations, this could have far-reaching implications for mental health service design and delivery. Accounting for generational status may be key to providing culturally sensitive care for the South Asian diaspora.

As Shah et al. (2023) rightly state, it is “time to address the mental health challenges of the South Asian diaspora.” Further empirical research is needed to reveal which cultural factors are important to South Asian immigrants and their descendants and how these cultural factors may be taken into consideration in mental health care.

Using qualitative methods to centre the voices of individuals with lived experience, I explored the role of culture on how first and second generation South Asian immigrants in the UK and Canada understand, experience, and seek help for psychological distress.

1.6.1 Research Question

What is the influence of culture on how first- and second-generation South Asian immigrants in the UK and Canada understand, experience, and seek help for psychological distress?

1.6.2 Research Objectives

From the onset of the study, I had three key objectives:

1. To examine and synthesise the evidence about a) explanatory models of CMDs and b) help-seeking attitudes, intentions, and behaviours for CMDs among South Asians in high income countries (Paper #1-Published- Transcultural Psychiatry).
2. To investigate the cultural conceptualisations of distress and help-seeking among first- and second-generation South Asian immigrants in the UK and Canada (Papers #2-5).
3. To analyse the convergences and divergences in the cultural conceptualisations of distress and help-seeking among first- and second-generation South Asian immigrants and between the UK and Canada (Discussion).

Additionally, I wanted to provide key stakeholders with a greater understanding of how South Asian immigrants, by generational status, may define, perceive, and seek help for psychological distress with the goals of informing equitable mental health service delivery and policymaking as well as advancing the inclusion of culture in mental health research in the UK and Canada.

CHAPTER 2: SYSTEMATIC REVIEW

2.0 Introduction

In my systematic review (in *Transcultural Psychiatry*), I examined the existing evidence on explanatory models and help-seeking behaviors for CMDs among South Asians in high-income countries—a topic not previously reviewed. The findings highlighted three key recommendations for my study: (a) prioritise recruitment from community-based settings, as most studies relied on participants who utilized formal care (e.g., GP practices); (b) incorporate researcher reflexivity in publications, addressing a primary limitation identified through my Critical Skills Appraisal Programme (CASP) analysis of qualitative studies; and (c) consider immigrant generation as a key variable, which was not addressed in any of the included studies.

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Article	**Explanatory Models of Common Mental Disorders among South Asians in High-Income Countries: A Systematic Review**
DOI	**10.1177/13634615241296302**
Journal	**Transcultural Psychiatry**
Author(s)	**Ruchika Jain, Ritsuko Kakuma, Daisy Singla, Kirsty Andresen, Khawater Bahkali, Abhijit Nadkarni**

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SECTION A – Student Details

Student ID Number	1702879	**Title**	Miss
First Name(s)	Ruchika		
Surname/Family Name	Jain		
Thesis Title	The Cultural Conceptualisations of Psychological Distress and Help-Seeking among South Asian Immigrants in the UK and Canada		
Primary Supervisor	Dr. Abhijit Nadkarni		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

Where was the work published?	Transcultural Psychiatry		
When was the work published?	January 9th, 2025		
If the work was published prior to registration for your research degree, give a brief rationale for its inclusion	NA		
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SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	Ruchika Jain contributed to all parts of the review as the lead author. Abhijit Nadkarni was the mentor author and provided guidance to Ruchika on all parts of the review as well as the design of the review and contributed to writing and editing the draft paper. Ritsuko Kakuma and Daisy Singla helped with the design of the review and contributed to writing and editing of the draft paper. Kirsty Andresen and Khawater Bahkali contributed to the screening process and reviewed the final paper.

SECTION E

Student Signature	Ruchika Jain
Date	10/01/2024

Supervisor Signature	Abhijit Nadkarni Digitally signed by Abhijit Nadkarni Date: 2025.01.11 09:04:42 +05'30'
Date	11.01.2025

Paper #1: Explanatory Models of Common Mental Disorders among South Asians in High-Income Countries: A Systematic Review

Abstract

Background: Mental health service use by individuals of South Asian origin living outside of South Asia is influenced by cultural factors such as endorsing psycho-social-spiritual over biological explanations, somatisation, and stigma.

Aim: The aim of this review is to synthesize the evidence about a) explanatory models of common mental disorders (CMDs) among people of South Asian origin residing in high-income countries, and b) their help-seeking for CMDs, including formal and informal care.

Method: The systematic review protocol was registered a priori on Prospero (registration number CRD42021287583). We ran extensive searches on explanatory models and help-seeking of people of South Asian origin across five databases (MEDLINE, Embase, Cumulated Index to Nursing and Allied Health (CINAHL), PsycINFO and Global Health). We extracted the data and conducted a narrative synthesis.

Results: We included 33 reports and 29 studies (9,030 participants). The participants in the included studies viewed CMDs from a psychosocial rather than a biological lens (e.g., resulting from family issues vs. neurotransmitters). Causal attributions included life stressors and attitudinal and religious/spiritual factors. Commonly used help-seeking strategies included private coping (i.e., crying or praying), speaking to friends and family, and visiting their General Practitioner.

Conclusions: We can conclude that cultural factors play an important role in how South Asian individuals experience and understand CMDs. To cope, they use pluralistic help-seeking strategies. Implications for clinical practice and policy include increasing research on the explanatory models of CMDs, involving family in services, and developing community-based interventions for individuals who do not engage with formal care.

Background

Common mental disorders (CMDs), which include depression and anxiety disorders, are leading causes of disease burden, with a global prevalence estimate of 29% for adults within their lifetime (Steel et al., 2014). The prevalence of depression ranges from 5-44% for first generation immigrant groups versus 8-12% for the general population, and for anxiety it ranges from 4-40% in first generation immigrant groups compared to 5% in the general population (Close et al., 2016). While prevalence estimates of CMDs among South Asian individuals vary (Bhavsar et al., 2018), there is consensus that people of South Asian origin who reside outside of South Asia experience similar or higher rates of CMDs than the native population. For example, in the UK, South Asians have lower levels of psychosis but higher levels of deliberate self-harm and psychological distress than the majority White population (Bhavsar et al., 2018) and in Canada the prevalence of depressive symptoms among South Asians (21%) was double that of the national average (10%) (Lai & Surood, 2013).

However, immigrants are less likely than the general population to access mental health care for reasons such as language, stigma, cultural perception, experiences (i.e., presentation of symptoms) and a limited understanding of a new healthcare system (Lu et al., 2020; Pollard & Howard, 2021). Even if mental health services are accessed, there is a significant delay when compared to the native population (Bhui et al., 2003; Fernando, 2014; Tribe & Marshall, 2020). South Asian immigrants (individuals originating from India, Pakistan, Sri Lanka and Bangladesh) underuse mental health services in comparison to their White counterparts and other ethnic minority groups (Bowl, 2007; F. Hussain & Cochrane, 2016; Prajapati & Liebling, 2021). For example, Pakistani and Bangladeshi women in England are less likely to access mental health services than White women (Pakistani OR=0.23, Bangladeshi OR=0.25) (Kapadia et al., 2018), and Asian groups in the UK are 38% less likely to have received treatment for a CMD than White groups in the UK (Ahmad et al., 2021).

Meeting the needs of immigrant groups is important considering the global movement of people, driven by interconnecting social, political, environmental, and economic factors, has increased, particularly from low-income country to HIC settings (Bhugra, 2004; United Nations Department of Economic and Social Affairs, 2020). Particularly, South Asians represent the most rapidly growing ethnic group in HICs such as the US, UK, Canada, and Australia (Prajabati and Liebling, 2022). Besides the challenges of the migration process itself (particularly in cases of forced migration), post-migration acculturative stress, socio-economic-political conditions, familial factors, age of migration and country of birth (e.g., discrimination, position in society) in the host country may cumulatively contribute to CMDs in immigrants and their subsequent generations (Bhugra, 2004; Karasz, 2005; Crowley, 2022; Lubin & Khandai, 2017)

In addition to systemic barriers, one explanation for poor service use is the explanatory models of illness—defined as "the way people perceive, interpret and respond to [illness]" (Dinos et al., 2017). Explanatory models influence whether someone seeks or receives formal or informal help, when they receive help, who they receive help from, and how effective the help is (Kleinman et al., 2006). If a healthcare provider's explanatory model differs from their patient's, providers may face difficulties empathising with their patient, as well as understanding their symbolic language, explanations of illness and their perspective on the role/responsibility of the healthcare provider (Bhui et al., 2013; Delara, 2016; Gopalkrishnan, 2018). This can lead to misdiagnosis, delayed diagnosis, or referrals to inappropriate services for immigrant and ethnic minority groups who may refer to maintain their cultural and religious perceptions of health (Bowl, 2007; Helman, 1994).

Discounting an individual's explanatory model in a clinical setting contributes to poorer treatment outcomes, particularly for immigrant and ethnic minority groups (Bhui & Bhugra, 2003). Conversely, exploring explanatory models can centre the role of culture in mental health experience and management, allow for a tailored response to an individual's generational status and life context, involve a patient's family in decision-making, reduce stigma, diversify treatment options/sources of help, and ultimately lead to greater and more appropriate use of mental health services (Dinos et al., 2017).

South Asian individuals living in high-income country (HIC) settings often do not perceive available mental health services or mental health prevention initiatives to be culturally appropriate (Bhui & Bhugra, 2002; Bowl, 2007; Islam et al., 2014). In Canada, South Asian individuals with a major depressive disorder had the highest percentage of unmet mental health care need (48%)

and perceptions of barriers to mental health service use (33%) compared to eight other ethnic minority groups (Gadalla, 2010; Islam et al., 2014) .

This may be partly explained by the overuse of the biomedical model in Western settings, which fails to account for psychological, social, and cultural factors, and emphasises individualism, biological explanations, and pharmacological treatment for mental health conditions (Deacon, 2013). These characteristics are in direct contrast with many South Asian individuals' explanatory models regarding the cause and appropriate treatment of CMDs, somatic expression of symptoms and collectivism. These are all directly related to refusal of mental health service use (Antoniades et al., 2017; Beiser et al., 2003; Karasz, 2005; Rastogi et al., 2014).

South Asian individuals in HIC settings understand CMDs through religious (e.g., supernatural forces or God's will), social (e.g., difficult life events) or moral (e.g., weakness) lenses rather than as an illness requiring biomedical intervention (Antoniades et al., 2017; Gilbert et al., 2006; Jacob, Bhugra, Lloyd, & Mann, 1998; Karasz et al., 2013; Rastogi et al., 2014). These explanations link with stigma, which may cause South Asian individuals to believe that seeking formal help could lead to humiliation in their community if their CMD is perceived to result from a character flaw (Karasz et al., 2019). South Asian individuals may therefore prefer to seek help for mental health problems from informal support (such as relying on oneself, family, or faith healers) rather than Western healthcare services (Bradby et al., 2007; Hussain & Cochrane, 2010)

South Asian individuals often express their mental distress as somatic symptoms (Anand & Cochrane, 2005; Gunasinghe et al., 2019; Hussain & Cochrane, 2016; Karasz, 2005). Along with language barriers, this can cause miscommunication between service users and care providers (who largely possess a biomedical view on health and disease such as body-mind dichotomy) (Bhui et al., 2013).

Individual-collectivism discord is an important cultural factor that plays a role in determining help-seeking (Soorkia et al., 2011). Collectivism is an important aspect of South Asian identity; South Asian individuals often prioritise family over the individual (Masood et al., 2009; Tummala-Narra, 2013). Collectivist values, for both South Asian parents and their children, can inhibit the sharing of mental health concerns if the affected individual does not want to place burden on their family members or is conscious of embarrassing their family in the wider community. If individuals do seek professional help, the care offered could be incompetent if a host country's Western model of medicine does not, for example, consider parent-child relations in immigrant families, where views on family obligation differ from the mainstream culture's ideology (Bismar, 2018).

It is well established in the literature that culture influences how individuals understand, experience and manage mental health conditions. However, there is yet to be a review on the specific cultural factors that influence mental health in the South Asian diaspora, which can inhibit the delivery of, and access to, culturally informed care for this population. To grow the evidence base, this systematic review aims to to synthesise the evidence about: 1) explanatory models of CMDs among people of South Asian origin residing in HICs; and 2) their help-seeking attitudes, intentions, and behaviours towards informal and formal mental health support for CMDs.

Method

Design

Systematic review of observational studies. The systematic review protocol was registered a priori on Prospero (registration number CRD42021287583).

Eligibility criteria

We included peer-reviewed research articles describing observational studies, published in English. We did not have any restrictions on year of publication. We included studies that described the explanatory models of and help-seeking for CMDs by South Asians (India, Pakistan, Sri Lanka, Bangladesh) living in HICs as categorised by the World Bank. CMDs were defined as depression and anxiety disorders such as post-traumatic stress disorder, panic disorder, generalised anxiety disorder, obsessive-compulsive disorder, and phobias (Kendrick & Pilling, 2012). Explanatory models were defined as "prior knowledge on the causation, perception, experiences, and traditional belief held by the patients, their caregiver, and the population in general" (Lilhare et al., 2020). Help-seeking was defined as "attempts to maximise wellness or to ameliorate, mitigate, or eliminate distress" (Arnault, 2009) through informal (personal networks such as friends and family) and formal (including professionals such as General Practitioners (GPs), nurses, psychiatrists, and non-health professionals such as teachers, spiritual and religious leaders, and community workers) support, and self-help ("use of support available online") (Kim & Lee, 2021).

Search

We searched electronic databases (MEDLINE, Embase, Cumulated Index to Nursing and Allied Health (CINAHL), PsycINFO and Global Health) on December 6th, 2021, using search terms under the following concepts: South Asian (e.g., Indian, Bengali), CMDs (e.g., depression, anxiety), and explanatory models (e.g., beliefs, attitudes, culture). We updated the search across all databases on February 1st, 2023, to find articles published in 2022-2023 to identify recent extant literature. The detailed search strategy is described in the supplementary materials. To identify other relevant articles, the bibliographies of the included studies were hand searched by the primary author (R.J.).

Procedures

After automatic and manual de-duplication in EndNote the search results were imported into the Rayyan software. Two reviewers (R.J. and K.B.) independently screened the titles and abstracts, and a third reviewer (A.N.) resolved any conflicts. Two reviewers (R.J. and K.A.) independently did the full text screening and conflicts were discussed until an agreement was reached. When the search was updated, one reviewer completed the title/abstract screening (R.J.) and two reviewers completed the full-text screening (R.J. and A.N.). A data extraction form was designed to extract data needed to meet the study objectives and covered domains such sample demographics, mental health condition under study, and findings pertaining to explanatory models and help-seeking. The data was first extracted 09/03/22.

Quality assessment

Qualitative studies were assessed using the Critical Appraisal Skills Programme (CASP) (CASP, n.d.) which covers appropriateness of research design and data collection tools, consideration of ethics and researcher/participant relationship, rigour of the data analysis, and the overall value of the research. For mixed methods studies, we used the 2018 Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018) which includes effectiveness of sampling strategy and sample, risk of no-response bias, and appropriateness of the measurements and statistical analysis for quantitative studies, and usefulness of using mixed-methods, and the interpretations of results of the quantitative and qualitative components for mixed methods studies.

Data synthesis

We conducted a narrative synthesis, which provides a qualitative summary of the findings. Informed by the ESRC's Methods Programme guidance (Popay et al., 2006) we followed these steps: (1) We conducted preliminary data synthesis using thematic analysis, in which "the main, recurrent and/or most important (based on the review question) themes and/or concepts across multiple studies" were identified; (2) We examined how the results converged and diverged for participant subgroups (i.e., immigrant generation status, gender, country of origin); and (3) We used the evidence grading systems described above, to assess the robustness of the synthesis. We used a flow diagram following the PRISMA guidelines to report the selection process and all results (Page et al., 2021).

Ethics approval

Ethics approval was not required for this study because it did not involve human participants.

Results

After removing duplicate articles, we screened 7,445 titles and abstracts, of which 145 records were eligible for full-text screening. A total of 32 articles met our eligibility criteria and were included in the review (Figure 1). When we updated the search in 2023, we screened 619 articles and found 7 articles for to be eligible for full-text screening. A total of 1 study was found to be eligible in this round of screening. Finally, we included a total of 33 articles of 29 individual studies (N=9,030 participants) (Table 1).

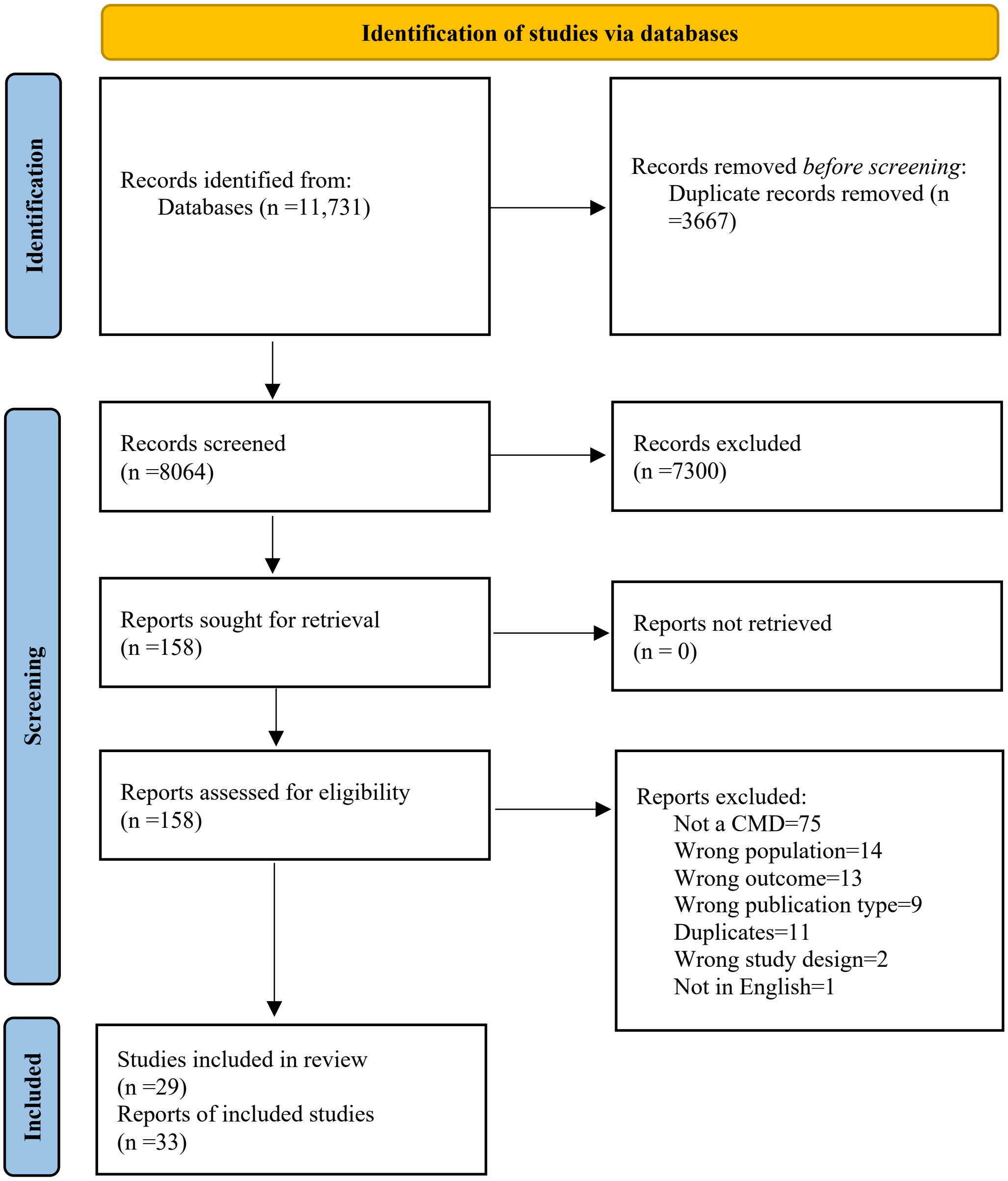

Figure 1. Prisma diagram of identification of included studies in 2022 and 2023.

Characteristics of included reports

Most of the reports were qualitative (n=15), focused exclusively on depressive disorders (n=21) and explored a combination of explanatory models and help-seeking (n=27). The studies were primarily based in the UK (n=20). Other countries included Australia (n=3), Canada (n=2), Norway (n=1), USA (n=2), and Greece (n=1). The participants in the included reports were recruited online (n=3), from the community (including educational institutes) (n=16), healthcare settings (n=11) or a combination of community and healthcare settings (n=3). The ages of the participants ranged from 16 to 90. The year of publication of the included reports ranged from 1994 to 2022.

Quality of included reports

The detailed quality assessment is summarised in the Supplementary Materials. The quality of the qualitative articles was generally high. The primary concern for seven out of fifteen of the qualitative articles was inadequate consideration of the researcher/participant relationship. Another issue with some of the qualitative studies was insufficient detail on the data analysis process. For mixed-methods articles, the authors' justified why this study design was used, and both the qualitative and quantitative components were explained with detail. The quantitative articles were assessed to be of good quality. However, many samples were sourced from primary care services, and therefore over-represented individuals who engage with mainstream healthcare, with consequent implications for findings on help-seeking.

In Table 1, we present the findings of the included studies in two categories (explanatory models and help-seeking), the definitions of which can be found in the eligibility criteria section of the Methods.

Table 1. Summary of included studies (n=29).

Author **Year**	**Country** **Setting**	**Sample** **Sample Size (N) of South Asian participants** **Mean age (SD)** **Range**	**Study Design** **Data Collection Method**	**Explanatory Models**	**Help-Seeking**
(Furnham & Malik, 1994)	UK University, Community	Native Britons and Asian-Britons (India, Pakistan, Bangladesh) N=76 *Mean=32 Range=17-62	Quantitative Questionnaire	The younger generation of Asian-Britons were more likely to understand depression through a Western lens, similar to their Native Briton peers, than the older generation of Asian-Britons.	The younger generation Asians preferred to talk to friends, while the older generation preferred to discuss their mental health issues with family.
(Jacob et al. 1998)	UK Primary care	Women of Indian origin N=100	Mixed Methods Interviews		Those participants who met the GHQ criteria for a CMD were more

		Mean= 43			likely to consult the GP than those who did not. Those with a CMD who did not want to seek medical help were found to have a higher CMD score.
(Bhui et al., 2001; Bhui et al., 2002)	UK Primary care	Punjabi and English subjects N=209 Range=16-86	Quantitative Survey	The participants with a CMD in the study had symptoms of poor concentration and memory, pain, and depressive ideas. There was no difference between Punjabi people and English people in somatisation. Medical/somatic symptoms were	GPs were less likely to diagnose Punjabi cases with depressive ideas with a psychiatric disorder. 46.2% of Punjabi cases did not seek help. Besides the GP, they relied on friends and family. Only 3.9% used religious or traditional strategies

				associated with psychological, religious, interpersonal, work, and financial beliefs.	
(Farver et al., 2002)	USA Colleges, universities, high schools	American-born Asian Indian adolescents and one of their immigrant parents N=360 *Mean=31 Range=14-65	Quantitative Questionnaire	Acculturation gaps (between parents and adolescents) was found to be related to anxiety.	
(Commander et al., 2004)	UK Primary care	South Asian and White people with a depressive disorder N=33 Range=16-64	Mixed Methods Interviews	Most participants (67%) saw their problem as psychosocial.	Most discussed the problem with a relative or friend (70%) and contacted their GP initially (94%), but only 55% discussed their problem with a GP, only 9% saw

					mental health professional, and only 9% took a psychiatric medication.
(Burr & Chapman, 2004)	UK Community	Women from South Asian communities N=46	Qualitative Focus groups (N=4) and interviews (N=10)	Participants were willing to use the term 'depression' and saw it as an illness but described members of their community as unwilling to. Depression was experienced as many different emotions and common symptoms were described as unable to sleep, crying, and fatigue. Causes of depression	Many participants talked about dealing with their depression alone and using "inner strength." The role of the GP was seen to be related to physical, rather than mental illness.

				mentioned include reproductive issues.	
(Kumari, 2004)	UK Community	First and second-generation women from Indian sub-continent (Pakistan, Bangladesh, and India) N=10 Mean=33 Range=16-60	Quantitative Questionnaire	Participants reported the following symptoms: over feeling, tiredness, feeling low and tense. 32% of the participants connected their aches and pains to unhappiness.	Help-seeking strategies included learning to deal with it or speaking to someone. Only 2/88 mentioned wanting to see a doctor. Other coping strategies cited were crying, relaxation and medication.
(Bhui et al., 2006)	UK Primary care, community	Bangladeshi, Black Caribbean and White British individuals with mental distress N=79 Mean=40 Range=19-77	Quantitative Checklist and interviews	The Bangladeshi participants were more likely to have a CMD and refer to it as a physical illness than the Black Caribbean group. They were	The Bangladeshi participants found self-management (59.5%), social treatment (55.7%), and medical treatment (41.8%) the most helpful.

				also more likely to give physical and spiritual explanations for the onset of CMDs, rather than behavioural issues. They saw the consequences of CMDs as psychological (96.2%) and social (49.4%).	
(Lavender et al., 2006)	UK Primary care	Yoruba, Bangladeshi and White British individuals N=20 Range=18-80 **Range not specific to South Asian participants	Qualitative Interviews	There was no consensus among the participants on whether depression could be categorised as an illness.	Most participants used friends and family as primary source of support. There were conflicting findings regarding the use of doctors and medicine.

				Causes of depression noted were mainly attributed to family issues.	
(Lawrence, et al., 2006; Lawrence et al., 2006)	UK Primary care	Black Caribbean, South Asian, and White British older adults N=33 Range=65-90	Qualitative Interviews	The South Asian participants in the "not depressed" group, participants were more likely to see depression as an issue of personality (such as being weak or too sensitive) rather than a biological issue. Other causes of depression were family issues and grief. A consequence of depression was	Various strategies to cope with depression emerged such as self-help (participants thought that depression should be dealt with alone using cognitive techniques such as distraction and altering your attitude), social support (such as receiving support from family and/or friends), religion (such as meditating and visiting the temple), and finally formal healthcare

				being unable to be around people and complete daily tasks. participants were not likely to consider depression to be an illness.	(there was no consensus on the use of GPs for treating depression- some saw the value of taking medication, while others were concerned about the side effects).
(Hanley, 2007)	UK Community	Bangladeshi mothers with postnatal depression N=10 Range=16-24	Qualitative Focus group (N=1)	Most of the participants did not consider postnatal depression to be an illness. Religious causes were often cited. Postnatal depression was described as "weakness, pain, problems of the heart."	Primary sources of support included parents and the wider community. Results regarding views/use of healthcare professionals were mixed. Issues with disclosing to healthcare professionals included presence of husbands, shame about talking about pregnancy and preferring to see

					religious leaders to cope. Other participants saw doctors and took prescribed medication.
(Mallinson & Popay, 2007)	UK Primary care	Individuals of Pakistani origin and White origin with depressive disorder N=31 Range=19-65	Qualitative Interviews	The participants were aware of the concept of depression and used this term. Depression was experienced as worrying, agitation, weakness, feeling low and down. While the results on somatisation were unclear, other physical symptoms such as chills, feeling hot and having a heavy and	

				tense head were mentioned.	
(Rüdell et al., 2008)	UK Primary care, community	Bangladeshi, Black Caribbean and White British N=57 Mean =43	Mixed Methods Survey		The Bangladeshi participants had many different help-seeking strategies. The group had the highest proportion of individuals who sought help from a GP. This group was also more likely to receive medication and find it helpful. 68.4% used social help seeking (such as talking to your family), 54.4% self-directed (such as exercise), 61.4% for keeping busy, 28.1% seeing a traditional

					healer, 49.1% praying, 52.6% talking to GP, and 59.6% taking medication. This group preferred complementary strategies (such as massages and yoga) the least.
(Gask et al., 2011)	UK Primary care	British Pakistani women being treated for depression N=15 Range=23-73	Qualitative Interviews	Three primary themes that emerged from this study were: feeling stuck (unable to manage depression due to their relation to situational factors such as family conflict), isolation (due to stigma or self-imposed), and losing a sense of	

				control (as a main experience of depression).	
(Rafique, 2010)	UK Specialist services	Pakistani women attending a counselling service for South Asian women N=7 Mean=36 Range=24-48	Qualitative Interviews	Causes of depression were loneliness, life issues (such as family conflict), and physical illness. Participants reported physical symptoms such as not wanting to eat, fatigue, aching bodies, and psychological symptoms such as many emotions, inability to concentrate, memory issues, nonstop crying, and	Many of the participants did not want to discuss their issues with other people (i.e., not wanting to burden family) but were sometimes willing to speak to a professional. Coping strategies included keeping busy, seeing friends, reading and using religion.

				loneliness/self-imposed isolation.	
(Loewenthal et al., 2012)	UK Community, NHS Trust	Bengali, Urdu, Tamil and Somali speaking individuals N=71 All participants over 40	Qualitative Focus Groups (N=2)		Four primary themes that emerged from this study were: understanding of mental health issues and available services (lack of understanding of Western conceptualisations of depression), cultural barriers to approaching service providers (participants mentioned feeling isolated and coping alone), interpreter and GP services (results were mixed on the usefulness of GPs

					when handling depression or anxiety-issues of privacy and language barriers were cited), and religion (religious explanations for the occurrence of depression emerged as did religions forms of coping, such as praying).
(Wittkowski et al., 2012)	UK Healthcare services (health visitors and midwives)	South Asian mothers N=10	Qualitative Interviews	Causes of postnatal depression were described and included unhappy marriages, missing family in country of origin, or evil whispers. It was experienced as tension or constant	The mothers were isolated and wanted support, but felt they could not get it from parents, husbands, or GPs due to cultural differences. Coping strategies included using religion, taking time for themselves,

				overthinking. Western conceptualisations of depression were not used by this group.	being optimistic and trying to use family.
(Ekanayake et al., 2012)	Canada Community	Women of South Asian origin with symptoms of depression N=10 Range=22-65	Qualitative Interviews	Causes of depression cited were individual issues, family issues (cultural differences, divorce, bereavement), isolating, ageing as well as migration and socioeconomic challenges.	
(Taylor et al., 2013)	UK Community	White British and North Indian women N=70 Mean (SD)= 33 (10.6)	Quantitative Survey	When discussing a vignette of a mother with depression, the Indian group was less likely to feel	The Indian participants were also significantly less likely to believe the mother with depression should visit

				like they understood her problems and that treatment would be helpful. They saw the cause as relationship or interpersonal challenges.	a GP. They endorsed seeing a religious or traditional healer. They also thought friends and family were a good source of support (at the same level as the White British group).
(McClelland et al., 2014)	UK Community	British Bangladeshi and British White individuals N=190 Mean= 28 Range=17-58	Quantitative Questionnaire	The Bangladeshi group was more likely than other groups to think shame is associated with depression and it can have an impact on the family of an individual with depression. They gave non-biological explanations of depression but did	For treatment, the participants preferred relying on friends, family, religion, and self-coping than on medical intervention. The older Bangladeshi group was more likely to see depression as an illness versus the younger Bangladeshi group.

				not endorse environmental explanations.	
(Roberts et al., 2015)	USA Community	Asian Indian women N=408 Mean (SD) Quantitative=42 (15.38) Mean (SD) Qualitative unstated	Mixed Methods Interviews (N=11), focus groups (N=4), survey (N=350)	This study found differences between older and younger generation participants. One participant described how cultural differences between themselves, and their parents was a cause for depression.	Stigma and fear of gossip in the community impeded help-seeking. The women participants were more likely to seek informal sources of support than professional mental health care. Help-seeking strategies differed between women who spoke Punjabi vs. English.
(de la Cruz et al., 2016)	UK Community	Ethnic minorities (including Indian parents) N=47 Mean(SD)=37(6.5)	Quantitative Survey	Participants in this study were less likely to believe that OCD could lead to symptoms and that	Indian parents possessed less information about OCD than White British parents. Indian

		Range=23-58		treatment would be helpful. They cited causes of their child's OCD as child's friends (95.5%), family or parenting issues (88.6%), personality or emotional struggles (86.0%).	parents mentioned they would seek help from a GP, family therapy and family/friends.
(Antoniades et al., 2017, 2018)	Australia Community	Sri Lankan migrants and Anglo-Australians with depression N=18 Mean=41	Qualitative Interviews	The participants described feelings of hopelessness, agitation, nervousness, and entrapment. Somatisation did not emerge as an important theme. The depression was seen as a result of situational factors	Some participants saw depression as a temporary state and related this to not wanting to take medication. Other coping strategies included seeing a priest, distraction, and sitting and thinking.

				such as family conflict or attitudinal factors such as overthinking. Biological factors and religious factors were rarely mentioned.	84% of participants engaged with healthcare providers. Issues with parents emerged – some participants cited that their parents did not understand their depression, while others mentioned they required permission from their parents to receive mental health care. Participants also mentioned that they used “compatriots” as someone to talk to because they did not feel like their social network understood.

(Brijnath & Antoniades, 2018)	Australia Community	Indian Australians and Anglo-Australians N=28 Mean (SD)=40 (15.8)	Qualitative Interviews	Many participants had not disclosed their depression to friends/family due to stigma. They saw the consequence of their mental health issues as impacting their social lives, rather than work lives (in contrast to the Anglo-Australian participants).	They cited stigma in the wider community as being apparent and a determinant of help-seeking. However, there was less stigma regarding counselling in the Indian-Australian group than the Anglo-Australian group.
(Chiu et al., 2018)	Canada Community	White, South Asian (Indian, Pakistani, Bangladeshi, Sri-Lankan origin), Chinese, and Black residents N=6779 Mean=38	Quantitative Survey		Mental health service use was found to be lower among South Asian participants, though 51.4% of South Asians reported seeking help in the past year. The participants

					sought help from GPs more than other health professionals and were more likely to see their family doctors than other professionals.
(Gilbert et al., 2019)	Australia Community	Indian-Australians and Anglo Australians N=36 *Mean=53	Qualitative Focus Groups (N=10)	Four major findings emerged from this study for the Indian-Australian partcipants: 1) the nature of depression (depression as stemming from situation and attitudinal factors), 2) causes of depression (such as missing friends/family in country of origin, participants did not	3) Help-seeking (strategies such as prayer, meditation, attempting to forget, drinking tea emerged), and 4) moral legitimacy (participants saw depression as stemming from weakness/personality and it meant that it must be dealt with internally, rather than seeking help from strangers).

				always see biomedical causes as legitimate)	
(Kateri et al., 2019)	Greece Community	First generation Indian immigrants N=114 Mean (SD)= 33 (7.97)	Quantitative Questionnaire	This study found that acculturation attitudes (‘separation’ where individuals prefer to maintain their culture of origin vs. ‘integration’)play an important role in how anxiety and depression is experienced.	
(Markova et al., 2020)	Norway Online	Immigrant groups (including Pakistani group) and Norwegian students N=117 Mean (SD)=29 (10.2)	Quantitative Questionnaire		The Pakistani participants preferred informal and traditional help seeking more than the other ethnic groups. This was found to be related

					to maintenance of cultural orientation. The participants had second highest preference for spiritual coping (after the Somali group) and endorsed other coping strategies such as exercise, time outside, reflection time, and looking for relationships. They used pluralistic help-seeking strategies.
(Birtel & Mitchell, 2023)	UK Online	White British and South Asian N=46 Mean (SD)=29 (7.62)	Quantitative Survey	The participants attributed depression to character flaws, God and life circumstances,	

				rather than biological reasons. The participants reported wanting more social distance and less closeness to a person with depression. They were also more likely than the White participants to report negative stigma by association.	

Note: The presented data is only for the relevant South Asian population. However, in one case, the age range is presented for the entire sample because the study did not disaggregate the data (**). Also, in some cases the mean age was calculated by the authors of this review (*).

Key Themes: Explanatory Models

Understandings of CMDs

Descriptions of mental health: Descriptions of mental health varied among the South Asian participants in the included studies. A 2011 UK-based study found that South Asian participants did not identify with diagnostic words based on Western understandings of CMDs. One Tamil participant drew on their experience working at a GP practice saying, *"Lots of people who come to us do not have a clue of what they are going through…there's still lack of knowledge and awareness among this community."* Another participant mentioned that there is no direct translation for 'anxiety' in Urdu (Loewenthal et al., 2011). The participants in this study were more familiar with general mental health concepts and this topic sparked discussion on the term "pagol" (mad or crazy in Hindi). Conversely, in Mallin and Popay's study with 31 individuals of Pakistani origin (19 first-generation immigrants to the UK, 12 UK-born) recruited from a GP practice, it was found that participants were willing to use diagnostic terms such as depression (Mallinson & Popay, 2007). Those Pakistani origin participants who did not use diagnostic terms such as depression or anxiety instead used descriptions such as "worried and on edge," "really down and weak," and "very low." In Brijnath et al.'s 2018 study, it was found that Sri Lankan participants with depression used terms echoing "a sense of entrapment" (i.e., hopelessness), while the Anglo-Australian participants used terms to convey "force weighing or dragging them down" (Brijnath & Antoniades, 2018).

Psychosocial Definitions: South Asian participants generally define depression in psychosocial (i.e., life circumstances), rather than biological (i.e., genetic factors or neurotransmitters) terms. For example, Commander (2004) and Bhui et al.'s (2006) studies found that 67% and 86.1% saw their CMD as a psychosocial issue, respectively (Bhui et al., 2006; Commander et al., 2004). In McClelland et al.'s study the British White participants were more likely to endorse biological explanations of depression, while the British Bangladeshi participants were more likely to endorse non-biological explanations such as a "mundane life" (McClelland et al., 2014).

Perceived causes of CMDs

Situational and Moral Factors: Many South Asian participants in the included studies saw the cause of their CMD as arising from situational factors, rather than biological factors (Roberts et al., 2015; Taylor et al., 2013). They mentioned family conflict, grief/bereavement, missing their family in their country of origin and generation gaps with their children as possible causes. One participant in Gask et al.'s (2011) study said that their child was disrespectful to their elders and this "*comes in form of depression for parents"*(Gask et al., 2011). In a study with South Asian parents of children with obsessive compulsive disorder, participants cited children's friends and parenting/family issues as the most likely causes (de la Cruz et al., 2016). This was also mirrored in Birtel and Mitchell's 2023 study where South Asian participants were found to "endorse greater supernatural but also moral beliefs [such as character flaws] about the causes of depression than White British" (Birtel & Mitchell, 2023).

Spiritual/Religious Factors: Participants gave spiritual/religious explanations for CMDs (Hanley, 2007), though less frequently than anticipated. In some studies, participants saw their distress because of "Jinn," a supernatural being in Islam, or 'evil whisperings' (Lavender et al., 2006; Loewenthal et al., 2012; Wittkowski et al., 2012). In Hanley's 2007 study of South Asian mothers with post-natal depression, religious causes were often cited (Hanley, 2007). However, in a qualitative study with South Asian women with depression in Toronto, no spiritual explanations were given (Ekanayake et al., 2012) and in a study of Sri Lankan-Australians with depression, only one spiritual explanation was given (Antoniades et al., 2018).

Experiences of CMDs

Symptoms: Common symptoms expressed were crying, tiredness, hopelessness, aches and pains and isolation (Bhui et al., 2001; Kumari, 2004), "*thinking too much,*" having "*too many emotions*" (Rafique, 2010; Wittkowski et al., 2012), trouble concentrating, memory loss, mental tension, and pressure/pain in the head (Lawrence et al., 2006; Rafique, 2010). In Bhui et al.'s 2002 study, it was found that Punjabi individuals with CMD were more likely to report poor concentration and memory than English individuals (Bhui et al., 2002). Punjabi individuals were also more likely to express their CMD as somatic symptoms than English individuals.

Consequences of CMDs: CMDs were conceptualised as stigmatised issues with social consequences. A 25-year-old male Indian-Australian participant reported, "*It's a social statement that, ''Oh he has depression, I don't want to get close to him' 'And it's almost like people think it's contagious"* (Brijnath & Antoniades, 2018). The same study showed that South Asian Australians were more likely to focus on the social impact of their depression, in contrast to Anglo-Australians who were more concerned with the work impact (Brijnath & Antoniades, 2018). Additionally, a mixed-methods study in California found that fear of gossip in the South Asian community was directly related to anxiety (Roberts et al., 2015).

Generational Differences in Explanatory Models of CMDs

Cultural differences in the understanding and experience of CMDs between parents and their children or older and younger generations were emerged as a common theme on CMD cause, experience, and help-seeking.

In some studies, participants noted that their CMD stemmed from cultural differences (e.g., thoughts on marriage, rules, Westernisation) between themselves and their parents and/or other family members (Ekanayake et al., 2012). In Roberts et al.'s 2015 study with Punjabi individuals in California, one participant said *"…as an adolescent it's depressing…you're growing up in this first-generation culture where it's like your parents don't understand where you're coming from…there can be times that it can be, you know, really depressing*" (Roberts et al., 2015). Additionally, Farver et al.'s 2002 study found that adolescents were more likely to be assimilated to their country of residence than their parents and that families with larger acculturation gaps had higher anxiety scores (Farver et al., 2002).

Beyond cultural differences being a root of CMD development, disparities in the understanding of, and attitudes towards, CMDs between parents/children and/or older/young generations were also apparent. In McClelland et al.'s 2014 study, the older British Bangladeshi participants "tended to show more negative attitudes towards depression than younger British Bangladeshis and British

Whites" (McClelland et al., 2014). The older British Bangladeshi participants also had more stigmatising beliefs about depression like it resulting from personal failures and leading to consequences for the family's respect. Similarly, Furnham and Malik 1994 found that the young South Asian sample in their study had "adopted a perception of depression that is similar to that of their British peers (Furnham & Malik, 1994). For example, an older generation South Asian participant stated, *"the depression that exists in Indian-Australians, it really is nothing, it's just the style of living"* (Gilbert et al., 2019). This result was mirrored in Antoniades et al.'s 2018 study; a 22-year-old participant stated, *"my parents were like 'there is no such thing as depression…no one is depressed in Sri Lanka"* (Antoniades et al., 2018).

Key Themes: Help-Seeking

Informal care

Many self-management techniques for depression and anxiety were reported such as distraction ("keeping busy"), getting married, crying, exercise, altering your perspective to a more positive one, and "sitting and thinking" (Brijnath & Antoniades, 2018; Gask et al., 2011; Kumari, 2004; Markova et al., 2020; Rüdell et al., 2008). In Norway, Markova et al. (2020) found that Pakistani immigrants preferred disengagement coping strategies (such as avoidance, distraction and finding a partner) in comparison to other immigrant groups and Norwegian students (Markova et al. 2020). While some participants reported wanting to keep their mental health issues private, others described talking to family and friends as a source of support. A mixed-methods study with Bangladeshi individuals in the UK found that 68.4% used social help-seeking (i.e., speaking with your family) (Rüdell et al., 2008). Additionally, spiritual coping strategies such as praying or visiting a faith healer were frequently cited in studies examining help-seeking (Taylor et al., 2013). Finally, one study highlighted how participants sought support from "compatriots" online, who in this case were people with lived experiences or those who had a deep understanding of mental health issues (Antoniades et al., 2018).

Formal care

South Asian participants' views on attending primary care to receive treatment for depression and/or anxiety were mixed. Some reported not wanting to see a GP for fear of judgement (73), issues of confidentiality and miscommunication, only going to the GP for physical health problems, and lack of access (Gask et al., 2011). For example, Wittkowski et al.'s study with 10 South Asian mothers with postnatal depression highlighted that they did not feel comfortable going to a male GP, especially since they thought they would be judged for the number of children they had (Wittkowski et al., 2012). In Kumari's 2004 qualitative survey, only 2/88 participants (who were all in counselling) said they would see a doctor for mental health problems. One participant mentioned that depression is a problem of the mind and as such "doctors' medicine cannot work" (Kumari, 2004). Conversely, participants in another study stated "the doctor should decide what is best for the patient as he knows better" (Gask et al., 2011). Another participant believed that medication could positively impact the mind (Lavendera et al., 2006). In Rüdell's 2008 study, Bangladeshi participants were more likely than their White British and Black Caribbean peers to visit a GP, receive medication and find it helpful (Rüdell et al., 2008).

A Canadian survey found that South Asians underutilised mental health care services; 51.4%of South Asians with suicidal ideation reported seeking help for their mental health concerns in the past year (Chiu et al., 2018). In Commander's 2003 study, it was found that most South Asian participants had contacted a family doctor, but only 55% had discussed their mental health concern (Commander, 2003). In Mallinson and Popay's quantitative study, White women and Pakistani individuals with depression were found to visit GPs a similar number of times for "depression and anxiety symptoms", but "GP consultation rates were higher in depressed people of Pakistani origin because they consulted more often for bodily symptoms" (Mallinson & Popay, 2007).

Finally, perspectives on strategies to address cultural issues in primary care were highlighted. A study based in a community health centre for South Asian women found that participants wanted to attend healthcare services with professionals of their own cultural background (Kumari, 2004). The presence of interpreters at GP services were not found to be useful to some because of mistranslation issues and preferring to speak to their doctor directly and confidentially (Loewenthal et al., 2012). Some participants in Lavender's study recommended the use of mullahs (Islamic religious leaders) alongside GPs - "Without mullah, doctor cannot do anything" (Lavender et al., 2006).

Generational Differences in Help-Seeking

Furnham and Malik's 1994 study found that younger generation participants preferred speaking to friends for support, while the older generation preferred to speak with family (Furnham and Malik, 1994). One explanation some participants cited was that their family members lacked understanding of mental health and would therefore be unable to help: "*they just have absolutely no understanding of it…if I said to my mum, all she is going to do is pray*" (Antoniades et al., 2018). Other participants mentioned that they would not seek help from mental health professionals without permission from their parents (Antoniades et al., 2018) - "*I would get permission from my parents first and then I would go there*." Antoniades et al.'s study also illustrated the role family plays in promoting help-seeking behaviour. The Anglo-Australian participants were more likely to be encouraged by their friends, while for Sri Lankan Australians, family members were more important (Antoniades et al., 2018).

Discussion

To our knowledge, this is the first systematic review that aimed to synthesise the evidence on explanatory models of CMDs and help-seeking among South Asians living in HICs. The following sections highlight our key findings.

Explanatory Models

The South Asian participants in the included studies primarily described CMDs in non-diagnostic terms such as 'feeling low', although some participants were comfortable using labels such as 'depression' or 'anxiety.' These descriptions were echoed in Anwan et al.'s systematic review (2020); South Asian participants with long-term conditions were more likely to use words such as "tension," "stress," or "anger" to explain their emotional distress than medical terms (Awan et al., 2022. This use of non-diagnostic terminology is likely related to how South Asian individuals often frame CMDs as psychosocial (resulting from factors such as family conflict or personality traits) or religious issues rather than biological. It may therefore be necessary to invest in the development of culturally adapted psychosocial interventions for this population in addition to pharmacological interventions. For example, psychosocial group interventions ("structured cognitive, behavioural and social interventions intended to improve mental health implemented among a group of people who meet together on multiple occasions") run in South Asia were shown to improve mental health outcomes at intrapersonal, interpersonal and community levels because they increased participants' awareness of mental health tools and resources, provided trusting relationships and increased their feelings of social support and inclusion (Mathias et al., 2023).

Stigma also influences the explanatory models of CMDs for this population. The included studies showed that many South Asian participants were concerned about the social consequences of their CMD, such as being labelled as 'weak' or 'crazy' in their family or wider community. Based on the definitions of Corrigan and Rao (2012), two types of stigma are particularly important for the South Asian diaspora in HICs; public stigma ("the prejudice and discrimination directed at a group by the larger population") and self-stigma ("when people internalize these public attitudes and suffer numerous negative consequences as a result") (Corrigan & Rao, 2012). Addressing all forms of stigma in South Asian communities is crucial to increase help-seeking and improve mental health outcomes. In Naeem et al.'s 2020 "Call to Action," the authors bring attention to how stigma acts as a barrier to accessing support for South Asian Canadians (Naeem et al., 2020).When discussing strategies to address stigma, they point to Fung et al.'s study with 495 Asian men in Toronto (including South Asian men). Stigma reducing interventions such as acceptance and commitment therapy (ACT), contact-based empowerment education, or both, and psychoeducation were found to be effective due to mediating factors such as empowerment and for ACT, "psychological flexibility" (Fung et al., 2022).

Family Dynamics

Family dynamics played an important role in how South Asian individuals perceived the cause, impact, and experience of their CMD, which in turn, influenced their preferred coping strategies. For some participants, family acted as a protective factor and their primary support, while for others family acted as a cause for CMD and a barrier to help-seeking. These mixed results are echoed in Anand and Cochrane's 2005 review of British South Asians' mental health status, where they found that for this group "family is both a source of strength and a source of stress" (Anand & Cochrane, 2005).

Family issues, a psychosocial factor, were cited as a cause for the onset of depression or anxiety in multiple studies (Antoniades et al., 2017; Ekanayake et al., 2012; Rafique, 2010; Wittkowski et al., 2012) . Our results highlighted that one of the most significant issues described was conflict arising from cultural differences within families, especially between first-generation parents and their second-generation children or grandchildren. Similarly, in a recent study, it was found that grandmothers with granddaughters who considered themselves 'Hindu' or 'Indian' over British, had better psychological adjustment scores (Guglani, 2000). Second-generation children, meanwhile, have the pressure of balancing their family culture and their host country's culture, which can lead to heightened levels of stress and anxiety (Shariff, 2009). These findings also appear to be true from the perspective of healthcare providers. Rastogi et al. (2014) and Islam et al. (2022) interviewed clinicians and mental health workers with experience working with people of South Asian origin in the US and Canada respectively and both groups of study participants perceived cultural differences (in ideas about mental health, academics, dating and clothing, for example) to be a cause for onset of CMD and a barrier to mental healthcare (Islam et al., 2022; Rastogi et al., 2014). Also, while this review was specific to HICs, attributing a CMD to life circumstances has also been seen in low-income settings. For example, a study of primary care attenders with a CMD in India found that the most common explanation for their illness was psychosocial factors such as "marital conflict [or] worries about alcoholism in the family" (Patel et al., 1998).

We also found that many participants were primarily concerned with the impact their CMD would have on their family, which is unsurprising given that it is well-established that South Asians endorse a collectivist orientation where the family is prioritised over the individual. In some cases, it emerged that CMDs were not discussed with family to protect them from pain, worry or humiliation (Brijnath & Antoniades, 2018). This finding was echoed in Rafique (2010)'s study, where participants did not want to concern their family with their worries (Rafique, 2010) and in Loewenthal et al.'s (2011) study where an older Tamil participant stated that they turned to religion as a coping strategy to remain "*strong*" for their family (Loewenthal et al., 2012).

Conversely, other participants stated that support from family was essential to combating depression and that they would share their mental health issues with family, rather than a professional (Lawrence et al., 2006; Practitioner, 2007). This finding is supported by the theory that perceived support from a spouse or family can reduce depressive symptoms (Singla et al., 2021). Further, family played an important role in accessing primary care services, which ranged from wanting a husband to be present when seeing a male doctor (Wittkowski et al., 2012) to requiring their child to be present to translate from their spoken language to English (Loewenthal et al., 2012). These results were also mirrored in Prajabati and Liebling's 2022 systematic review of South Asians and mental health service use in the UK, which found that "family was viewed as the main source of support" (Prajabati and Liebling, 2022).

Coping Strategies

Individual coping strategies such as crying, praying, exercise, isolation or thinking were a prominent finding in this review. One proposed reason is that the familial factors often translate to private coping strategies as they avoid issues of shame, stigma, and familial burden (Cinnirella & Loewenthal, 1999). This may be especially true for girls and women. For example, in Loewenthal et al.'s (2011) study, in addition to stigma, the female participants expressed that they wanted to remain strong [and therefore not seek help] given the patriarchal nature of the community (Loewenthal et al., 2012). This finding is mirrored in a 2021 study with British-born South Asian girls, who found that the "desire to avoid disrupting cultural norms can close down opportunities to seek help" (Sangar & Howe, 2021). Additionally, a study in Scotland found that shame resulting from stigmatised views on mental health problems decreased social and professional help-seeking in Indian, Pakistani and Chinese communities in Scotland (Knifton, 2012).

Besides family considerations, there are other plausible explanations for why self-reliance and individual coping strategies (such as using 'inner strength') were found to be popular in the included studies. We found that South Asian individuals attributed depression/anxiety to attitudinal factors (Lawrence et al., 2006). This was also seen in a study that found that South Asian students were more likely to link character deficit to mental illness than their White counterparts (Mokkarala et al., 2016). Considering that "cultural causal beliefs about mental distress [are] significant predictors of attitudes for seeking help" (Shiekh & Furnham, 2000), we can posit that viewing CMDs as a consequence of personal problems is correlated to the use of individual help-seeking strategies.

Implications for Clinicians and Service Delivery

To better integrate culture into mental health service delivery in high-income settings, the following should be considered: First, it is important for healthcare professionals to acknowledge, and therefore make time for, exploring their South Asian patients' cultural context in order to deliver person-centred care (Keynejad, 2011). Efforts in clinical settings have escalated in recent years through the implementation of tools such as the Cultural Formulation Interview, which is a guide to help clinician's elicit information on their patient's social and cultural context. However, there are some limitations. In a recent review of its trial, Jarvis et al. highlight that some clinicians without social sciences backgrounds struggled to understand a question intending to determine "clinically relevant aspects of the patient's cultural identity" (Jarvis et al., 2020). Second, healthcare professionals and decision-makers must be aware of the significant role that families and differing immigrant generation status play in the development and treatment of, and recovery from CMDs. In the Kingdom of Saudia Arabia, for example, pharmacological intervention (i.e., prescribing medication) was the most common form of support offered to patients for mental health issues (71%), compared to family therapy (8%) (Algahtani et al., 2017; Rathod et al., 2017). A study with South Asian families in America has suggested that care providers allow for differences in values between parents and their children when addressing mental health concerns (Sharma et al., 2020). Culturally adapted family therapy could use the tool of "cultural brokering" in which issues between first generation South Asian parents and their second-generation children are reframed as a difference in cultural values, rather than a problem stemming from an individual (Segal, 2018; Shariff, 2009). Third, strengthening and diversifying the healthcare workforce may make care more accessible to some South Asian individuals, which can include involving traditional or faith healers in primary care or working with key community members to deliver educational workshops (Keynejad, 2011.; Shah et al., 2023.). Fourth, community-based interventions, outside of the traditional healthcare system, need to be considered to increase access to care for South Asians with CMD. Digital technology could offer an important avenue to deliver said interventions; "these platforms can be designed with features that are culturally tailored and available in multiple languages" (Shah et al., 2023.). Finally, future research should focus on South Asian sub-groups (i.e., by country of origin) and immigration generation to develop prevention strategies and service delivery (Prajabati and Liebling, 2022).

Limitations

This review had some limitations. First, we only included English publications. However, considering that most research from HICs is published in English journals, it is unlikely that we have missed publications that are published in non-English languages. Second, some articles in the search did not define South Asian in their study context and were excluded. Therefore, some articles may have met this review's inclusion criteria but were excluded due to lack of detailed definitions. Third, most of the studies were based in the UK, which potentially limits the generalisability of these findings, considering a host country's political-social-cultural environment can impact individual's explanatory models. Fourth, inter-rater reliability was not calculated between the reviewers for the data selection process, which could impact the reliability of the review. Fourth, considering this is an exploratory systematic review, we did not weight the findings of the included reports based on the quality assessment.

Importantly, the selected articles included varying sub-groups within the group of "South Asian," which meant that sub-group analysis by country of origin was not possible. This limitation is important given the economic, political, cultural, and social differences that exist within this group (Prajapati & Liebling, 2022). Additionally, many articles were not clear about immigration generation of the South Asian participants, which is important considering that the characteristics associated with ethnicity, passed through generations could shift through processes such as migration (Durà-Vilà & Hodes, 2012; Rutter & Tienda, 2005). Nevertheless, it was possible to make some conclusions on how the views of parents and their children converge and/or differ regarding CMD understanding, experience and help-seeking.

Conclusion

Academics, policy makers and clinicians must work with South Asian communities in their local context to achieve 'vertical equity' where healthcare services are tailored to meet the needs and expectations of diverse groups, as opposed to 'horizontal equity' where identical services exist for everyone (Tribe & Marshall, 2020). In the past, even when efforts have been made to address issues of diversity and achieve equity in the healthcare systems of high-income countries, there are “numerous examples of stereotyping of specific cultural groups leading to interventions that are often inadequate or inappropriate” (Gopalkrishnan, 2018). An important step in achieving vertical equity is to continuously develop the evidence base on how culture influences explanatory models of, and help-seeking for, CMDs (Deacon, 2013). Exploring the cultural influences on the explanatory models of, and help-seeking for mental healthcare among South Asian individuals, which this review aimed to do, can provide valuable knowledge to mental health service providers who work in diverse contexts.

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CHAPTER 3: METHODS

3.0 Introduction

In this chapter, I discuss the methodological approaches I employed for the qualitative and public engagement portions of my study. I begin by discussing the foundations of my study such as intersectional theory, my epistemological positioning, and my conceptual paradigm. I then describe in detail how and why I conducted semi-structured interviews to answer my research question. I lay out the ways in which we worked with key stakeholders (i.e., South Asian individuals with lived experience, clinicians, and community leaders) to determine the scope of the study, design materials, recruit participants, ascertain the usefulness and relevance of our findings to the South Asian community, and write recommendations for policy and practice. Finally, I outline the ethical consideration of the study.

3.1 Intersectional Theory

For this study's purposes, I use intersectionality as a methodological approach (Abrams et al., 2020). Intersectionality was central to my thinking from the beginning of the study, though I did not explicitly refer to it as 'intersectional theory' until I finalised my research plan. My understanding of intersectionality meant I focused on collaborating with community members from the beginning of the study, undertaking reflexivity journaling, and designing a robust dissemination plan for the results.

Intersectionality has been described in the literature as a theory, a framework, and a form of activism (Warner et al., 2016). Intersectionality implores us to understand how the core factors that shape our identity including gender, race and ethnicity, class, age, sexuality, ability, and Indigenous status "intersect to reflect significant social structural inequalities" (Olanlesi-Aliu, 2013, Cho et al., 2013). In intersectional theory, the above characteristics are characterised as 'social structures' (Cho et al., 2013) and identities shaped by social-cultural factors are therefore changeable (Abrams et al., 2020; Else-Quest and Hyde, 2016).

The concept of intersectionality emerged in the 1800s and 1900s through the works of individuals and organizations such as Sojourner Truth, Anna Julia Cooper, Frances Beal and Combahee River Collective, who explored the connection between multiple facets of identity (e.g., gender and race) (Abrams et al., 2020). But the term "intersectionality" was first coined and popularised by feminist legal expert, Kimberle Crenshaw, who explored how mainstream systems worked to marginalize and oppress Black women (Crenshaw, 1989).

Applying an intersectional lens to this study is essential to understand participants' experiences as minoritized immigrants in Western countries. Other researchers have also advocated for use of an intersectional lens when exploring mental health in the South Asian diaspora. In Chowdhury and Okazaki's 2020 review chapter, for example, they argue that the mental health experiences of South Asian Muslim Americans are incomprehensible without studying intersecting contextual factors such as Islamophobia and anti-immigrant sentiment as well as demographic characteristics such as gender, sexuality, and socioeconomic position.

Operationalising intersectional approaches in qualitative health research remains muddy, partly because researchers tend not to explicitly state how intersectionality informed their work. For clarity, I followed the guidance of Abrams et al., 2021; Delucio and Villicana, 2021; and Misra et al., 2021 who aim to help researchers consider intersectionality at each stage of the research process. This guidance highlights the history and main concepts of intersectionality, persistent confusion in the field and proposes how researchers can apply intersectionality in qualitative studies.

As outlined by the authors, researchers can take many actions to apply an intersectional approach to data collection. I have summarised my specific actions here, but more detail is provided throughout the chapter.

Research Material: I wrote high-calibre interview guides (i.e., I developed mine based on existing, pre-validated interview guides, piloted them for clarity, and continuously reviewed them through the interview process).

Research Validity: I triangulated results (i.e., I ran public consultations to ascertain whether our data analysis was useful, interesting, and relevant to the South Asian community and I co-coded with other experienced qualitative researchers to assess the quality of my coding).

Reflexivity: I was transparent about my own background and identities (i.e., I was open and forthcoming when community leaders and participants asked about my background and wrote a positionality statement).

Collaboration: I collaborated with individuals from my population of interest (community members did not hold decision-making power in this study, but their expertise was sought out, leveraged and valued throughout the entirety of the study).

Research Scope: I made attempts to "understand experiences within the context of the community rather than as a comparison to the dominant norms" (we designed the study to focus on the experiences of South Asian individuals explicitly, rather than in comparison to a dominant white ethnic group, which is a common form of research in cultural psychiatry) (Abrams et al., 2021).

3.2 Research Paradigm/Epistemological Position

I chose to present my epistemological position (i.e., my perspective on how knowledge is created) to be open about what I perceive the relationship between the researcher and research material to be (Creswell, 2007).

Social constructivism is one of four worldviews that can be applied to qualitative research (the others being post positivism, advocacy/participatory, and pragmatism) (Creswell, 2007). Social constructivism posits that "individuals seek understanding of the world in which they live and work. They develop subjective meanings of their experiences…[which] are varied and multiple, leading the research to look for the complexity of views" (Creswell, 2007; 20). This worldview was conceptualised approximately 30 years ago borrowing from the disciplines of social and existential psychology, social history and hermeneutics (Phillips, 2023). Major contributors were Berger and Luckmann (1966) ("social reality observed daily can be constructed via the network of interpersonal and socio-cultural interactions that occur in life") and Holzner (1972) (Phillips, 2023).

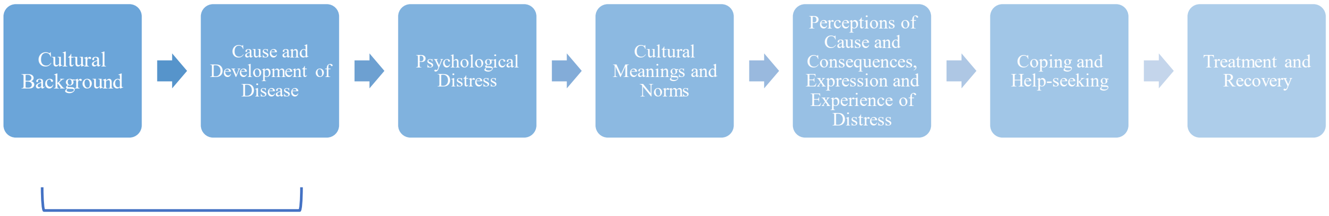
By endorsing a social constructionist perspective, I acknowledged that there is no one ‘truth’ and that multiple perspectives can be held equally (Phillips, 2023). I centred participants’ viewpoints and aimed to present the ‘complexities’ in these viewpoints rather than summarise them as a few coherent ideas (Creswell, 2007). From the beginning of this study, I have reiterated that this research is not meant to treat ‘South Asians’ as a homogenous group, which would allow for the results to become a “how to” guide on treating South Asian patients with a mental health condition. Rather, I wanted to highlight individual experiences. This approach has been seen in similar mental health research with ethnically diverse populations. For example, in a qualitative study exploring Black women’s attitudes towards help-seeking for depression in the US, the authors used a social constructionist lens to underpin their analysis because they felt it was important to situate their findings according to the study country’s context (in America, Black women are subject to many layers of oppression) and provide an avenue to present their voices and interpretations of their lives (Nelson et al., 2020).

I also borrowed from the advocacy/participatory worldview, which highlights that the overall aim of research should be facilitating change that ultimately improves the lives of marginalised participants (also an important facet of intersectional approaches to qualitative research). Research should focus on “issues such as oppression, domination, suppression, alienation and hegemony…and provide a voice for these participants” (Creswell, 2007). While this study is exploratory, and I could not guarantee that it would improve the lives of the participants, I hoped to at least contribute to a growing body of evidence used to transform existing Western, white-dominated health services.

Finally, the issues with positivism and post positivism (primarily used in quantitative study designs) including random sampling and importantly, a lack of interaction between researchers and participants (which can be an emotional and transformative experience) further deterred me from positivism and towards constructivism (Ponterotto, 2010).

3.3 Conceptual Paradigm

Given that my study examines the intersection between culture and mental health, I have amalgamated three pre-existing models on this topic to develop my conceptual paradigm (see below). A study's conceptual paradigm explains the study's most significant factors and how we assume they relate to each other (Miles and Huberman, 1984). This conceptual paradigm informed the research question and objectives as well as the interview schedule and the categories for data analysis. As highlighted in Figure 1, I investigated how cultural meanings and norms influence how an individual defines their psychological distress, interprets the cause and consequences of their psychological distress, and both expresses and experiences their psychological distress. I then analysed how these three factors synergise to shape how an individual copes with, and seeks help for their psychological distress, which is also tied to their expectations for treatment and recovery. I did not investigate how an individual's background may lead to the development of psychological distress in the first place.



Outside the scope of my study

Figure 1. Conceptual Paradigm: the influence of culture on mental health.

I have adapted my conceptual paradigm from:

The Cultural Influences on Mental Health Model (CIMH): This model was developed by Hwang et al. (2008) to facilitate the inclusion of culture in mental health research, teaching and clinical practice. The model connects six domains: "the prevalence of mental illness, aetiology of disease, phenomenology of distress, diagnostic and assessment issues, coping styles and health seeking pathways, treatment and intervention issues." CIMH includes two pathways that I considered outside the scope of my study: a) a pathway from cultural background to etiology to psychological distress and b) a pathway between diagnosis, prevalence, policy and ultimately treatment. Though they are important considerations, the aim of my study is not to explore how an individual's cultural background causes mental illness (e.g., how an individual's ethnicity could lead to discrimination and therefore psychological distress) or to examine how misdiagnosis (e.g., due to culturally informed symptom expression) can lead to under-calculation in prevalence of mental illness and therefore impact public health policy and treatment.

Cultural Determinants of Help-Seeking (CDHS): This theoretical framework was developed by Saint Arnault (2009) and is based on qualitative study findings as well as medical anthropology and trans- and cross-cultural psychiatry. It places culture as the most integral part of the research question to expose the cultural influences on mental health expression and treatment.

Cultural Formulation Interview (CFI): The CFI was first developed in 2013 as part of the DSM-V. It is a series of questions that aim to elicit a patient's views on their experience, life context, past and future help-seeking, and treatment requirements in a psychiatric setting (Jarvis et al., 2020).

I also considered the five illness dimensions (identity, causal attributions, timeline, consequences, and cure) (Dinos et al., 2017) and the McGill Illness Narrative Interview (MINI) (a semi-structured interview aimed to explore the explanatory models of illness) (Groleau et al., 2006) while developing my conceptual paradigm.

3.4 Interviews

3.4.1 Ethical Approval

This study was reviewed and given favourable opinion by the London School of Hygiene and Tropical Medicine Research Ethics Committee (UK) (ref:28173) and Mount Sinai Hospital Research Ethics Board (Canada) (ref: 23-0030-E).

3.4.2 Study Design

To address the research question, I used a qualitative study design. As an emic approach to research, it allowed me to write a detailed description of the participants' illness experience and place them as their own life experts.

As described by Ponterotto (2017), I utilized a qualitative design for the following several reasons. First, qualitative methods can help uplift and empower marginalised individuals and groups to "share their worldview and lived experiences in their own words, in their own way." Second, qualitative research allows for close contact between the researcher and the participant, which can transform both parties by shifting their previously held assumptions and stereotypes. Third, qualitative research enables "discovery" by supporting exploration of ideas, rather than explanations. Finally, qualitative research and reporting can help lay members of the public learn about, and appreciate, the research.

I considered qualitative data collection tools such as ethnography and focus groups, but eventually excluded them. While ethnography is considered a useful form of inquiry for expanding knowledge on culture, I decided it was not appropriate to answer the research question. Ethnography is meant to create a "firsthand" account of a specific context through observation, open-ended interviews, and perhaps primary document analysis (Hammersley, 2006). However, in my study, there were no obvious settings in which I could conduct an ethnography; my aim was to explore how participants engaged with various forms of mental healthcare (in places of worship, primary care practices, and community organizations, for example) and constricting my study to just a few specific locations would have been limiting. I also decided to exclude focus groups due to the sensitive nature of mental health in South Asian communities. I wanted participants to have a space where they could share their experiences of distress without fear of confidentiality breaches or judgment. Though social desirability is also a limitation in semi-structured interviews, it is likely more prevalent in focus groups, where participants must establish trust and rapport not only with the interviewer, but co-participants as well (Bergen and Labonte, 2020). Finally, I did not think focus groups would allow for in-depth exploration of the explanatory models of, and help-seeking for, distress.

I chose to conduct semi-structured interviews to answer my research question because they are shown to provide “richer data and a better understanding of illness representations and experiences” than other methodologies (Dinos et al., 2017), particularly when investigating culture. I am aware of the critiques of using interviews as the primary form of data generation, especially that interviews are over-used in qualitative study designs and analysing the way people view things means one neglects understanding how people do things. However, my intention with this research *is* to understand how people see things in relation to distress, as opposed to how they do things.

Semi-structured interviews are a commonly used tool in qualitative designs. They can be described as conversations, a vital way humans have learned about one another throughout history (Leary, 2014). In fact, qualitative interviewing can be traced back to Ancient Greek times when historian Thucydides interviewed survivors of the Peloponnesian War for documentation. More recently, qualitative interviewing was used by Sigmund Freud, who conducted therapeutic conversations to develop his psychoanalysis theories. Then, jumping forward to 1924, Emory Bogardus (sociologist at the University of Southern California) stated that interviewing “is as old as the human race” (Leary, 2014). Finally, more contemporary outlooks on qualitative interviewing were highlighted in The Ethnographic Interview (Spradley, 1979) and Research Interviewing: Context and Narrative (Mishler, 1986) (Leary, 2014).

In a semi-structured interview, as opposed to a structured or unstructured interview, the researcher has a pre-determined set of questions to ask, but there is flexibility to ask additional questions of interest based on the participant’s answers. There are four key aspects of semi-structured interviews that were relevant to my study: purpose (what is the interviewer’s reason for the interview), descriptions (in qualitative interviews, one is asking participants for “descriptions” rather than “speculations,” “reflections,” or “theorizations”), lifeworld phenomena (atheoretical phenomena that is experienced in a “intersubjectively shared and meaningful world in which humans conduct their lives”) and interpretation (researcher’s interpretation of how participants describe their experiences) (Leary, 2014).

3.4.3 Study Locations and Context

My study has a geographic focus on Canada and the UK.

My study sites include:
Toronto, Canada.
London, United Kingdom*.

*Towards the end of the data collection period, I broadened my geographic scope to other major cities in the UK (Manchester, and Birmingham) to help boost recruitment. Ultimately, I worked with Jamila's Legacy, a mental health charity in Birmingham, to recruit two second-generation participants who were based in the city.

I believe collecting data in these two study sites is justified due to several similarities (see Table 3. Demographic Snapshot of South Asians in the UK and Canada). The UK and Canada are both high-income, Western and English-speaking countries, home to a large population of South Asians that is continuing to grow. In both countries, South Asian individuals are considered minorities and are subject to racist and anti-immigration rhetoric. These individuals also likely experience higher levels of psychological distress than other ethnic groups and have a higher perceived unmet need for care (Shah et al., 2023). Additionally, initiatives such as the UK's "Delivering Race Equality in Mental Health Care" (Department of Health for England and Wales, 2005) and Canada's Mental Health Strategy (Mental Health Commission of Canada, 2012) outline the need for the creation and provision of cultural-specific health services to reduce health inequalities.

In line with the research goal, collecting data in two study sites allowed for more information on the *cultural* influences of distress and help-seeking to be collected, rather than structural, country-specific influences. This approach has been used in other studies; for example, Krendl and Pescosolido (2020) conducted a cross-country comparison between several countries in the East and West to investigate the impact of stigma on mental health and analyse culturally specific factors rather than country-specific ones (Krendl & Pescosolido, 2020). Finally, I believed cross-country comparison could help draw out experiences and lessons learned that can help shape policy and practice in both the UK and Canada.

Table 3. Demographic Snapshot of South Asians in the UK and Canada.

	The UK	**Canada**
South Asian Population – Country*	**South Asians make up 7.5% of the UK population.** Visas: Immigrants from India primarily enter the UK on skilled, student, or family reunification visas (Sharma, 2014), immigrants from Bangladesh to the UK held a variety of 'skill' levels through waves in the 1920s, 1960s, and 1970s but were mostly from uneducated backgrounds (Siddiqui, 2010) and, most Pakistani immigrants to the UK come for education or skilled work (Platt and Luthra, 2017).	**South Asians make up 5.6% of the Canadian population.** Visas: Approximately half of South Asian immigrants entered Canada as economic migrants, except for Sri Lanka where the majority were refugees. The second most common reason for all South Asian countries was family reunification (Statistics Canada, 2024).
South Asian Population- City	London, UK. In this city, **approximately 20% of the population is of South Asian origin** (Mayor of London, 2022).	Greater Toronto Area, Canada. In this city, **approximately 14% of the population is of South Asian origin** (Statistics Canada, 2022).
World Bank Classification	High-Income (World Bank, 2023)	High-Income (World Bank, 2023)
Prevalence of Mental Health Conditions among South Asians**	South Asian individuals, especially women, likely experience lower levels of psychosis but	An analysis of the national health survey of 1996-1997 found lower rates of depressive

	higher levels of deliberate self-harm, depressive and anxiety symptoms, and psychological distress than the majority white population (Williams et al., 2015; Rees et al., 2016; Anand and Cochrane, 2005). Older South Asian women are at high risk of suicide (Gnanapragasam and Menon, 2021).	symptoms in South Asian individuals than other ethnic groups (Wu et al., 2023), while the 2016 Census found that **South Asian participants had poorer mental health outcomes than other visible minority groups** (Statistics Canada, 2020). A telephone survey study with South Asians elders in Calgary found the prevalence of mild depression to be 21%, which was slightly more than double the national average at 10% (Lai and Surood, 2008).
Estimated Unmet Need for Care for South Asians	Asian groups in the UK **are 38% less likely to have received treatment for CMDs** than the white ethnic group (Ahmad et al., 2022).	South Asians diagnosed with major depressive disorder reported **the highest unmet mental health care need at 48%** in comparison to eight other ethnically diverse groups (Gadalla, 2010).
Mental Healthcare System	**Mental health services in England are primarily funded by the NHS.** Services exist in the community, primary care, hospitals (emergency and in-patient) and online. Often, services vary according to age groups. Mental health service delivery is unique to each	**Mental healthcare in Canada is the responsibility of the government of each province or territory.** Primary care and hospital-based care is funded under Canada's Health Act, while services outside of these realms are usually privately funded. GPs are

	locality – Integrated Care Boards are tasked with ordering NHS services for their local area (Garratt, 2024).	generally thought of as the first port of call for mental healthcare. Some community based mental health services are publicly funded, but most are delivered by not-for-profit organizations (Esmail, 2023).

*In national datasets, “all immigrants of a national origin (and often their descendants as well) are treated as a single category” (Platt and Luthra, 2017), which makes it difficult to ascertain the number of first- versus second-generation South Asian immigrants in each country.

**Estimates of mental health problems among the UK and Canada’s South Asian population vary depending on the nature of the sample, the type of analytical approach and the type of outcome.

I decided to focus on urban settings for this study. Generally, immigrants tend to move to urban settings, particularly world cities such as London and Toronto. Urban settings have different cultural environments than rural ones with each city having their own set of "industrial areas, transportation and infrastructure systems, market economies and width of social networks" (Goregenli et al., 2016). Spatially, cities are places where immigrants can group together based on shared ethnic or cultural backgrounds and interact with each other as well as the native population, or geographically mix with the majority population to spatially assimilate. As such, immigrants develop part of their identity due to their interaction with their urban environment (Lalli, 1992) and may develop different acculturation levels and strategies than those in rural settings (Goregenli et al., 2016). Additionally, people living in urban areas are more exposed to different cultures and may be less resistant to shifting traditions than those in rural areas, as was seen in Korean immigrants in America (Jun et al., 1993).

I must note that the mental health experiences and help-seeking of individuals residing in cities may be different than those residing in rural areas, though the prevalence of psychiatric diagnosis and need for mental health treatment is likely similar (Lawrence-Bourne et al., 2020). In contrast, mental health awareness and stigma levels are different for urban versus rural settings; a recent global desk review found that stigma was more prominent in rural areas (Chebet, 2024). Finally, the availability of specialist mental health services is lower in rural areas than in urban areas (Morales et al., 2020). I believe exploring the experiences of immigrants in cities is important considering city services must be designed to provide adequate care for ethnically diverse individuals.

3.4.4 Sample

I considered "a priori which intersections are most likely connected to the phenomenon being measured, and whether the self-report instrument has the ability to capture the lived experiences of individuals at these intersections" (Warner et al., 2016). When deciding who to include in the study, I identified the commonalities that existed in our population of interest (i.e., resident in an urban setting, minoritized ethnicity, self-reported psychological distress). I thought about how characteristics beyond South Asian ethnicity may impact participants' experiences with healthcare services including immigrant generation, gender, age, and socio-economic status.

To access my population of interest, I used purposive and snowball sampling and recruited from diverse places including libraries, community groups, and places of worship. I took time to build close relationships with community leaders to better understand our topic from the community perspective. These individuals, in turn, voiced their support for our study, which helped us recruit participants. I also share commonalities with some participants in that I am also a second-generation South Asian immigrant, which possibly improved recruitment rates due to shared cultural understanding with community leaders and participants.

I made four important considerations when choosing a sample for research using interviews as the method of choice: inclusion and exclusion criteria for potential participants, sample size, sample strategy, and sample sourcing (recruitment) (Robinson, 2013).

3.4.4.1 Eligibility Criteria

Adults (18 years +), English speaking, any gender, residing in Toronto or London, who self-identify as:

born in India, Pakistan, Bangladesh, or Sri Lanka; migrated directly to Canada or the UK as an adult; and have lived in the UK or Canada for at least 5 years (first-generation immigrant) **OR**

born in Canada or the UK and have both parents descended from India, Pakistan, Bangladesh, or Sri Lanka and at least one parent born in one of these countries (second-generation immigrant) **AND**

Have had a self-reported experience of psychological distress* that impacted their daily life for a sustained period within the past five years.

*Formal diagnosis of anxiety or depression was not required to ensure that individuals who do not attend mainstream healthcare services were not excluded from the study.

I chose to include individuals born in India, Pakistan, Bangladesh, and Sri Lanka for several reasons. Firstly, these countries are commonly used to define ‘South Asians’ in the literature (Sharma, 2014). Secondly, most first-generation immigrants to the UK and Canada from South Asia originate from these four countries. Finally, although there are many common cultural characteristics shared across South Asia and the diaspora due to a long-shared history, I felt it was important to narrow the scope of the study by restricting the eligibility criteria regarding country of origin. Unfortunately, this criterion means that individuals from other countries in the sub-continent such as Nepal, Bhutan, Mauritius, and Afghanistan were not included in the study.

I wanted to ensure that first-generation participants' move to the UK and Canada was their first migration from South Asia, hence why I included "migrated directly" in the eligibility criteria. I gathered that the reasons for migration as well as the challenges faced by immigrants migrating for the first time may be unique to those who had migrated a few times or more. Additionally, the literature suggests that South Asian individuals in East Africa may have a distinct culture that separates them from South Asians migrating from South Asia (Ghuman, 1994).

Additionally, I specified that the first-generation participants must have moved to the UK and Canada as an adult (>18). This decision was based on evidence from the literature, which establishes that age of migration can influence acculturation processes as well as help-seeking behaviours (Torres et al., 2019).

I decided to specify length of residence in host country after conducting one interview with a first-generation immigrant who had lived in the UK for six months. This interview reminded me that the experiences of psychological distress would be different from those who were more established immigrants, which would make comparisons more challenging (Dorsett et al., 2015). I speculated that five years in a host country would give first-generation participants sufficient time to discuss their distress and help-seeking in relation to the host country, rather than in their country of origin.

I initially defined second-generation South Asian immigrants as those who were born in the UK or Canada and had both parents born in India, Pakistan, Bangladesh, or Sri Lanka. However, after an interaction with a potential participant who has one South Asian parent born in South Asia and one South Asian parent born in the UK, I decided to expand this criterion. This definition of second-generation immigrant aligns with that of the European Union, which specifies that only one parent must be born abroad for an individual to be considered 'second-generation', which validated my decision to change the criterion (European Commission Migration and Home Affairs, n.d.).

To answer the research questions, it was important for me to recruit first- and second-generation South Asian immigrants with recent lived experience of mental health problems to share their stories, rather than lay members of the community. From my systematic review, personal anecdotal evidence, and multiple conversations with South Asian community leaders, I knew that recruiting these individuals may be challenging due to cultural factors such as prevalent stigma, reluctance to speak about personal problems, and the use of culturally specific terminology to express distress that is not diagnostic or include the word 'mental health.' In addition to these cultural barriers, I was aware of many valid criticisms of current diagnostic models (as discussed in the Introduction). Based on these considerations, I decided against using words such as 'mental health' or formally screening for distress using a pre-existing tool to both recruit participants and determine their eligibility for the study. Clearly, it was necessary to create an alternative measure of psychological distress, which would be culturally specific and, hopefully, non-stigmatising.

In the end, to recruit South Asian immigrants who have experienced self-reported psychological distress at some period in their life, I designed a recruitment materials poster that included the question *"Have you experienced one or more of the following in a way that has impacted your daily life for a sustained period of time…?* and included a multi-language word cloud that has the most common words associated with psychological distress for South Asians (Figure 2). The word cloud was generated through a literature review and with the help of my existing network. Six interdisciplinary South Asian professionals (including mental health leads in local boroughs and community organizations, individuals with lived experience of mental health conditions, and clinicians with academic backgrounds) with experience working with South Asians in the field of mental health shared 10 words they associated with South Asians and psychological distress. I amalgamated this list to generate the word cloud. Examples of words that were included are tension, depression, thinking too much, anxiety, worry, and *chinta (*the Hindi word for worry).

Figure 2. The multi-language word cloud with the most common words associated with psychological distress for South Asians that I used to recruit participants.

This decision was corroborated in the literature. For example, Karasz et al. (2013) worked closely with 16 Bangladeshi women in the Bronx to create the South Asian Tension Scale. They reasoned that a culturally sensitive scale needed to exist because "evidence suggests that symptoms associated with CMDs may not be labelled or recognised as mental health problems, but either explained in somatic terms or attributed to social, contextual, religious or spiritual factors." The symptoms used to measure tension in this scale were also reported in studies with other South Asian groups. Additionally, some research also demonstrates that using cultural idioms rather than diagnostic terms could help address stigma issues and ultimately improve outcomes. Finally, due to acculturation, the ways in which distress is expressed may shift with time meaning that Western tools such as the General Health Questionnaire and culturally specific screening tools such as the Amritsar Depression Inventory may differ in their validity for immigrants with varying levels of acculturation (Bhui et al., 2000).

I considered the recall time frame in my eligibility criteria because of issues such as "telescoping," where an individual recalls events that are outside of the time period under investigation and "memory decay," where individuals misremember the number of events (Bhandari and Wagner, 2006). When dealing with emotional experiences, people tend to overestimate negative affect and underestimate positive affect, especially if participants are experiencing distress at the time of the study (Colombo et al., 2020). To address some of these issues, I decided to interview participants who had experienced psychological distress within a given time frame (such as in the past one year, two years, five years, or ten years). Studies that look at mental health service utilisation generally use a period no longer than 12 months (Bhandari and Wagner, 2006); however, this period was not useful for my study, especially given that the COVID-19 pandemic may skew mental health experiences and help-seeking behaviours. Additionally, recall bias due to self-reporting is a more significant issue when measuring healthcare service utilisation in the absence of administrative data. While my study aimed to explore help-seeking and formal and informal service use, accuracy in the number of visits for example, is less important than highlighting the participant's experience, in their own words. Also, interviews can be more accurate than these research tools because there is the possibility to clarify both the questions (for the participant) and the answer (for the researchers) (del Boca and Noll, 2000). Ultimately, I decided that a period of five years could address some of these issues and allow enough time for participants to have engaged with any type of mental health service. To mitigate the effects of recall bias in my analysis, I also ensured that participants were given ample time to consider the question so that they can recall the relevant memories while participating in the interview (Del Boca and Noll, 2000).

I also asked participants to describe the intensity of their psychological distress (using a graphic representation of a Likert scale such as smiley/sad faces), the most recent time they experienced the psychological distress, and how long their psychological distress lasted. Likert scales have been established as a reliable and valid tool in mental health screening and research across various settings. For example, the Kessler Psychological Distress Scale uses Likert-based questions. This scale has been applied in clinical and non-clinical samples and used for screening in regions across the world (Choi et al., 2015).

3.4.4.2 Sample Size

I estimated that I would recruit approximately 10 to 15 first-generation South Asian immigrants and 10 to 15 second-generation South Asian immigrants in each study country (minimum of 40 participants, maximum of 60 participants). However, consistent with qualitative research procedures, I planned to end data collection when I reached saturation. Some researchers have critiqued the concept of saturation to justify their final sample size (the end of data collection) in qualitative research (Braun and Clarke, 2019). Saturation aligns with a realist understanding of research, where it is possible to find “a total amount of facts” (Braun and Clarke, 2019). This view conflicts with the notion that meaning in data emerges from a combination of the data itself as well as the researchers’ context and theoretical influences. Ultimately, this means that data can always be interpreted and there is no prefixed endpoint. Clarke and Braun (2019) suggest an alternative way to determine a sample size: information power (Braun and Clarke, 2019). “Information power indicates that the more information the sample holds, relevant for the actual study, the lower number of participants is needed” (Malterud et al., 2016). Though I felt it was important to suggest an initial sample size with lower and upper limits, I reconsidered it throughout the research process.

I considered five important aspects when estimating what sample size was likely needed to obtain enough information power (Table 4). A smaller sample size is needed when the study scope is narrow, the participant sample is specific, the study has a theoretical underpinning, the quality of the dialogue between the researcher and participant is strong, and no cross-case analysis is being conducted (Malterud et al., 2016).

Table 4. Determining a sample size for information power.

Aspect of Study	**My Project**
Study Aim (Scope)	Narrow in scope
Sample Specificity	Pre-defined participant sample
Established Theory	Underpinned by a conceptual framework
Quality of Dialogue	I am a novice researcher, but I received training on conducting interviews and am a second-generation South Asian woman, which may encourage dialogue
Analysis Strategy	Cross-case analysis (first- compared to second-generation)

Given the dimensions of my study outlined above as well as significant practical considerations (such as time and financial limitations) I chose a sample size with a lower limit of 40 and an upper limit of 60 (Braun and Clarke, 2019). I planned to stop data collection once I had achieved ample information power, within the practical constraints of my study (Malterud et al., 2016).

3.5 Data Collection

The data collection period lasted approximately one year; I conducted interviews from February 2023-March 2024.

3.5.1 Recruitment

As part of developing my recruitment strategy, I considered potential barriers to recruitment that the literature and consultations with individuals from community health organisations have illustrated (Mukherjea et al., 2018; Quay et al., 2017; Waheed et al., 2015). The most significant risk to the study I identified before starting data collection was the lack of buy-in from South Asian community organisations and leaders because they were an important part of recruiting South Asian immigrants to my study in both the UK and Canada. However, literature focusing on the recruitment of South Asians outside of South Asia in research has highlighted several mitigation strategies, which I employed (LaRocca et al., 2012; Quay et al., 2017):

⇒ Researching a topic that is appropriate and important for the community.
⇒ The use of significant community leaders.
⇒ Recruitment materials that are culturally appropriate.
⇒ Building relationships based on trust and organisation.
⇒ Providing participants with financial compensation.

To recruit participants, I conducted purposive (criterion i) sampling, meaning I identified participants through pre-determined criteria (stated above). Purposive sampling is “used to select respondents that are most likely to yield appropriate and useful information” (Kelly, 2010; pg. 317; Campbell et al., 2020) and is a way of identifying and selecting cases that will use limited research resources effectively (Campbell et al., 2020). I also used snowball sampling, meaning I asked key informants and participants whether they are aware of any individuals who meet the criteria and potentially would like to participate (Palinkas et al., 2015). Specifically, I attempted to conduct maximum variance sampling, an approach to purposeful sampling that would allow me to "describe the variation in the group and to understand variations in experiences while also investigating core elements and shared outcomes," in line with my research objectives (Patton, 1990).

Participants were primarily recruited through community organisations that agreed to support the research. Participants were also recruited through the research team's existing networks and visits to South Asian community centres and hubs, local libraries, and places of worship in London and Toronto.

Specifically, community organisations and individuals from the research team's existing networks were asked to place recruitment posters in their buildings and on websites and to send the recruitment poster through general mailing lists. They were not asked to identify specific individuals who met the participant criteria. Visits from the research team to South Asian community centres and hubs, local libraries, and places of worship in London and Toronto included distributing/displaying posters and having conversations with key individuals (e.g., community leaders, faith leaders) about the research to encourage them to highlight the project to their communities. Key individuals (as mentioned above) were also contacted via email to place recruitment posters in their buildings and on websites and to send the poster through general mailing lists or share information about the research through word of mouth. If they identified specific individuals as potential participants, I did not approach them directly to maintain privacy and confidentiality; the key individuals were asked to provide the potential participant with my contact information.

3.5.5.2 Procedures

Individuals who contacted me to be part of the study were sent an information sheet (which is part of the consent form document in Toronto and a separate document in London) after they agreed to communicate via email. If they agreed to be interviewed, the information sheet was once again shared with them (either with a physical copy if in-person or digitally if online).

I took consent. I previously took modules on qualitative research and ethics as a MSc student at the London School of Hygiene and Tropical Medicine and have experience conducting qualitative research (specifically interviews) with vulnerable groups in Ontario, Canada. I also received additional support from my supervisors at the beginning of the interview process.

In-person interviews: Consent was obtained using a physical consent form from the participant before they completed the demographic form and the interview began. The participant was given as much time as they needed to review the consent form and ask questions. The consent form was only available in English (a conversational level of English was required for participation). This part of the process was not audio or video recorded. At the beginning of the interview, it was reiterated that the participant could stop the interview at any time or choose not to answer questions they did not feel comfortable answering.

Online interviews: The participant was sent the informed consent form (in English) as an email attachment (in Toronto) or in the body of the email (in London) after they agreed to communicate via email. The participant was given as much time as they needed to review the consent form and ask questions. The participant must have returned the signed form via email. I then signed the form as a witness and sent it back to the participant. At the beginning of the interview, I reiterated that the participant could stop the interview at any time or choose not to answer questions they did not feel comfortable answering. This part of the process was not audio or video recorded. Before the interview began, the participant was asked if they consented for the audio recording to begin. After audio recording had begun, the participant was asked for verbal consent to start the interview once again so that their consent was recorded.

In some cases, and to facilitate culturally sensitive communication for both in-person and online interviews, it was necessary to obtain verbal consent from the participant instead of written consent. The consent form was sent to the participant prior to the interview. The verbal consent was obtained and recorded in an audio recording of the participant giving their name, confirming they read the consent form, confirming that they did not have any questions or comments and confirming that they understood what they were agreeing to participate in.

The participant was also asked to complete the following forms:

Demographic Information Form: The participant was asked for the following demographic data: gender, ethnicity, age, occupation, education level, country of birth, parents' country of birth and for first generation only, age of migration, purpose of migration, and length of residence in the UK/Canada. The collection of this demographic data was to ensure that the generational status of the participant is clear, and the sample was as intersectional as possible based on factors such as gender and socio-economic status. If the participant preferred to have the demographic information form read aloud and/or filled in on their behalf (based on their verbal answers), I did so. For online interviews, the demographic information sheet was read out to the participant and filled out on their behalf. This part of the process was not audio or video recorded.

Contact Details Form: The participants participating in-person were asked to sign a physical form and provide their email address if they would like to be contacted with the study results (i.e., a website link or a 1–2-page summary). Online participants received the form as an attachment via email (in Canada) or in the body of the email (in the UK).

3.5.5.3 Interview Schedule

The interview schedule (Appendix) was designed to elicit information on two key areas: explanatory models of distress and help-seeking behaviours. Specifically, participants were asked how they explained their distress to others, their perceived causes, and how the distress manifested both mentally and physically. In terms of help-seeking, I inquired about the sources of support they had used, whether these were effective, and their motivations for seeking help.

The schedule was drafted to align with these objectives and was informed by a literature review, existing tools such as the MINI, Kleinman's 8 questions, and a piloted interview schedule my supervisor provided. Consultations with key experts and informal piloting with South Asian friends and family in the UK and Canada also informed revisions. The schedule was structured around the study's conceptual framework and is divided into five domains: (1) introduction, (2) cultural definition and experience of distress, (3) cultural perceptions of cause, (4) context and support, and (5) help-seeking and coping mechanisms.

Interviews began with open-ended questions to establish rapport, such as asking participants to introduce themselves and describe their identity. I then reminded participants of their eligibility, inviting them to share their experiences of psychological distress ("You were asked to take part because you identified as someone who has experienced emotional distress over the past five years. Can you tell me more about that?"). Follow-up questions addressed perceptions of causality ("What do you think caused [name for distress]?"), and communication with friends and family about their distress.

Participants were asked about contextual factors such as life changes since the onset of distress and their social support systems. If support was mentioned, I probed further about its effectiveness. The discussion then shifted to formal and informal help-seeking, with questions like "can you describe what you did/do to make yourself feel better?" and "are there any sources of help that you would have like to have used?" The interview concluded with questions on recovery expectations and broader considerations of mental health within South Asian communities. Finally, I thanked participants and closed the interview.

3.6 Data Analysis

I analysed the interviews using a reflexive thematic analysis to "identify patterns in the data, describe and interpret those patterns, and provide a theoretically informed interpretation of them" (Braun and Clarke, 2021). Though it is not tied to any epistemological assumptions, reflexive thematic analysis is well suited to social constructivism, my epistemological position, because it places importance on the role of the researcher in data analysis (Braun and Clarke, 2019). There are many other advantages to using a reflexive thematic analysis to address a research question. The most relevant to my project is that reflexive thematic analysis is useful to explore the similarities and differences across cases, which is important considering I wished to highlight how the cultural conceptualisations of psychological distress and help-seeking for psychological distress converges and diverges between South Asian immigrant generations and between study sites. Additionally, results from a reflexive thematic analysis can be translated to policymakers and the public, which is important considering one of my research objectives is to disseminate the findings to those groups and reflexive thematic analysis can be used to summarise large amounts of data, which is a practical advantage given I interviewed 38 study participants.

One potential drawback of a reflexive thematic analysis is that the research community has questioned its rigour. However, this belief is changing rapidly. I ensured that I made the steps for the data analysis clear (for transparency), conducted preliminary coding with another researcher (for accountability), and wrote a reflexivity journal throughout the research process (for bias mitigation) (Nowell et al., 2017).

I considered other data analysis methods but decided against them for various reasons (Table 5).

Table 5. An outline of my decision to exclude other qualitative data analysis methods (Clarke and Braun, 2021).

Type of data analysis	**Reason for exclusion**
Grounded theory	Goal is to generate a theory rather than to identify and interpret patterns in the data
Interpretive phenomenological analysis	Requires a small sample size (less than 10); homogenous sample; is not well suited to practice-oriented goals; does not consider wider socio-political-economic nuances
Content analysis	Aligns with a positivist ontological position; generally, atheoretical
Discourse analysis	More useful when analysing the power of language

I made key decisions regarding the definition of a theme, type of analysis, type of theme and the analytical process due to the flexibility of reflexive thematic analysis.

Theme definition: A theme is a “pattern of shared meaning” (Campbell et al., 2021). Themes were defined depending on how important they were to my research question, which ultimately aimed to highlight how the cultural conceptualisations of psychological distress and help-seeking for psychological distress converges and diverges between South Asian immigrant generations. I also considered the prevalence of a theme, though I gave this less importance than key-ness.

Semantic or latent themes: I explored latent themes, which are "underlying ideas, assumptions, and conceptualizations within the data" in line with my conceptual framework and relevant ideas in the literature (Campbell et al., 2021). Analysing latent themes also aligned with my epistemological position (Clarke and Braun, 2006).

Type of analysis: I conducted a deductive/theoretical analysis considering I did a systematic review and developed a conceptual framework and therefore have prior understanding of the topic. I focused on specific parts of the data such as: how psychological distress is defined; how the cause of psychological distress is explained; how the context of, and the support for, psychological distress is perceived; how psychological distress is expressed and experienced; how psychological distress is dealt with (coping and help-seeking); and how psychological distress treatment and recovery is envisioned. I did also, however, remain open to new codes and themes that emerged (Gale et al., 2013).

Analytic process: I followed the steps of a reflexive thematic analysis (see below) as initially described by Clarke and Braun (2006) and adapted by Campbell et al. (2021).

1. **Data familiarisation**

After transcribing audio recordings of the interviews, I immersed myself in the data to begin to familiarise myself with it and begin exploring patterns and meanings.

2. **Initial code generation**

I conducted open coding.

3. **Generating (initial) themes**

I grouped together the codes to generate initial themes and begin describing the key characteristics of the themes.

4. **Theme review**

I re-evaluated the initial themes and ensured that there is sufficient data to support a theme and no overlap between themes. I looked at the entirety of the data.

5. **Theme defining and naming**

I explored the "story" of the themes and how they answered the research question.

6. **Report production**

I reported the themes and how the relate to each other and the research question, specifically focusing on presenting the convergences and divergences between first- and second-generation participants and between participants in the UK and Canada.

3.6.1 Interpretation of Findings

I used participatory methods to help me validate and disseminate my findings and write recommendations for key stakeholders.

Participatory research "refers to forms of action research anchored in the belief that the research process itself serves as a mechanism for social change" (Ponterotto, 2017). Participatory research involves working with community members (outside of the research team) at all points in the research process from ascertaining a research topic to sharing results (Duea et al., 2022). There are five domains into which participatory methods can be organized (Duea et al., 2022). I highlight what actions I took under each domain.

Engagement and Capacity Building: Engaging stakeholders can involve a one-time activity or a continuous, active collaboration. Communities can work with academics to identify research gaps and make decisions in the research process.

I held multiple informal meetings with South Asian community leaders (in some cases with individuals with direct experience delivering mental health services for the South Asian community) to ascertain research gaps and narrow the scope the study. These actions involved building close and trustworthy relationships with community organizations and attending community groups and events.

Exploration and Visioning: Using mixed methods approaches to work with multiple stakeholders and involves activities such as priority setting and problem-solving.

I worked with South Asian healthcare professionals and individuals to design culturally specific recruitment materials.

Mobilization: Working with key stakeholders to disseminate research findings that influence policy and practice.

I hosted six public consultations to explore the usefulness and relevance of the findings to the South Asian community as well as determine recommendations for key stakeholders. I also ensured that I shared the results with the wider public by sending results to participants and over 35 individuals and organizations who helped me conduct the study.

I was unable to engage in two domains of participatory research, which fell outside the timeline and scope of my study:

Visual and Narrative: Employing using visual and narrative ways to collect and present data including theatre performances, oral-history, concept mapping, photography, and videography.

Evaluation: Determining the success of the work and partnerships between researchers and community collaborators.

I must note that I did not action ‘true’ co-production because it requires each person’s contribution to be considered equal throughout the research process. While I worked closely with many members of the public throughout the entirety of the study (from study conceptualisation to dissemination), unfortunately I cannot claim to have used co-production because ultimately, only my supervisory team and I made final decisions relating to the project.

3.6.2 Public Consultations

The detailed methods for the Public Consultations are described below. I summarise these consultations in the Additional Results (Chapter 6).

I was awarded a grant from the London School of Hygiene and Tropical Medicine to conduct public consultations in London, UK and Toronto, Canada.

To actively involve the public in this study, three consultations at each study site were hosted. The consultations explored cultural appropriateness, usefulness and relevance of the systematic review findings and initial data analysis to the community they work with and/or themselves and their peers.

Consultation with the public offers unique perspectives, and these perspectives can improve the research design and the credibility of results, especially for qualitative studies. Public involvement can boost recruitment into research studies, especially for delicate topics, by bettering the quality of information participants are given, building relationships with community members, and having them champion the study in their community (Duea et al., 2022). It can also increase the validity of the data analysis process because researchers can check their initial and final results with the public (reference).

Consultation #1 on Initial Results (London, UK, Toronto, Canada): Participants in this consultation were asked to provide their perspective on emerging interpretations and themes, identify potentially missed themes, (from de-identified, analysed interviews) comment on the findings that they feel are most useful and relevant and, ultimately, help the study team address their own beliefs and attitudes that influence data analysis.

Consultation #2 on Final Results (London, UK, Toronto, Canada): Participants in this consultation were asked to provide their perspective on the final themes of the study. They were asked to comment on the usefulness and relevance of the themes and provide suggestions on how the findings can be used to improve mental health service provision in their city.

All participants must have been based in the UK/Canada, be 18+, and fluent in English. I invited a) people of South Asian origin who are health professionals (e.g., therapists, GPs), academics, community organisation staff and community leaders (e.g., faith leaders) with experience working with the South Asian community in the UK/Canada, and b) lay members of the South Asian community in the UK/Canada (direct or indirect experience with mental health problems was not necessary). For the purposes of the consultations, a South Asian individual was defined as someone who self-identifies as originating or descending from India, Bangladesh, Sri Lanka or Pakistan. Immigrant generation did not matter.

Purposive snowball sampling was used to recruit participants. Individuals who met the aforementioned criteria were identified and emailed directly (using publicly available information), invited to participate in the public consultations, and asked for their recommendations for other potential participants. The recommended individuals were also only emailed using publicly available information. If their email was not publicly available, the recommender was asked to pass on the study information to the recommended individual and ask them to contact me directly.

I also recruited lay members of the South Asian community in Toronto, Canada (direct or indirect experience with mental health was not necessary) using purposive and snowball sampling. Recruitment posters were placed in public places (such as places of worship, libraries, and community centres). I also asked community organisations to disseminate the information via social media and general mailing lists.

Individuals who participated in the interviews were directly contacted to participate in the consultations. Due to Research Ethics Board requirements in Toronto, if they did contact the study because they would like to participate, they would be allowed to do so and their status as a study participant was not divulged to the rest of the consultation participants (ultimately, no interview participants also participated in a consultation). In London, interview participants were not eligible to participate in the consultations.

The consultations were hosted both in-person (at a private room at in a public library in London) and online via Zoom. The consultations were run as a focus group and lasted for approximately one hour. Light refreshments were provided to participants who attend the consultation in-person.

At the beginning of the focus group, it was reiterated to all participants that the consultation were private and confidential, and other participants' answers should not be shared with people outside the group. The consultation was audio recorded only (no video recording) using an encrypted recording device. All participants were sent a participant information sheet, consent form, contact details form, and demographic form (as an attachment), and asked to send the filled-out copies back no later than 24 hours before the consultation. They were told that participation was private, confidential, and voluntary. Participants were sent relevant documents (for example, a lay summary of the systematic review, initial interview findings (the summary of the key emerging themes with supporting short, anonymised quotes), and general topics of discussion one week before the workshop via email. The documents were in plain English. Participants were offered the opportunity to complete both the consent process and the demographic form verbally if they were uncomfortable doing it over writing/electronically.

Feedback was documented during the consultation and after (using the transcript) and summarised. I also wrote down my personal reflections on the consultations because this is an important part of reflexivity. The feedback was incorporated into the data analysis and is reported in this PhD thesis and any relevant publications and dissemination materials.

3.7 Ethical Considerations

Toronto-based interview study participants received compensation of 25.00 Canadian Dollars (CAD) (cash gift card), which is the median amount of compensation offered by researchers in Toronto for interviews, according to a study by the Wellesley Institute (Cheff, 2018). London-based interview study participants were given compensation of 25.00 Great British Pounds (GBP), in the form of a cash gift card, as is standard according to the National Health Institute for Research

(NIHR, 2024). The gift cards were user-friendly, locally valuable (i.e., can be used at local shops) and the participants did not incur a fee upon its use. In-person participants received a physical gift card and online participants were given a virtual gift card via email.

Consultation participants were given a small token of appreciation for their time (50 CAD in Canada or 50 GBP in the UK as a gift card. The workshops were one hour; however, relevant documents were sent to participants ahead of time for their review. Payment was sent in the form of a cash gift card via email at the end of the consultation.

I did not anticipate that the interview study participants would suffer from any physical or emotional harm due to the research. However, I believed that participants could potentially experience emotional discomfort considering that the interview explored experiences of psychological distress. I ensured that the participant was aware that they can withdraw from the study at any time or can skip questions they are not comfortable answering. Participants were also given ample time to answer questions. Though it did not occur, if a participant became distressed to the point where they could not continue the interview, the interview would have been stopped, and the participant would have been given a list of local and online mental health resources. If it became clear during any interview that the participant was currently suffering from mental distress or disclosed information to the point where I was concerned about the safety and wellbeing of them or the wider public, I would have referred the individual to someone that can help (e.g., appropriate mental health support such as an acute mental health crisis team, emergency services). This information was included in the participation information sheet and the informed consent form.

I did not anticipate that the consultation participants would suffer from any physical or emotional harm due to the research. However, I prepared for this potential occurrence in the same manner as I did for the interviews in case a participant experienced emotional discomfort.

3.8 Positionality and Reflexivity

For the purposes of this study, and in line with intersectional theory and social constructivism, I chose to reject the ‘insider-outsider’ dichotomy, instead acknowledging that individuals contain multitudes (Ademolu, 2023). As Bukamal (2022) writes, “the seminal work of Crenshaw on intersectionality and the coalition of racism and patriarchy illustrates how a researcher's intersectional identity creates a reflexive experience and multifaceted positionality.” For example, while I am a young, cis, South Asian woman who grew up in a city in Canada and share those characteristics with many of the study participants, I was also raised in a predominantly white, middle-class neighbourhood, which influences the way I think about race and ethnicity and could act as a point of difference between researcher/participant.

I agree with the sentiment that “the researcher is assumed to have a *position*, and this position affects the nature of the observations and the interpretations that they make” (Bukamal, 2022) and endorse the idea that a researcher’s position as an insider or outsider to their research is an important consideration in qualitative research. An insider, who could be referred to as an “insighter,” can be described as someone “who has access to and an understanding of the history, culture and social life of a marginal group owing to his/her ‘continued socialization in the life of a group’” (Merton, 1972:15; Chhabra, 2020). Shared factors between researcher and participant can include gender, ethnicity, disability status, and sexual orientation (Yip, 2023). The primary benefits of being positioned as an insider include pre-existing knowledge and rare access to a marginalized group, which facilitates rapport building and “co-production of knowledge” (Chaudry, 2018; Chhabra, 2020). However, there are also drawbacks to maintaining an insider position, such as influencing the answers participants give (as the participants may be keen to “impress” or “agree” with the researcher). On the other hand, an outsider is someone who provides an ‘etic’ view on culture (Ademolu, 2023). They may be more likely to create culturally neutral research materials (that are scientifically sound but not culturally specific) (Holmes, 2020), “ask naïve questions” and alienate participants, especially if the participants come from vulnerable backgrounds (Chhabra, 2020).

Critics have similarly challenged the ‘insider-outsider’ dichotomy, arguing that positionality exists on a sliding scale and ‘insider’ and ‘outsider’ can be found on opposite ends; throughout the research process, researchers move back and forth on this scale in a “dynamic, continuous way” (Wilson et al., 2022). A newer idea in reflexivity and positionality thinking is the idea of being an “in-betweener researcher” who is not fully an insider or an outsider (Chhabra et al., 2020; Wilson et al., 2023).

Intrinsically linked with positionality is the concept of reflexivity. Reflexivity requires researchers to actively discover their pre-conceived ideas and beliefs and ascertain how these may have impacted how the research was designed and the data collected and analysed (Holmes, 2020). Reflexivity is an important way for researchers to continuously consider their position within the research and how it changes depending on the context (Holmes, 2020).

I considered how my identity was dynamic, fluid, and continuously changing throughout the research process. A few reflexive questions became particularly important for me on this journey (inspired by Ademolu’s 2023 work), “how is an ‘ethnoracialised sameness’ understood and instrumentalised in the researcher/researched interaction [and] what are the implications of this for negotiating and shaping fieldwork relationships?”

As is common in reflexive practice, I wrote in a journal to note my perspectives, biases and assumptions in the research process (Olmos-Vega et al., 2022). I noticed early in the ethics application and data collection process that I was reflecting on the study (my biases, how the participants perceived me, on comments from other academics) constantly. Since I did not always carry my reflexivity journal with me, I decided to jot down thoughts on the ‘notes app’ of my phone to ensure they were captured as accurately as possible.

I acknowledge that positionality and reflexivity have been criticized as a practice in recent literature. Some scholars argue that reflexivity is a form of “narcissism” and “self-indulgence” (Bukamal, 2022; Olmos-Vega et al., 2023). Gani and Khan (2024) highlight how positionality statements have racial and hierarchal implications, rooted in coloniality. They argue that positionality/reflexivity aids researchers in validating themselves as researchers, rather than the research itself, and can also ‘re-centre’ whiteness (i.e., positionality statements can act as a way to ‘other’ ethnically minoritized participants and help researchers assuage their ‘white guilt,’ both of which do not benefit the participants) and that rather than removing power dynamics between the studier and the studied, positionality statements can actually “constitute hidden power moves in which one is able to signal and re-instate one’s authority vis-à-vis people, but especially women, of colour” (Gani and Khan, 2024). Though valid, I feel as though this criticism does not apply to me considering I am a Person of Colour. Rather, I agree that “positionality, when used by the [Woman of Colour] WoC, *can* potentially contribute to decentring whiteness, as was in- tended by PoC anthropologists” (Gani and Khan, 2024).

Nonetheless, to limit the possible negative impact of positionality/reflexivity I avoided allowing my voice as the researcher to overpower that of the participant (by using quotations in any documents or presentations of the findings, for example) and clearly acknowledging the limitations of positionality. Ultimately, I believe that reflexivity is important; engaging in reflexive practices in this study added nuance to the findings *and* played a significant role in my growth as an early-career researcher and South Asian woman.

3.9 Dissemination

I wrote five manuscripts to be published in global, scholarly, peer-reviewed, open access journals during my PhD and have presented findings at international conferences.

Additionally, a fundamental part of intersectionality in healthcare research is ensuring that the results are translated into social activism (Rosenthal, 2016). Although I believe it would be an embellishment to refer to this research as a form of activism, I am still disseminating the findings beyond the world of academia (e.g., to participants, clinicians, community organizations, local councils, and mental health charities) to ensure that it is applied to policy and practice that aims to reduce inequalities in the healthcare system. For example, I did voluntary consulting work with Mind in Harrow. I have shared my expertise and study results to help the Mind team develop and run a peer-support group for mental health problems for the South Asian demographic in Harrow and beyond. Finally, all consenting participants and the 35 community leaders/organizations who supported this study will receive a short summary of the research findings.

CHAPTER 4: REFLEXIVITY

4.0 Introduction

In the following section, I have categorised my reflexive thoughts into three sections: personal and interpersonal reflexivity (how my identity shaped the research and my interactions with the participants), methodological reflexivity (how my chosen methodology impacted the research) and contextual reflexivity (how local and global context impacted the research as well as myself and participants) based on Olmos-Vega et al.'s (2022) work which attempts to guide qualitative researchers on how to engage with reflexive practices. In some parts, I feature excerpts from my reflexivity journal.

4.1 Personal and Interpersonal Reflexivity

While I have always been uncomfortable with insider/outsider dichotomy in positionality, I felt that my ethnicity was the biggest factor that I shared with the participants, which made me believe I was closer to an 'insider' than an 'outsider' if a spectrum exists. I still believe this point to be true, but eventually, it became clear to me that there were many aspects of my South Asian identity that most impacted my shared understanding with the participants.

My status as a second-generation South Asian first came under question when a first-generation participant in Canada directly said to me in an interview *"we are both Brown but we are not the same"* (noted in my reflexivity journal 26th June 2023) because of our differing immigrant generation. It was at this moment that I realised that the participants may not have perceived me as "one of them" as much as I had hoped. It contradicted so much of what I had felt from the second-generation participants, who sometimes commented that they felt like I would understand their struggles. First-generation participants may have felt more reserved in what they shared with me if they perceived that I did not have an inherent understanding of their lives or struggles, while second-generation participants could have been impacted by social desirability bias, considering me one of their peers.

I wrote about this on the 24th of April and 1st of May 2023:

“One participant said “I hope this doesn’t offend you Ruchika” and I became acutely aware of the role an interviewer plays in an interview.”

“…another time was when a [London-based] participant noted my [Canadia] accent. They asked me at the end of the interview “you’re obviously not from here?””

My second-generation status also likely affected my analysis. My upbringing and personal experiences made me particularly interested in the identity crisis among second-generation individuals and how cultural norms in family life could also lead to mental health problems. Conversations around second-generation bi-culturalism are so prevalent in South Asian culture – I jotted down a reminder of the phrases I heard so much growing up on June 3rd, 2023: *ABCD (American Born Confused Desi) and Oreo (Brown on the outside, white on the inside).* It is possible that I applied my own assumptions and understandings about identity conflict and distress to the data, rather than letting these themes emerge from the data themselves, though I hope through transparency and reflexive practice, I have mitigated its impact.

On the 21st of March 2023, I wrote the following:

“In many ways I have had similar experiences (pressure, not fitting in two cultures) but in others I haven’t (bereavement, domestic abuse). In the first case, I want to be their friend and in the second, I feel so guilty.”

I reiterated a similar sentiment on the 9th of July of the same year:

“Once again I feel a lot of empathy for recent immigrants to Canada. So many have said that it is not the country they thought or hoped it would be. And that they struggled to share how badly they were feeling to their family back home. It makes me feel guilty for thinking Canada is a pretty good country. Of course it also makes me understand my parents a little bit more. On FaceTime

yesterday, Papa was telling me he would make chopped tomato curry and eat it with rice because it was cheap. Buying fresh chapatis was only $1 but he couldn't afford it. This reminded me of a participant who only drank black coffee throughout the day because it was cheap and kept her full…"

Most of the participants in the study followed the Muslim faith. I am a practicing Jain, meaning that while I could academically appreciate how their faith may interact with their distress, I could not claim to share a directly similar experience. This difference may have influenced the research in two ways: how participants perceived me in relation to them, and in my analysis. To illustrate the first point, in one instance I felt guilty because an older participant had assumed I was Muslim or that my father was Muslim. I wondered for a second if she had only felt comfortable to do the interview based on that assumption. In truth, she was just curious to know more about my background. Regarding the analysis, it may be that my understanding of the ritual of praying five times a day as a coping strategy, for example, is superficial.

Additionally, my age and gender are an additional two personal characteristics that may have influenced the research. I am a young cis woman, characteristics which I believe participants noticed right away. In some cases, older participants would assume a parental role and ask me if I had eaten that day or would suggest nearby South Asian restaurants to pick up food from on my way out. They were also curious to know about my parents (particularly my father) and marital status. At least one community organization leader and one participant commented that I must come from a "good" or "nice" family. Despite not actually knowing the truth, I felt at the time that these comments would likely not be made to a male South Asian researcher. Considering most of the participants were women, I believed it was easier to build a rapport and for them to share some of the struggles associated with being a South Asian woman without reserve. Recruitment of male participants in my study was low; perhaps this can be partly attributed to my gender, which could be easily identified by my name on the recruitment poster.

Another important factor of my identity that I did not predict would shape my interactions with participants, but likely did, was my identity as a student at a well-known academic institution. While I have been doing my PhD, LSHTM had been publicly criticized for treating their non-

contracted staff, who are mostly all racialized individuals, poorly and refusing to bring them in-house despite strikes. Prior to that, in 2021, LSHTM was also subject to an exposé in the Guardian: "Structural racism at London School of Hygiene and Tropical Medicine, finds report." I experienced this firsthand myself – a comment from the Ethics committee which insinuated that South Asians in the UK are illiterate left me speechless. In my upgrading examination, my examiner commented that she, as a white woman, would never be told to "go home" when walking down the street, whereas I could be. At research days and public talks, I would invariably receive comments from white individuals about how the main limitation of my study was that I could only conduct interviews in English, and that I should be comparing my work to the white British or white Canadian experience. Once again, I felt like the South Asian community was being pigeonholed as an uneducated group and being told to centre whiteness for this study to matter.
In contrast, whenever I spoke about my work at informal or formal events, I had so many young, racialized people (South Asian, East Asian, Black) come up to me and say what I was doing really resonated with them and their families. It was very hard to reconcile the public perspective on LSHTM with my own experience of the work I was trying to do. I worried that potential participants who had heard of the university would be unwilling to participate due to LSHTM's past and current colonial and racist legacy. While I cannot say for sure if this did impact recruitment, I had to contend with the university's reputation throughout the data collection process.

4.2 Methodological Reflexivity

I made several methodological decisions based on my review of the literature, logistical and financial factors, and guidance from my supervisors. Some of these decisions are discussed here.

From the onset of this study, I knew that it was very important for me to consider the opinions of South Asian academics, healthcare practitioners and community leaders. Participatory research fit with my epistemological position and intersectional methodological approaches and my desire to centre voices within the South Asian community. However, since I was ultimately the decision maker, it meant that in some cases, I could not take their valuable and well-intentioned opinions on board. At times, this felt difficult to explain. For example, at a community centre for South Asian women in Toronto, I was asked to change my eligibility criteria so that the experiences of newcomers could be captured, as most of the community centre's clients had just arrived from South Asia, often due to difficult circumstances (like forced marriage). I attempted to explain that while the experiences of newcomer immigrants were very important, it did not fit within the scope of my study and that I had not received ethical approval from the university to speak to these individuals. This conversation created some tension because the community leaders held the opinion that universities' priorities were misaligned with community needs and I was the representative of the university. My first response was to agree, a lot of university-community work can feel superficial, but I knew I had to be firm and justify my choices. It made me realise that my relationship with these key stakeholders would have been even more beneficial if our relationship was formalised and we held equal decision-making power.

Another methodological consideration that may have had implications on the research was the location of the interviews. I decided to offer participants the option to have the interview conducted online or in-person. I assumed that most people would choose to do an online interview because of the convenience and comfort afforded by this option as well as the potential discomfort of meeting a new person in an unfamiliar location. In the end, I conducted 6 interviews in-person and the remainder online. I did notice a difference in the experiences that may have impacted the research. Firstly, some participants cried while speaking about emotional topics- I noticed I was more able to be present with the participants and sit in the discomfort with them when in person. I was also able to offer tissues or hold someone's hand (with permission). Secondly, I felt participants were more concerned about privacy and confidentiality in the online interviews because they did not always have a space to go. For example, one participant, typed out many of her answers in the Zoom chat because she had family members home and did not want to be overheard. Another participant had to have the interview while they were sitting in a café, which meant there was a lot of background noise and occasional hesitancy to answer questions. Thirdly, I am afraid that some older participants who were unfamiliar with video calling were deterred from participating in the study. I received a few phone calls from individuals who were interested but preferred to have the interview done on the phone. While I was pleased that these individuals were able to participate in the study, it means that there was no face-face interaction, which may have impeded my ability to build trust and rapport.

Finally, since I am a self-funded student, I had to make some methodological decisions based on my financial position. I received two small grants that funded compensation for participants from LSHTM, for which I was grateful, but there were many other project costs that I had not anticipated. For example, I had insufficient funds to rent rooms in public spaces (it is over 30 GBP to rent a room in a library in East London) in the case that a participant wanted to have their interview in-person. Additionally, to save money, I moved in with my sister in Toronto, but it meant that I was based far away from key locations with a dense South Asian population. I did not have access to a car, public transport would take me two hours each way and the costs of taxis and Ubers was too great. Unfortunately, I think the inconvenience and expense of getting to libraries, community organizations and places of worship meant that I did not visit these important locations as often as I had hoped, which may have hindered my recruitment efforts in Toronto.

4.3 Contextual Reflexivity

Between February 2023 and June 2024, the period in which I collected data, many global events occurred that affected both me and my participants. Perhaps the biggest event was the beginning of Israel's ongoing genocide of Palestinian people. Many people of South Asian origin told me they were deeply hurt to see Brown bodies treated as inferior to white ones and that witnessing the decimation of an entire population was difficult to comprehend. I was ashamed sending out recruitment emails on particularly destructive days – I felt silly trying to go on with the study and was worried that I would seem inconsiderate. I also think people were being overwhelmed with sad news and did not feel like they had the capacity to speak about their mental health. It was clear that the topic of Gaza was on the forefront of people's minds. It came up in different ways- one participant said she was too burdened by her own distress to be able to care about Gaza, while in a public consultation a participant said they feel guilty for their distress, considering the conflict ("*do you think people in Gaza have time to think about their mental health?").* Overall, I believe this event may have slowed down the recruitment process and tied the data to a specific point in time. More positively, it has also showed me and other members of my community why this study was so important. Although miniscule in scale, this study is part of a wider movement to overcome white supremacy and shift power imbalances globally.

Then, in July 2024, violent, racist, anti-migrant and Islamophobic riots across the UK incited fear and trauma across many South Asian communities. I knew many racialized individuals, especially brown individuals, who were afraid to leave their homes. This fear was well justified; there were reports of hotels housing asylum seekers being set on fire, bricks being thrown at Mosques and people being called racist names in public places. The legacy of these riots, in my opinion, is the evidence that years of austerity and far-right politics in the UK have left the country in chaos and it is ethnically diverse and migrant populations who are most dealing with the consequences. It is possible that if the riots had happened during my data collection period, themes around racism and discrimination and its connection to distress would have been more apparent. I also wonder how the results would differ if I repeated the same study in more deprived areas of the UK, where most of the riots took place. Currently, my data is very London-centric and the experiences of South Asian immigrants in other cities is also important to consider.

On a more positive note, this study was also conducted in the context of growing interest on mental health in the South Asian community. For example, the challenges faced by second-generation South Asians became an important topic in pop-culture through TV shows and movies such as Never Have I Ever and What’s Love Got to Do with It. Instagram accounts such as BrownGirlTherapy, which gives advice on how to navigate South Asian family dynamics, also rose in popularity globally to the extent that the creator now has a book on this subject. Through the research process, it felt validating to know that the South Asian community was being seen and that efforts to address mental health were becoming more widespread and culturally sensitive. Ultimately, I believe this study can benefit from this interest; lay individuals, healthcare professionals, policymakers may be more likely to pay attention to the findings.

CHAPTER 5: QUALITATIVE PAPERS

5.0 Introduction

In this next section, I present four qualitative papers. These papers highlight how the study participants a) perceived the symptoms, causes and consequences of their psychological distress (explanatory models) and b) where they went to for help and whether they considered that help to be successful. The first two papers focus on the results pertaining to the first-generation participants, while the second two papers focus on the second-generation participants. I chose to present the results in this manner due to the lack of existing studies that distinguish by immigrant generation. A detailed discussion of the convergences and divergences of the results between immigrant generations is presented in the Discussion chapter.

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SECTION A – Student Details

Student ID Number	1702879	**Title**	Miss
First Name(s)	Ruchika		
Surname/Family Name	Jain		
Thesis Title	The Cultural Conceptualisations of Psychological Distress and Help-Seeking among South Asian Immigrants in the UK and Canada		
Primary Supervisor	Dr. Abhijit Nadkarni		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

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Where is the work intended to be published?	PLOS Global Public Health
Please list the paper's authors in the intended authorship order:	Ruchika Jain, Ritsuko Kakuma, Daisy Singla, Abhijit Nadkarni

Stage of publication	**Not yet submitted**

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	Ruchika is the lead author. She was involved in conceptualisation, data curation, formal analysis, funding acquisition, investigation, methodology, project administration, validation, and writing (original draft, review and editing). Ritsuko, Daisy, and Abhijit contributed to supervision, study conceptualisation and methodology and also reviewed and edited the manuscript.

SECTION E

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Date	07/01/2025

Paper #2: Explanatory Models of Psychological Distress among First-Generation South Asian Immigrants in Canada and the UK: A Qualitative Study

Abstract

Background: Mental health conditions are a leading cause of global disease burden, with immigrant populations facing higher prevalence rates due to factors such as discrimination, acculturative stress, and economic vulnerability. First-generation South Asian immigrants in high-income countries, such as Canada and the UK, experience similar or higher levels of mental health problems compared to the general population but underutilize mental health services due to systemic and cultural barriers, including stigma and differing explanatory models of distress. This study investigates how first-generation South Asian immigrants in Canada and the UK define, experience, and perceive psychological distress to inform the development culturally sensitive mental health interventions.

Methods: We conducted semi-structured interviews with first-generation South Asian immigrants in London, UK and Toronto, Canada with a self-reported experience of psychological distress within the past five years (n=17). We analysed the data using a reflexive thematic analysis. We validated the results by hosting six public consultations with the South Asian community (n=40).

Results: Participants attributed their distress to post-migration stress, physical ill-health, familial factors and racism and discrimination. Their distress manifested as psychological and physical symptoms such as overthinking and disturbed sleep. Participants felt that their experiences of distress led to isolation, which deteriorated their relationships and impacted their work and daily lives. Participants used a range of medicalised and non-medicalised terms to describe their distress, whether they had been diagnosed with a mental health condition or not.

Implications: This study highlights the critical need for enhanced mental health support for first-generation South Asian immigrants. Incorporating individuals' explanatory models of distress into

standard practices in clinical and non-clinical settings is essential to improving communication, treatment outcomes, and reducing stigma.

Introduction

Mental health is among the top ten leading causes of disease burden worldwide and the number of disability-adjusted life years attributed to mental health conditions are growing rapidly (GBD 2019 Mental Disorders Collaborators, 2022). This global burden is currently estimated to cost five trillion U.S. dollars (Arias et al., 2022) and this economic consequence, as well as other societal impacts, will continue to increase (Arias et al., 2022).

Migration can negatively impact mental health due to factors such as ethnic discrimination (including interpersonal racism, xenophobia, and social exclusion) (Cerda et al., 2022), acculturative stress, and economic vulnerability (e.g., unemployment) in the host country (George et al., 2015; Disney, 2021). Therefore, the risk and prevalence of mental health conditions is higher in immigrant populations (Shea and Wong, 2022). Close et al. (2016) estimate that depression and post-traumatic stress disorder levels are 5-44% and 9-36% respectively for immigrants compared to 8-12% and 1-2% in the general population.

As of 2020, there were 281 million individuals residing in a country outside of their country of birth. It is the responsibility of host nations to respond to the needs of their increasingly populous and diverse societies, particularly when it comes to mental health services. Immigrants face many challenges in accessing mental health care such as language barriers (and consequent communication issues), unique make up of family units, and, perhaps most importantly, differing cultural values than that of the general population (Kirmayer et al., 2011). Though culture is variably defined in research, it is well established that it can impact the way individuals understand, experience, and seek help for illness, commonly referred to as 'explanatory models' (Kleinman,1980). Understanding an immigrant or ethnically marginalised group's explanatory models for mental health, without allowing for stereotyping, can improve overall health outcomes (Dinos et al., 2017).

Immigrants originating from South Asia make up a significant part of the population of high-income and Western countries such as the United States of America, Australia, Canada, and the United Kingdom (UK) (Buettner, 2020). In fact, in 2020, the highest number of migrants globally had come from India (Vakil et al., 2023). Although estimates of mental health conditions in the South Asian diaspora vary depending on the nature of the sample, the type of analytical approach and the type of outcome, evidence suggests that first-generation South Asian immigrants experience similar or higher rates of mental health conditions than the general population (Karasz et al., 2019). For example, Islam et al. (2014) found that South Asian immigrants experienced anxiety disorders and life stress more than Canadian-born South Asians (3.4% versus 1.9%). Older South Asian women, in particular, are at high risk of attempting suicide (McKenzie et al., 2008). This heightened prevalence is likely due to economic and societal disadvantage, racism and discrimination, and culture shock (Shah et al., 2023).

In both Canada and the UK, despite South Asians experiencing similar to higher levels of mental health problems compared to the white population, they tend not to engage with mental health services. In the UK, the Asian ethnic group was found to be 38% less likely to receive treatment for a Common Mental Disorder (CMD) than the white ethnic group (Ahmad et al., 2022). Although systemic barriers (such as lack of translators, inappropriate or discriminatory treatment by healthcare professionals, and long waiting times for specialist services) significantly impact help-seeking for this population, cultural factors such as somatisation, collectivism, and stigma can also inhibit informal, semi-formal and formal coping and as such, require formal investigation.

Both research and public health interventions are primarily targeted at immigrant groups by ethnicity; generational status is often disregarded (Iqbal and Golombok, 2018; Chimienti et al., 2019). However, evidence suggests that the epidemiology of mental disorders as well as explanatory models and help-seeking is shaped by generational status, age of migration and length of residence in a host country. The experience of psychological distress and help-seeking patterns differ between immigrant generations because of factors such as acculturation, which is “cultural change that results from continuous, first-hand contact between two distinct cultural groups" (Berry, 2005). In fact, ethnically diverse first-generation immigrants are less likely to engage with mental health services than ethnically diverse second-generation immigrants (Soorkia, 2011).

While the issue of mental health in the South Asian diaspora is gaining attention, there is little to no research to date that disaggregates participants by immigrant generation, age of migration and length of residence in host country. In this study, we interviewed first- and second-generation South Asian immigrants in Canada and the UK with at least one self-reported experience of psychological distress to understand these groups' explanatory models and help-seeking intentions, attitudes and behaviours and help inform the delivery of culturally sensitive services. In this paper, we report on how first-generation South Asian immigrants experience, define, and perceive the cause and consequence of, psychological distress.

Methods

Study Design

We conducted semi-structured interviews with a convenience sample of eligible and consenting participants. Qualitative methods such as interviews are particularly well suited to investigate culture, an historically ill-defined concept in research, because they can "generate the kinds of descriptive data that render culture more concrete and local" (Karasz and Singelis, 2009).

We took an intersectional methodological approach because we were concerned with "how an array of social systems intersect to shape each person's experiences" (Misra et al., 2020). Actions included using culturally sensitive recruitment materials and sampling techniques, conducting reflexive practice, and recommending policy and practice changes based on our findings with a social justice orientation. In line with this intersectional lens, we took a social constructivist epistemological position, which shifts away from biomedical explanations and emphasises the role of culture in mental health definition and help-seeking (O'Reilly and Lester, 2017).

Study Sites

We interviewed participants who lived in 1) the Greater Toronto Area (Canada), and 2) London (UK). Both cities are based in high-income, Western countries and host a significant and growing minoritized South Asian population (Statistics Canada, 2021, Mayor of London, 2022).

Participants

Participants were eligible if they 1) spoke conversational English, 2) were over the age of 18, 3) had experienced self-reported psychological distress that has impacted their daily life for a sustained period in the past 5 years. Additionally, they 4) must have been born in India, Pakistan, Bangladesh, or Sri Lanka, 5) have moved directly to the UK or Canada as an adult and 6) have resided in their host country for 5 years or more.

Participants who migrated before the age of 18 were excluded because the mental health experiences of children and adolescents are distinct from those of adults. Immigrants classified as 'newcomers'—those residing in their host country for under five years—were excluded from the study. This decision was informed by an interview with a participant who had been in the UK for six months, which highlighted the distinct mental health challenges faced by newcomers compared to those who are more established.

We developed a culturally and linguistically sensitive tool for potential participants to gauge whether they met our criteria for 'psychological distress' or not. Six South Asian individuals with professional or personal experience in the topic provided us with a list of symptoms they associated with CMDs in the South Asian community. We used these words to create a word cloud (Figure 1) that was placed prominently on the recruitment poster along with the question: "*within the past 5 years, have you experienced one or more of the following in a way that has impacted your daily life for a sustained period of time…?*"

Figure 1. Multi-language word cloud of symptoms used to recruit participants.

Sample Size

We aimed to interview a maximum of 20 participants but stopped data collection prior to reaching this number due to gaining considerable information power, meaning our sample provided us with rich and important information (Clarke and Braun, 2019).

Procedures

We recruited participants using purposive and snowball strategies (Abrams et al., 2020). RJ connected with community organizations who in turn shared the recruitment poster with their clients. RJ also shared the study information via online newsletters and social media. Finally, she placed posters in public spaces including libraries, community centres and places of worship. We believe that most participants heard of the study through community organizations such as Punjabi Community Health Services in Canada and Henna Women’s Group in the UK.

We used an interview schedule (Appendix) to guide the conversation with participants. It was inspired by conversations with relevant professionals and a systematic review of the explanatory models of, and help-seeking for, CMDs (Jain et al., 2025) as well as existing tools (Lewis-

Fernandez et al., 2020; Groleau et al., 2006, Kleinman and Benson, 2006). The interview schedule was designed to ask participants about their symptoms, how they would describe their distress to friends and family, who they went to for help and how successful the help was. Initially, we piloted the interview schedule with four members of the South Asian community in the UK and Canada and incorporated the feedback to ensure the questions were clear. We reviewed the interview schedule during the data collection process and added or rephrased questions based on initial findings.

RJ conducted the semi-structured interviews and each interview lasted approximately 45 to 75 minutes. They were hosted via Zoom and in-person at a local community organization. We recorded the interviews and stored the audio files on secure servers. One participant preferred not to be audio recorded so RJ took detailed notes. In another case, a participant answered some questions via the Zoom chat (because she did not want to be overheard by other members of her household), which was also thoroughly noted. RJ and ND transcribed and de-identified the audio recordings. The transcripts were then uploaded and analysed on NVivo 12.0.

Analysis

We undertook a reflexive thematic analysis, using work by Clarke and Braun (2006) and Campbell et al. (2021).

RJ re-read the transcripts multiple times to familiarise herself with the data and look for patterns and meanings. She conducted open coding, using both semantic and latent codes. Codes were organised under the following categories: *problem definition, perceptions of cause and context, expression of distress, and experience of distress.* We then grouped the codes to create themes and subsequently defined them. We constantly assessed the themes to ensure they were detailed and unique. We then evaluated how the themes worked together to address the research question.

In line with the goals of the study, we analysed the UK and Canada datasets separately and then triangulated the themes.

RJ conducted the analysis with supervision from AN, RK, and DS.

To enhance the credibility of our coding process, we initially invited two qualitative researchers (NA and GV) to independently code randomly selected sections of the interview transcripts in order to calculate kappa scores (Landis & Koch, 1971). Although the use of kappa scores is typically associated with a positivist epistemological position (where "findings [are]… presumed to represent an objective reality rather than an artefact of the research process") we considered this step a way to increase transparency in our coding (O'Connor & Joffe, 2020).

Importantly, our study is grounded in intersectional theory, which emphasises that qualitative research should have tangible implications for policy and practice. We initially believed that reporting kappa scores might help the findings be taken more seriously by multidisciplinary stakeholders, a view which advocates of intercoder reliability have also shared.
However, the use of intercoder reliability remains contentious within qualitative research. Braun and Clarke, whose guidance informed our use of reflexive thematic analysis, argue that kappa scores "essentially contradict the interpretative agenda of qualitative research" (Braun & Clarke, 2013; O'Connor & Joffe, 2020).

Consistent with a social constructivist epistemology, we reject the notion of a single, objective 'truth' and instead recognise the legitimacy of multiple, situated perspectives. As such, we acknowledge that our interpretations are inevitably shaped by our intersectional identities and lived experiences. For instance, R.J., the lead researcher, is a second-generation South Asian, whereas the co-coders do not share this background.

Following further reflection on our epistemological position, and discussion with other qualitative researchers we changed our minds and decided not to present the calculated kappa scores, recognising that doing so would be incongruent with our social constructivist orientation. Nevertheless, we remain transparent about having undertaken this step and would like to critically engage with its implications.

We asked individuals belonging to the South Asian community in the UK and Canada (who were above the age of 18 and English-speaking) to comment on the initial and final study results at six different occasions. This allowed us to ascertain whether our data analysis rang true with the South Asian community and which key cultural issues they felt we should share with stakeholders.

Ethics

Ethics approval was granted by the London School of Hygiene and Tropical Medicine (UK) and Mount Sinai Hospital (Canada). We developed a list of support services to be shared with participants if they became visibly distressed during the interview. As compensation, we provided participants with a gift card of $25CAD/£25GBP.

Reflexivity

RJ engaged with reflexive practice for the duration of the study, particularly focusing on how her identity as a young second-generation South Asian Canadian female may have impacted the research. Considering intersectional and social constructionist perspectives, RJ did not approach the study as an 'insider' due to the idea that all individuals (especially ethnically minoritized ones) possess multiple identities (Ademolu, 2024). She considered how her upbringing, biases and lived experiences influenced the design of the study, her relationships with participants and the data analysis.

Results

Participant Demographics

We interviewed a total of 17 participants of whom most were women (n=13). The participants were born in India (n=7), Bangladesh (n=4) and Pakistan (n=6). Their ages ranged from 29-76. The participants were retired (n=4), a 'housewife' (n=3) or in full-time employment (n=10). Their distress ranged from a little intense to very intense, as rated on a graphical Likert scale. Reasons for migrating included marriage (n=8), education (n=5) and wanting a ‘better life’ (including escaping political instability) (n=4). Participants were between the ages of 18-34 when they migrated and had spent 5-58 years in their host country. Participants were based in the UK (n=10) and Canada (n=7).

Key Themes of Explanatory Models

The primary findings from the analysis are presented here. When describing the themes, we use the term ‘distress’ to refer to participants’ self-reported mental health experiences.

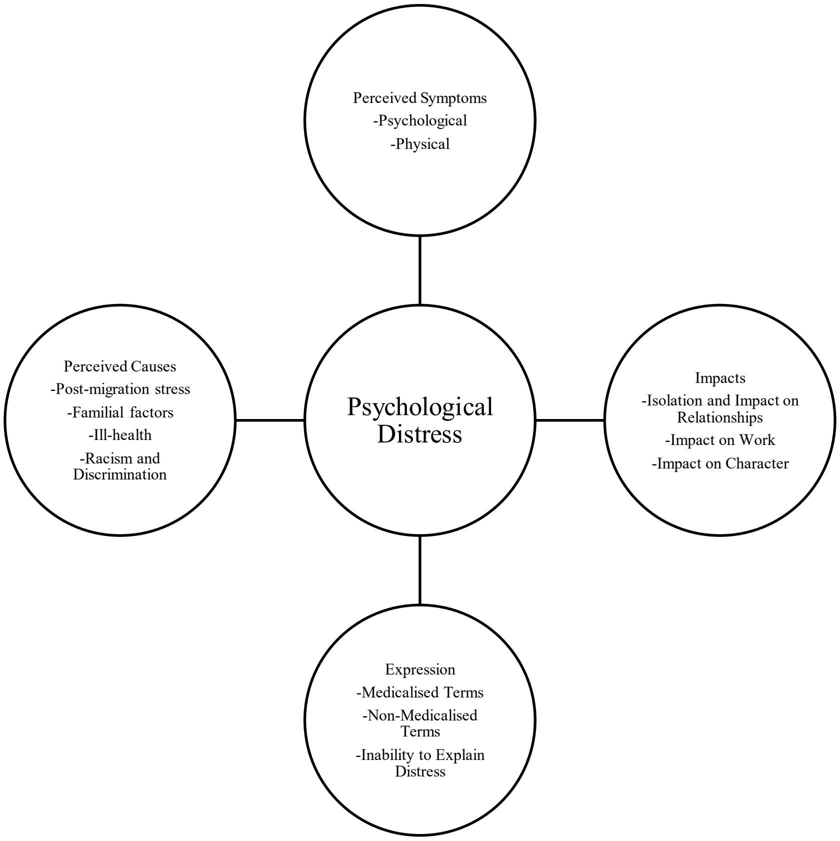

Figure 2. Explanatory models of psychological distress among first-generation South Asian immigrants in the UK and Canada.

Manifestation of Distress

Psychological Symptoms

Participants reported experiencing a range of mental/emotional symptoms related to their psychological distress. The most commonly reported symptoms were overthinking (about their current or future problems) and crying (including crying hysterically or continuously, screaming or feeling like one could cry at any time).

"I used to be hysteric. I used to bawl my eyes out. I used to cry. I used to lament." (Canada, Woman, 34)

"Emotional is like heavy hearted, your heart, you feel like the world, and then the tears come in your eyes, like I am feeling sorry" (UK, Woman, 75)

Participants also described a lack of motivation, feeling unable or unwilling to complete routine tasks or socialise with people. In some cases, the lack of motivation was described as "depression" "laziness" or a "bad mood".

"It's more like depressed but, I don't know if sometimes, to me it might feel like laziness as well. But honestly, maybe now, but at some point I'm pretty sure it wasn't laziness. Depression it's more like, I just don't want to get out of the bed, I don't want to get out of my place. I don't want to see anyone" (Canada, Woman, 29).

"You don't feel like doing things or going out, you just stay at home, and not…not taking interest in doing work, housework, attending the party or this thing" (UK, Woman, 75).

Participants cited symptoms also such as frustration, irritability, anger and negative thinking. One participant described feeling angry, annoyed and "disgusted" when experiencing racism and discrimination in the workplace. Another participant described getting very angry at "small things" and feeling like she wanted people to do things right away. Another mentioned that frustration, irritability and negative thinking, were not key features of his personality when he lived in India.

"…but then when I am down, I talk a lot of negative. I give everything that is bad about the place and I feel I, I have been more of a negative oriented, you know, thinking because of this mood swing of mine as compared to what was it before. I talk more negative than positive in my life you know." (Canada, Man, 53)

In two rarer cases, participants described having suicidal thoughts (but knowing that they would likely not act on these thoughts).

"And at some point I was feeling that it was not worth living. But I only felt I need to live because I don't want to make my parents suffer and cry" (UK, Man, 30s).

Other mental/emotional symptoms mentioned by participants included feeling low (described as sadness, anxiousness and hypervigilance, depression and "feeling bad," forgetfulness, a lack of concentration, nervousness, fear, and getting hallucinations or flashbacks.

Physical Symptoms

Participants primarily reported experiencing physical symptoms related to their distress in two domains: appetite and sleep.

Participants claimed that they were unable to sleep when feeling worried or stressed about something. For a couple of participants, when they were falling asleep or had fallen asleep, they experienced hallucinations and vivid dreams. In one case, a participant cited their lack of sleep as a cause for, and symptom of, psychological distress.

"I would wake up in the middle of the night…it was just so unsettling that I would wake up at night and then my heart would be palpitating and I would have to like drink some water and put myself at ease" (UK, Woman, 41).

Psychological distress also impacted their eating habits. Some participants felt unable to eat, while others described overeating (as a symptom of distress and as a coping strategy, which will be discussed below).

"I eat too much when I'm stressed out…I can't eat too much sugar…I eat too much when I'm stressed out, I will eat chocolates, I'll eat sweets, I'll eat everything when I'm stress out. Which is not good for my health" (Canada, Woman, 37).

"[When feeling angry, participant binge eats] then you realise that it is not good for your health and then you just stop. At the moment you don't know what you are doing, that's it" (UK, Woman, 75).

Many participants described physical symptoms such as heart palpitations, "heart sinking" and difficulty breathing (e.g., "choking").

"I'm feeling down I could feel that my heart is sinking like something bad is going to happen" (Canada, Woman, 38).

Perceived Causes of Distress

Post-Migration Stress

Participants mainly attributed their distress to post-migration stressors such as adapting to a new culture, lack of a support system after moving, housing and financial difficulties and loss of self-esteem/confidence.

"So I would say as a first immigrant or as a first generation coming outside, it's not easy. You have to face like, every single thing to get that success in your life so that your second generation could get a better life here" (Canada, Woman, 30).

Many female participants felt distressed by having to manage all of their household responsibilities, which was not the case in their country of origin where they had access to paid house help (e.g., drivers, cooks, maids).

"I have to do some work here, in Pakistan I have servants, four servants I have. But now whole work I have to do and it's very…and I have arthritis, this is the problem of me. And it is very difficult to walk and do the work. Look at my hands. And…I am just…very miserable…life…very miserable life" (UK, Woman, 76).

"Because here it is like a one thing at a time works the best, in India maybe we can do multiple things, but we have multiple support systems, we have a house help that is coming twice a day so you don't care about taking care of those chores that you are taking care of here" (Canada, Woman, 35).

Some participants reported losing their self-esteem and confidence after migrating because they did not know how to tackle chores or were finding it tough gaining employment, which they perceived contributed to their distress.

"I did start questioning my skills, my worth, you come in to a situation of self-doubt entirely…It kind of started demotivating me, I'm a person who talks a lot, and I stopped talking at all, only whatever is required, and I wasn't feeling good anytime. There came a point where I was feeling that my only job was to clean the house, cook meals, take care of, feed the babies. And that's not who I was, because since childhood we started going out, we went to school, college and then start working, there never ever [was] a day where I stayed home like this and now here I am not getting any opportunity" (Canada, Woman, 35).

Household tasks and taking care of children were especially challenging for the participants because many did not have family members who could be available for support (e.g., babysitting) in their host country.

"So when I came here actually, like back home we have lot of support. We have parents there, we have our families there whenever you need them. And especially when you have little kids and managing that balance between a family and work is very hard" (Canada, Woman, 37).

Participants also found it difficult to spend time with people in their host country (the UK or Canada) because it is not in the culture to just show up for a visit, unlike their countries of origin. One participant even said that Canada was more individualistic and selfish in culture, which was difficult to adapt to.

"My whole family are near that's why we are very happy, sometimes they come at my house and sometimes I go to their house. But not here. There is nobody come at my house and I can't…very difficult to go to their house" (UK, Woman, 76).

"But here [Toronto], I have found selfishness is there. I don't know that is the correct word to put it in there. Like, people are very like very private, it's a very individualistic society" (Canada, Woman, 35).

Many participants also faced/are facing housing and financial difficulties in their host country. Housing in the UK and Canada was perceived to be smaller. Basement apartments (in Toronto) were also distressing, due to their claustrophobic nature and lack of natural light. Financial insecurity was also a frequently cited as a cause of distress. Participants were unable to afford groceries, rent, or in one case, boots to walk in the Canadian winter. One participant said due to her finances, she was unable to invite her friends over for a meal, saying "they are inviting me, and I feel shame." Another participant spoke about how she may have to sell her home to cope with the increased cost of living in Canada, but how going back to a "poor life" means that people in her community could "bully" her and that she "lost…[her] social life."

"But when I moved to Canada…so the basement culture is new for an immigrant person. Back in home you don't have basements…it's kind of a bunker feeling that you were in a war zone and you're just stuck inside you cannot see the light you cannot feel the air you know you feel restricted" (Canada, Woman, 38).

"But then slowly, slowly, I adjust there, and now I am happy here, I don't want to go back home, but some depression and some troubles, flat trouble. My husband on the pension now and it is very difficult with the pension for old people" (UK, Woman, 76)

Familial Factors

Participants cited a range of factors relating to family that they perceived related to their distress.

Female participants described being abused, manipulated, or controlled by their partners (boyfriends or husbands), leading to intense psychological distress. The distress stemmed from a lack of freedom and independence, not being allowed to work, being the only person accountable for household responsibilities, inability to leave their partners due to the cultural expectation to not divorce, and constant fighting.

"So, most of the time, 80% stress give me, my husband." (Canada, Woman, 34). This participant described how her husband controlled her finances, forcing her to hand over her earnings, and prohibiting her from seeing certain members of the Bangladeshi community in Toronto that he did not approve of.

"Of course, the social pressure that we have in our South Asian community. The first divorced daughter, that's not good thing. I've got my three other siblings I was going to impact them all of that, so you know I decided to stay [after finding out that her husband had been cheating and controlled where she went and when]" (UK, Woman, 41).

"My husband said no you can't do work after I…when I had children because of the child minding…I said no, I want to work, but he said no. So, I used to look after them…that's all" (UK, Woman, 75).

Participants tied the aforementioned factors to gender expectations in South Asian culture. Particularly, participants found it challenging to balance their work and household responsibilities. In some cases, participants were expected to work full-time (due to financial pressure) and be primarily responsible for the household. In others, participants were banned from working outside of the household to raise their children.

"…even if you have a partner…still the household responsibility for the child rearing responsibilities are still on woman even though the woman is still going out to work spending almost ten hours outside, you know, one hour commute, one hour back to commute, then in the kitchen, her job never ends." When asked how this impacts the participant's distress, they replied, *"it takes a toll on you because you care for everybody, and you cannot make everyone happy, so you feel like a failure at times and then there's always so much things to do like in your life there are so many things to do even if you've done so much" (Canada, Woman, 38).*

"…feel like I don't have support that's what I feel like I'm overwhelmed like my husband he's busy with his business and stuff and sometimes I have this disagreement with him, an argument with him, like that he is not helping me enough… I feel like he's not sharing my mental burden like he's not thinking ahead with the children or what should we do about it or…I feel like I have all the burden on me I feel like I'm overwhelmed" (UK, Woman, 41).

Participants also attributed their distress to grief, having experienced a recent bereavement (e.g., a participant's mother passed away in India during COVID-19 pandemic and she was unable to attend the funeral) or illness of a close family member (e.g., a participant's young daughter was diagnosed with a rare condition and was hospitalised, leading to a "the feeling of extreme helplessness."

Some participants claimed that their distress was due to birthing and raising their children in their host country. For example, some participants struggled with teaching their children the values of their country of origin, especially regarding respect for their elders. In contrast, other participants were grateful to be raising their children in a different country, where their children could meet individuals from diverse backgrounds and learn more in school.

“In my back country, my son is like 11. This age is, we are very respectful from our parents, but in Canada, they are not very much respect for their parents. They treat like, they are know everything, they are adult.... But in my back home, in this age, we are very obey to our parents, we listen to our parents, we listen to our parents, But here… they don’t respect our struggle, our sacrifice” (Canada, Woman, 34).

“…then again respect, NOT talking about agreeing but being polite is ingrained. loose or crude language is abhorred we don't classify it as freedom of expression…we have strong commands about respect to parents in the Quran” (Canada, Woman, 68, via Zoom chat).

“We want to give them our values, whatever we’ve learned from our families back in India, the way we grew up. I know times have changed. We were different then, the situation is different now. But, I always have that fear, what’s going to happen next, whether they’ll be able to understand our values, our religion, because they are growing in a mixed community here, diverse community” (Canada, Woman, 37).

“I feel better…definitely knowledge is…they gain her knowledge, a lot of knowledge, you can’t get a lot of knowledge in Pakistan. They are very social in this country; they are not social there” (UK, Woman, 76).

Some participants felt that the pressure from their families was partly to blame for their distress. Pressure usually came from parents, who needed financial support, wanted the participant to be perfect and succeed as an immigrant or were desperate for the participant to get married.

“But this [getting married] is not in my hand and someone like sitting on my head and trying to pressurize me about something that’s not in my hand is like actually really hard to handle” (Canada, Woman, 29).

“Family. I was not even afraid of like going to the class or something, but the most stressful thing was, you know when they called me and asked me “how's everything?” [Participant would reply:] “Good”. And I was like if I tell them it's not good, they would just be like, why? Are you doing

something, you know, like the brown parents always telling you be valued, you know, try to do this with everybody, like they want you to be perfect rather than anybody else" (Canada, Woman, 30).

Ill-Health

Some participants attributed their distress to ill-health due to child rearing such as a miscarriage, trauma from a C-section, pain from sutures after giving birth and being very sick with COVID with a baby to care for. Other participants reported that the health condition of a close family member (e.g., a participant became distressed at her son's autism diagnosis, a participant suffered from Post-Traumatic Stress Disorder after his daughter became sick with a rare condition and another participant was impacted by her husband's increasing dependence due to old age) caused their distress.

"Because of the postpartum depression you feel like there's part of it that is gone even though the baby's in your hand but you still feeling that something was there and now it's not and you start to relate OK because of her I went through so much pain and I'm not feeling the happiness that I should be feeling when I can actually see the baby and hold her but I was more relating to the pain that the surgery had caused me and the panic that that was around the whole process. And then because of the depression I cannot breastfeed my child for that much time" (Canada, Woman, 38).

Racism and Discrimination

A few participants commented that they experienced racism and discrimination (particularly when looking for jobs), which caused them distress. Participants in Toronto were told by potential employers that their overseas qualifications were not adequate and that they lacked Canadian experience. For example, one participant was a national swimmer in India, but was unable to get a job as a swim instructor in Canada.

"If you move to Canada, it is going to be a first-rate country but the third-rate citizen and I really felt that, you know, because I don't know, I don't feel myself belonged here" (Canada, Man, 53).

"Distress would come up in when you feel like there's a barrier or there's some sort of discrimination or you are being held back because of your ethnicity or your background" (Canada, Man, 73).

"So, at the time I used to wear a scarf so I faced some Islamophobia and discrimination from some of my colleagues and you know these odd comments and at the time I was like really…cause I was just settling in so I didn't know how to deal with that" (UK, Woman, 41).

Expression of Distress

Participants described their distress using a combination of non-diagnostic and diagnostic terms.

Non-Medicalised Terms

Participants used numerous non-medicalised terms to describe their distress. "Stress" was a particularly popular term. A couple of participants also referred to their distress as feeling disturbed or not mentally fresh. Some participants used metaphors such as "[feeling] uncomfortably out of water," "[being in a] sink hole," and having "strings pulling at you" or thoughts "eating [my] brain and my nerves up."

Medicalised Terms

Many participants used diagnostic terms (e.g., depression and anxiety) despite never having been diagnosed with a CMD by a clinician. There was one exception: a participant described their distress as Post-Traumatic Stress Disorder after having been formally diagnosed.

The results regarding whether the participants would use diagnostic terms to describe their experiences to others were mixed. One participant would use the word "depression," while another said that she would not use the term if describing her distress to friends and family (because they may equate the term depression to something too serious for the participant's liking). Another participant mentioned that the term depression is used very loosely ("even for normal, silly things") in the South Asian community now. In some cases, participants learned these terms from their second-generation children or by conducting independent research (by going to the library or reading articles online).

"So, I wouldn't use the word depression. Definitely. I might camouflage it with some other word like I am feeling low, down or something like that. I won't use the word depression, definitely" (Canada, Man, 53).

"I would use the word because sometimes just explaining all those things they're like…we also go through these things… but it doesn't mean that you have something" (Canada, Woman, 38).

"at least depression is now a loose term. used v casually but still somewhat ok" (Canada, Woman, 68, via Zoom chat).

Inability to Explain Distress

One participant expressed being unable to put their distress into words and others had some difficulty explaining what they meant by feeling anxious or depressed.

"…because sometimes there is no reason behind why are you feeling this way, you can't actually explain them that why you're behaving that way or why you're feeling that way because you actually don't know the answer yourself so how are you going to explain something to someone when you are actually unaware yourself that what is happening" (Canada, Woman, 38).

Consequences of Distress

Isolation and Impact on Relationships

The primary way participants felt distress impacted their lives was isolation. Participants explained that their symptoms of distress ultimately hurt their relationships. Their symptoms had two negative effects: rendering them unable to reach out to others (leading to isolation and loneliness) as well as affecting individuals close to them.

Participants' distress made them unwilling or unable to socialise (e.g., stop attending parties, returning text messages and phone calls, staying in your office during coffee breaks and lunch) and connect with other people. Loneliness was one of the consequences of isolating themselves because of their distress.

"Despite having family. Despite having a partner. Despite having a social circle. I still feel very lonely. I am not attached, you know" (Canada, Man, 53).

Another consequence was deteriorating relationships with friends and family because the participants would feel inadequate (from low self-esteem and confidence) and/or not communicate with them.

"I think because then you separate yourself from people who care about you and stop texting back to people who are checking on you" (Canada, Woman, 38).

Additionally, participants described how their symptoms unintentionally hurt the people immediately around them.

"My relationship was impacted of course, badly in terms of my conjugal life. I was always crying. I was always, you know. I was always banging my head; I was always breaking down. Of course it cannot be…it cannot solve…living life with a person like that, of course, would not feel pleasant, but thanks to my husband who showed great patience, bared with me, baring with me, my tantrums, my frustration, my breakdowns" (Canada, Woman, 34).

"I found out that [participant's symptoms of distress such as negativity, anger and anxiousness] was really affecting my ability to kind of you know be with my daughter, support them in a good way" (UK, Man, 35).

Although results pertaining to help-seeking will be discussed in another paper, it is important to note that participants' negative experiences with help-seeking also impacted their relationships (i.e., some participants stopped speaking to their friends and family members because they did not know how to explain their distress, did not think that anybody would understand, and want to avoid questions/having to speak about their distress).

"And this does disturb your family life as well because if you go home and you say I don't want to talk to anyone, I want to sit alone, in our culture, they will probe you more further rather than leaving you alone and getting you back in some time. They will…no no, what is wrong, tell me what is the issue and all those. So you get more irritated…just leave me alone, please don't talk to me. Then that adds to it. Then of course that adds a few issues with the relationship but luckily it didn't go into the extremes" (Canada, Man, 53).

Impact on Work

Some participants also mentioned that their distress impacted their work because they get triggered by their clients' stories, do not go for interviews or take career risks, and procrastinate.

"I love my job, and I have some difficult clients sometimes. They are part of me, so sometimes I take their stress as well. Like something is going on in their lives I think too much you know… I just take it sometimes personally, like what if it happens to us you know" (Canada, Woman, 37).

"I think I have never really admitted it a lot that I feel way behind in my life. Work wise specially…" (Canada, Woman, 29).

Impact on Character

A few participants also discussed how their distress led to an impact on their personality. For example, two participants said they were previously extroverted; they loved going out and chatting to strangers, but then, because of the distress, they stopped talking entirely. Besides a shift in socialising, some participants also mentioned that they were no longer able to care for themselves (e.g., started overeating, stopped going to the gym) after their experience of distress.

"All these things, like your personality, your character, not character, I mean the way you express, I think everything changes" (UK, Man, 30s).

Discussion

In the currently study, we found that first-generation South Asian immigrants attributed a range of symptoms to their psychological distress including overthinking, crying, anger, lack of motivation, sadness, and altered eating and sleep patterns. The participants felt that their distress was caused by post-migration stress (due to loss of support systems, economic disadvantage, cultural shock and racism and discrimination), gender-related factors (such as abusive and controlling husbands, sole responsibility for household and childcare), as well as familial, societal, and financial pressure, bereavement, and physical ill-health. Although participants would not always use medicalised terms when describing their distress to others (preferring words such as 'stress' for example), they did comment that the use of these terms was becoming more common in the South Asian community. Participants felt as though distress fundamentally affected their personalities and relationship (i.e., participants were unable to socialise or interact with their friends and family when in a period of distress), leading to feelings of loneliness and isolation.

Somatisation, "a tendency to experience and communicate somatic distress in response to psychosocial stress" (Lipowski, 1988; Lanzara et al., 2018) of mental health conditions in the South Asian diaspora has been an important topic of discussion in the field of psychiatry and beyond. Somatisation is framed as arising from the inability of South Asian individuals to communicate their emotional distress in 'psychological terms.' In the literature, this phenomenon has been used to evidence the "primitiveness" of South Asian people; Western culture considers "psychological idioms more 'advanced' than somatic idioms" (Burr and Chapman, 2004; Kirmayer and Young, 1998). Members of the South Asian community are subsequently blamed for misdiagnosis and unsuccessful treatment when they do access formal healthcare services. It is as if the sentiment in psychology and medicine is 'if only the South Asian community had the ability to express their distress in psychological terms, then their mental health outcomes would be better.'

As Burr and Chapman (2004) highlight, “an important facet…of the cultural influence on health experiences is that in ‘racialised’ societies the majority cultural expressions are invariably regarded as definitive (Fernando, 1988). Ultimately, this can lead to dangerous stereotyping and a disregard of cultural shifts over time. In the present study, for example, the participants described a range of symptoms resulting from their psychological distress such as overthinking (a commonly described symptom among the South Asian diaspora in the UK (Burr and Chapman, 2004)), lack of motivation, anger, and sadness. While disturbed sleep and eating patterns were also frequently reported, this study shows no evidence that South Asian individuals are unable to relate their symptoms to psychological distress. In fact, participants commented that they were learning about their symptoms through online resources and their younger, second-generation children. One participant spoke about how when she was panicked because she felt out of breath after ‘worrying too much’, her daughter explained to her using her computer that she was experiencing anxiety and that it would go away after some time.

This finding was also seen in Karasz et al.’s 2007 study, where 0% of the South Asian participants’ psychological problems were explained by physical health. This is not to say that *all* South Asian individuals no longer somatise psychological distress (for example, Garcia-Sierra et al. (2020) found that South Asians scored the highest on the somatisation scale compared to other immigrant populations in Catalonia), but rather that modern, Western, white-dominated mental health professionals must move on from *assuming* their South Asian patients will present with somatic symptoms towards delivering person-centered care, where listening to a person’s story and explanations about health and illness are of the utmost importance (Choy-Brown et al., 2020).

Regarding perceived causes of distress, the study results align with the body of evidence that South Asians tend to attribute distress to situational factors, rather than biological ones (no participants in this study felt like their distress was caused by genetics or chemical imbalances) (Jacob et al., 1998, Karasz et al., 2013, Rastogi et al., 2014, Antoniades et al., 2017, Gilbert et al., 2006). For example, a UK-based study on Indian women with depression found that the participants credited their depression to personal and economic challenges; they were willing to receive biomedical treatment for physical health issues, but not mental health ones (Taylor et al., 2013).

This study demonstrates that South Asian women are in particularly vulnerable positions and must grapple with intimate partner violence, poor social support, immense household and childcare duties, and financial insecurity. These risk factors have been demonstrated to be directly linked to mental health outcomes. This finding has significant consequences for policy and treatments; our focus must be on addressing wider inequalities (such as poverty, racism, and gender-based discrimination), that contribute to the development of distress, alongside adapting formal healthcare services to be culturally sensitive.

An important consideration is that some of the emerging themes from this study can be seen across diverse contexts, highlighting how elements of explanatory models of distress may be universal across cultural groups. Take 'perceived consequences of distress' for example. Participants in this study found that their distress made them want to isolate themselves, and shifted their character, which therefore impacted their relationships. This finding was mirrored in Green et al.'s qualitative study with 27 Caucasian mental health service users in the UK; a participant reported that while they previously had a full social life prior to experiencing mental health problems, now they "*expect people normally just to sort of write me off as a dull person*" (Green et al., 2003). Similarly, regarding 'perceived causes of distress,' this study's participants attributed distress to social isolation. In a cross-country longitudinal study with older adults in England and Japan, social isolation was significantly associated with the start of depression in both settings, demonstrating that the relationship between social isolation and mental health problems is not unique to the South Asian immigrant cultural group (Noguchi et al., 2021).

Strengths and Limitations

We agree that "the incorporation of cultural difference within the medical model is frequently in the form of stereotypes that pathologise South Asian cultures" (Burr and Chapman, 2004). To combat this, it is imperative to conduct research such as ours that centers the voices of this diverse and important group and challenge stereotyping. We believe that this study should not be used as a 'how to' on how to identify and treat mental health conditions in South Asian individuals, but rather as a sign that culture must be continuously investigated and incorporated into service delivery (Kleinman, 2006).

Unfortunately, men were underrepresented in this study, as is common in mental health research (Ryan et al., 2019). Future research should focus on the experience of first-generation immigrant men, who face unique barriers to accessing mental health services.

Implications

The results of this study clearly demonstrate that first-generation immigrants of South Asian origin require more support for mental health. These forms of support can include increasing support services for newcomers, especially considering how post-migration factors can still contribute to distress 5+ years after settlement and creating opportunities for first-generation immigrants to interact and develop social systems, perhaps through their children's schools or local community groups. Most importantly, the study results indicate that it is critical that exploring an individual's explanatory models of distress becomes part of standard 'good practice' in clinical and non-clinical settings. Explanatory models can help "increase understanding of forms of sufferings, improve clinical communication and treatment outcomes and reduce stigma" (Kaiser et al., 2015). Future research must focus on how explanatory models and other cultural conceptualisations of distress can be incorporated into psychological assessments and interventions, particularly for the South Asian diaspora (Cork et al., 2019).

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SECTION A – Student Details

Student ID Number	1702879	**Title**	Miss
First Name(s)	Ruchika		
Surname/Family Name	Jain		
Thesis Title	The Cultural Conceptualisations of Psychological Distress and Help-Seeking among South Asian Immigrants in the UK and Canada		
Primary Supervisor	Dr. Abhijit Nadkarni		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

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Where is the work intended to be published?	PLOS Global Public Health
Please list the paper's authors in the intended authorship order:	Ruchika Jain, Ritsuko Kakuma, Daisy Singla, Abhijit Nadkarni

Stage of publication	**Not yet submitted**

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	Ruchika is the lead author. She was involved in conceptualisation, data curation, formal analysis, funding acquisition, investigation, methodology, project administration, validation, and writing (original draft, review and editing). Ritsuko, Daisy, and Abhijit contributed to supervision, study conceptualisation and methodology and also reviewed and edited the manuscript.

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Date	07/01/2025

Paper #3: The Cultural Influences on Help-Seeking and Coping Strategies for Psychological Distress among First-Generation South Asian Immigrants in Canada and the UK: A Qualitative Study

Abstract

Background: Although the topic of mental health in the South Asian diaspora has come to the forefront in public health due to research during the COVID-19 pandemic, there is still a lot of work to be done on developing mental health services that are culturally acceptable for this growing population.

Methods: We conducted semi-structured interviews with first-generation South Asian immigrants who had a period of psychological distress, which they reported impacted their daily lives (n=17). The participants were primarily based in London, UK or Toronto, Canada. We analysed the data using a reflexive thematic analysis and validated the themes using double coding and ascertaining the usefulness and relevance by hosting six public consultations with the South Asian community (n=40).

Results: Participants described multiple barriers to help-seeking, which primarily involved cultural expectations to keep personal problems to themselves and feeling like other people were unable or unwilling to understand them. The participants relied on self-help to make themselves feel better. Self-help included privately praying or reading religious texts, exercise, or socialising. Participants did not engage with formal care for the most part but those that did found it helpful for managing distress.

Implications: This study shows how culture informs mental health help-seeking and coping strategies for South Asian immigrants. We hope that this study will highlight some ways that mental health services can be redesigned to be culturally safe for this population.

Introduction

Common Mental Disorders (CMDs), such as depression and anxiety, are a leading cause of disability, morbidity, mortality and increased economic costs globally. Despite the existence of evidence-based prevention strategies and treatments for mental disorders, their accessibility remains low. While treatment coverage for depression and anxiety disorders is low in low- and middle-income countries, even in high-income countries (HICs), it can be as little as 36.8% - this gap is unparalleled by any other health condition (Evans-Lacko et al., 2018). The treatment gap can be greater for marginalised populations, including ethnically diverse individuals, in HICs, which is important given the increase in global migration and, more recently, the disproportionate impact of the COVID-19 pandemic on these populations.

North America and Europe are becoming increasingly diverse. South Asians represent a quickly growing ethnic group in countries such as the US, UK, Canada, and Australia (Prajabati and Liebling, 2022). First-generation immigrants from South Asia face elevated levels of distress compared to the general population due to factors such as racism and discrimination, economic disadvantage, and loss of support systems. Considering the increased migration from South Asia to HICs, as well as a high prevalence of mental health conditions, understanding the mental health needs of this population is an essential step in reducing health disparities and providing culturally appropriate care.

South Asians face many barriers to mental health service use and therefore underuse mental health services in comparison to their white counterparts (Soorkia, 2011; Prajapati and Liebling, 2021,; Hussain and Cochrane, 2016). Western theories and practice of mental health are based on concepts of individualism, mind-body dichotomy, and reductionism and healthcare providers commonly hold biomedical views on health and disease (Gopalkrishnan, 2018). For many reasons, these ideas do not always translate to the South Asian community's understanding of health. First, South Asians in HICs understand CMDs as the result of social (e.g., difficult life events) or moral (e.g., weakness) issues rather than as an illness requiring biomedical intervention (Jacob et al., 1998; Karasz et al., 2013, Rastogi et al., 2014; Antoniades et al., 2017; Gilbert et al., 2006). Second, South Asians sometimes express their mental distress as somatic symptoms (Hussain and

Cochrane, 2016; Gunasinghe et al., 2019; Anand and Cochrane, 2005; Karasz, 2005). For example, individuals in the Punjabi community may express mental ill-health as chest pain (known as ‘sinking heart syndrome’) (Krause, 1989). Third, South Asians often prioritise family over the individual (Masood et al., 2009, Tummala-Nara, 2013). Collectivism is an important aspect of South Asian identity, which can conflict with the host country’s healthcare system’s emphasis on individualism. Perceptions about the cause and treatment of poor mental health, somatic expression of symptoms and collectivism are directly related to refusal of mental health service use (Rastogi et al., 2014; Antoniades et al., 2017; Karasz, 2005; Beiser et al., 2003).

South Asian individuals living in HICs often do not perceive available mental health services or even mental health campaigns to be culturally appropriate (Bowl, 2007; Islam et al., 2014; Bhui and Bhugra, 2002). For example, a study of Sri Lankan individuals in Australia found that psychosocial treatment was preferable to medication (Antoniades et al., 2017). Understanding a patient’s culturally informed beliefs about their mental health can enable healthcare providers to suggest suitable treatment. Tailoring mental health services to be culturally specific is imperative to delivering person-centred care.

Efforts to address the mental health care needs of increasingly diverse populations have escalated in recent years through strategies such as cultural competence, cultural brokering, and cultural adaptation. For the most part, culturally adapted interventions have been shown to improve mental health outcomes for members of the South Asian diaspora (Naeem et al., 2015; Naeem et al., 2019). But a recent large-scale trial (ROSHNI) implemented in the UK which delivered culturally adapted Cognitive Behavioural Therapy to British South Asian women with post-natal depression, contradicts this message. The results demonstrated no sustained effects on reduced depressive symptoms of the culturally adapted intervention compared to ‘treatment as usual’ (Husain et al., 2024). This mixed evidence suggests that more work must be done to understand the facilitators and barriers to help-seeking and preferred coping strategies for this population.

In this paper, we will explore how culture influences the way in which first-generation South Asian immigrants in the UK and Canada seek help for, (defined as “attempts to maximise wellness or ameliorate, mitigate, or eliminate distress") (Saint Arnault, 2009) and cope with, psychological distress.

Methods

Study Design

Qualitative study with semi-structured interviews with a convenience sample. Our methodology was designed with an intersectional and social constructivist approach. For example, we created multi-language and culturally sensitive recruitment materials.

Study Sites

Greater Toronto Area, Canada and London, UK. The two sites share many similar socio-demographic characteristics (such as their sizable population of people of South Asian origin, urban settings, and location within high-income countries).

Participants

Participants were eligible for the study if they 1) spoke English, 2) were adults (18+) and 3) had some form of self-reported psychological distress that impacted their daily life for a sustained period in the past 5 years. To meet "first-generation" eligibility, participants were required to have 4) come directly from India, Pakistan, Bangladesh or Sri Lanka to the UK or Canada when they were 5) *18 or over and 6) **to have lived in the UK or Canada for five or more years.

*We chose to only include those that migrated over the age of 18 because the mental health experiences of children and adolescents differ from adults.

**We chose to exclude 'newcomer' immigrants (defined for the purposes of this study as immigrants who had been in their host country for less than 5 years). We made this decision after conducting one interview with a participant who had been in the UK for six months; this interview served as a reminder that the mental health experiences of newcomers would be different than those who were settled.

We intended to interview up to 20 individuals and decided to stop when we reached sufficient information power (Braun and Clarke, 2019) and partly due to limited time (PhD timeline of RJ) and resources (funds to compensate participants).

Procedures

We employed purposive and snowball strategies to recruit potential participants, mostly working with community organizations in both settings to spread the word about the study. We also displayed recruitment posters at places of worship, community centres and libraries in each study site.

We used an interview schedule (Appendix) to guide the conversation with participants. The schedule was constantly reviewed for relevance and clarity from the pilot stage to the end of study.

RJ, a doctoral student, was the interviewer and hosted the interviews via Zoom and in person based on the participant's preference. The interviews were audio recorded and stored on secure servers. They were then transcribed (by RJ and ND), de-identified and uploaded to NVivo 12.0. One participant was not comfortable being audio recorded: RJ contemporaneously documented detailed notes instead.

Analysis

We conducted a reflexive thematic analysis (Clarke and Braun, 2006; Campbell et al., 2021), which involved 1) data familiarisation 2) open coding (semantic and latent codes were acceptable) 3) theme generation and definition and 4) re-evaluation and re-formulating of themes and how they answered the research questions.

We analysed the UK and Canada transcripts separately and then merged the themes.

We generated kappa scores to ensure valid of our findings. Two pairs of researchers conducted double coding; NA and RJ and GV and RJ (Landis and Koch, 1977). Ultimately, we chose not to present the kappa scores due to the tension between this process and our social constructivist epistemological position, which endorses the belief that realities are subjective.

We also held six public consultations (n=40) with people of South Asian origin in the UK and Canada (three in each setting) to ascertain (a) if the findings were interesting, relevant, and useful to the South Asian community, and (b) key findings that were perceived to be most important to disseminate to key stakeholders.

Ethics

The Research Ethics Boards of the London School of Hygiene and Tropical Medicine (UK) and Mount Sinai Hospital (Canada) oversaw ethics for this study. Participants had to provide informed consent (either written or verbally, depending on their preference). If they were distressed in the interview, we provided a list of mental health services that could access for further support. Compensation for participation was a $25 CAD/£25 GBP gift card.

Reflexivity

RJ maintained a reflexivity journal for the duration of the data collection and analysis process to assess how her identity (she is a cis woman born in Canada to parents who migrated from India in the 1980s) may have influenced the results.

Results

Participant Demographics

Participants (n=7 in the UK and n=10 in Canada) included individuals who identified as women (n=13) and men (n=4). The participants were born in, and migrated from India (n=7), Bangladesh (n=4) and Pakistan (n=6). The youngest participant was 29 while the oldest participant was 76. Participants described their jobs as retiree (n=4), housewife (n=3) or in various full-time occupations (n=10). The reported severity of distress ranged from a little to very intense. Marriage (n=8) was the most reported reason for migration, followed by education (n=5) and desiring a 'better life' (n=4). Some participants had moved to their host country more recently than others (ranging from 5 to 58 years). Participants migrated between the ages of 18 and 34 years.

Key Themes of Help-Seeking

Barriers to Help-Seeking

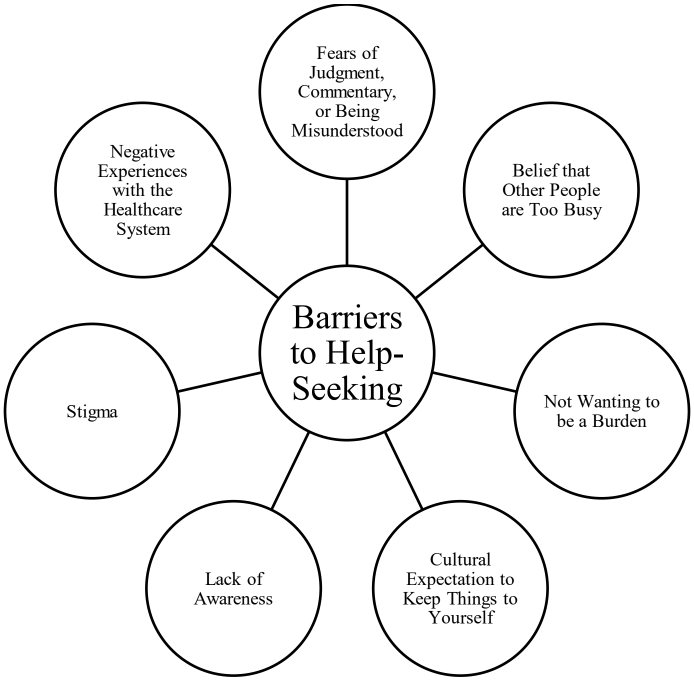

Figure 1. Perceived barriers to help-seeking.

Cultural Expectation to Keep Things to Yourself

Participants mostly felt that in South Asian culture, it was considered out of the ordinary or impolite to share difficulties with others. They discussed how 'personal' things such as distress were not meant to be discussed with others and doing so made them feel uneasy. When asked why, one participant said, "*because it doesn't look nice that you tell your own problems to other peoples" (UK, Woman, 75).*

"I really don't like discussing about my personal thing with other people. So I always try to hide myself, let's put it this way. Sometimes if I'm in a group, and there happens to be another man from the same culture, if they get to know all these things that can play [a] negative part in my life…"(UK, Man, 30s).

Fear of Judgment/Commentary/Being Misunderstood

A few participants' negative experiences with other people stopped them from social help-seeking. They felt that individuals they shared with blamed them for their distress ("why, did you do something?") or would take sides (if the cause of the distress involved another person). In other cases, participants were concerned about being judged for having or sharing distress. They discussed how this worry or fear was the reason did not reach out to others. Participants also believed that their family members who did not migrate would not be able to understand the circumstances in their host country and instead ask questions that could potentially lead to more distress. Further, some participants felt like their family members or other people in their communities, would often get "over involved" in their lives and in some instances, provide unsolicited advice, perhaps without fully understanding the reality of the participant's situation.

"I felt that people are going to judge me like if I tell them that I can't manage, I can't balance without anybody's help, my job and my kids. They will judge me because it's common that you're going to have kids, you're going to manage it no matter what. It's not your choice. And everybody else is doing, why can't you do it? Others are not complaining, why are you complaining? Which means that there is something wrong with you, and then I felt that I'm not going to show that." (Canada, Woman, 37).

"Definitely not my family because they don't understand this thing. They're back home, right? But for my friends and they're mostly like citizens here, right? And then some of them has family, so they don't really pay attention you know, when you are actually struggling with something, they would be like listening, like oh yes, it's okay, you'll get it. They will give you suggestion, but of course, like, you know, there's no point of telling anybody who cannot even feel it. And mostly my parents always asking these kind of questions, which actually gives me stress like, please don't ask me, I don't know when it's going to happen. You know, like "when are you getting PR? When are you going to get your home and when are you gonna get this?" It actually gives you stress when your family wants to see you successful and then you know you can't get that success that easily. It's distressing" (Canada, Woman, 30).

Belief that Other People are Too Busy

Participants highlighted how other individuals in their network were also struggling (due to their immigration status or cost of living) and therefore prioritised themselves and their families. Ultimately, some participants felt that other people were too pre-occupied in their own lives and did not have the capacity to help people with their distress. Additionally, a couple of participants described how new immigrants cannot make friends who they can trust and rely on because those types of friendships take time to make (which they do not have because they are always working) and most of their family is back in their country of origin. Also, socialising in their host country felt different to participants' experiences in South Asia, where transport is easier (especially if you have a driver) and you can drop by to other people's houses unannounced.

"I think family support is the most important. That's what I feel. Because other people they'll meet for one hour or two hours, or maybe half an hour, maybe friends or whatever it is. But family is the one that stays continuously. I think family support is the most important" (Canada, Man, 53).

Not Wanting to be a Burden

A couple of participants mentioned that they did not share with others, especially their family members, because they did not want to be a cause for concern.

"So one thing, if I'm sad about something 1st reason is that I don't want them to stress about me for anything. That would be point number 1. Point number 2 is depending on what I'm depressed about, if I want to share that thing with my parents, that also is a factor. But most of the times it's more about me not wanting to cause them any kind of stress or tension for me" (Canada, Woman, 29).

Stigma

Participants mostly spoke about external and internal stigma in the South Asian community inhibited help-seeking for mental health problems. For example, one participant's father-in-law told him that he had to maintain a brave face (especially as a man) in the face of extreme anxiety due to his daughter's illness. Other participants also feared being perceived as weak. Specifically, they did not want to show their families how much they were struggling with the post-migration experience.

Lack of Awareness

Some participants were unaware of which social, semi-formal or formal resources existed and how to access them, while others were aware but did not see how this help could improve their situations. Participants did not comprehend the potential benefits of counselling or therapy, citing how counsellors did not understand, were too focused on the past, did not provide any practical advice, and that they could not do anything about the physical pain caused by distress.

"Honestly I have zero knowledge or even expectation about it. I mean I know some people who have been to therapy and it's helped them. But I feel like it's a very hard thing to find a proper therapist who would understand what I'm going through specially as a South Asian woman" (Canada, Woman, 29).

"I didn't know what help is available so I think that is another issue with a lot of South Asian immigrants in this country. You are not really aware…there is a lot of help available out there but we're not really aware of those channels" (UK, Woman, 41).

Lack of awareness also extended to being confused about what the distress was in the first place, so it would be difficult for participants to seek help for something they had not formulated.

"I don't even know that I have a problem. I am myself not able to…convince [myself] that this is an issue. So if I feel like that it is really disturbing…it doesn't disturb my day to day life, doesn't disturb too much my relationships. It does disturb me internally" (Canada, Man, 53).

Negative Experiences with the Healthcare System

Some participants mentioned that it was very difficult to find a General Practitioner (GP), especially when as a newcomer to Canada, you are unable to get an Ontario Health Insurance Plan card, which provides free access to healthcare. For example, one participant was traumatised after she was mistreated by multiple doctors and had to pay thousands of dollars to be treated in the Emergency Room. Even if participants did have a GP, they found it difficult to get an appointment, especially one that was long enough to discuss multiple mental and physical health issues.

"I used to hear that Canadian healthcare is so good, you know, and then I am getting treated like a pig, you know, we don't care about you. If you have the money you can pay, you can go ahead, otherwise no" (Canada, Woman, 30).

Key Themes on Coping Strategies

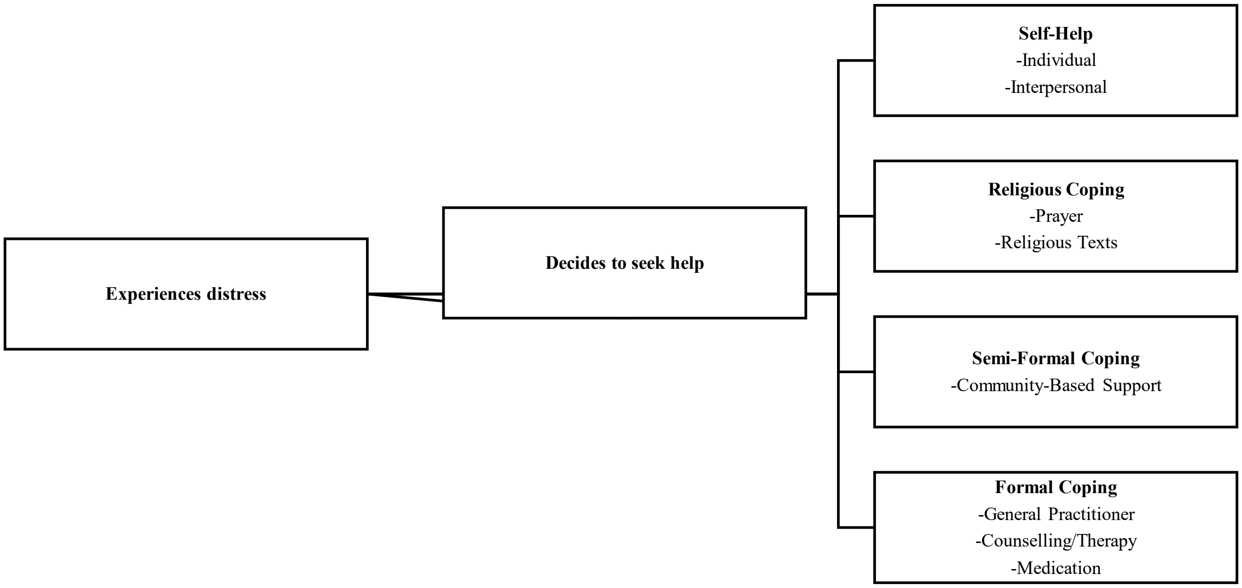

Figure 2. Participants reported coping strategies.

Self-Help

Individual

Most participants described that they aimed to manage their distress by themselves. They reported that when in distress they wanted to 'control it', 'rise above it' (meaning having a more positive outlook on life) and be 'strong'.

"I have to be very strong and all. My husband…he is a very very strong person. Probably I have become like him, becoming like him, trying to control" (UK, Woman, 75).

"Work life, personal life, sometimes it can be really stressful, but I have to say that I'm strong mentally. I try to self-manage" (UK, Man, 30s).

The primary way participants dealt with their distress was by doing things to keep themselves busy. This mainly included watching TV or movies, listening to music, reading, and doing housework. Other ways of staying busy such as exercising, spending time with people, and helping others are described in more detail below. Cited benefits of staying busy include keeping one's mind busy so it does not overthink or have negative thoughts and allows time to pass.

"It [mechanically playing computer games] stops thinking. It keeps you from overthinking everything" (Canada, Woman, 68).

"I just don't talk with anybody, I just keep with me and keep doing some of my own things, my own hobby, reading book or watching movie and this kind of things. Or going out with my other friends" (UK, Man, 30s).

Many participants engaged in some form of exercise to cope with their distress. This included going for walks, dancing, running, and swimming. Participants believed that exercise was helpful because it could help them boost their mood, connect to their body, distract them from intrusive thoughts and feel calmer.

"It helps me because I try to get away with my thinking. So I…it helps me to be distracted from that mood from that feeling, from the emotion. So obviously, if you're stuck in your room, or if your house, you are going to have all this negative vibe, you end up scrolling on your phone… but if you go in the gym, you just workout for two hours, you tire your body, go home, have your meal, lie down, you sleep. I think that's how I self-manage and recover from this" (Canada, Man, 30s).

Interpersonal

Some participants described that it was important to go out and meet people to prevent and cope with distress. Going out to meet people (like going to a women's group) or taking children to the park with other parents could act as a distraction from over or negative thinking, reduce isolation and loneliness, and give participants the opportunity to share and laugh.

"Because you don't have time to think about…your mind works and when you are talking to somebody, your mind is not thinking that thing, your mind is thinking something else. If you are singing, your mind is thinking, what song should I sing? You don't think of anything else then. Your mind plays a lot of, you know, games with you. To control the mind is a very, very important thing. It does place a lot of role "(UK, Woman, 75).

While most participants refrained from sharing their distress and preferred to cope themselves, some did mention reaching out to their friends or partner. In most cases, speaking to another individual allowed the participant to ventilate their feelings, which ultimately made them feel like they were no longer keeping things in their heart. Sometimes the person they shared with would provide them with words of assurance. Some participants described that they would discuss what they see as common problems in the South Asian community such as death, raising children and having too much housework, but not necessarily provide details or speak about their emotions.

"I would just cry it out and talk to her. Because she experienced depression at one point in her life as well. So she understands, better I believe than my husband" (Canada, Man, 73)

"Few problems we tell each other. My friend is sitting and we talk about problems of work, what we do, we all have too much work. She told me about we have so much to do, I am tired. Natural things we talk about. Everybody has problems, naturally" (UK, Woman, 76).

"Sometimes share my husband don't like this, don't like that. And they said 'yeah, my husband also the same'… not for help, it's just discussion. It's what you like, what going on, how my life. I just compare each other – how they are happy, how they manage, ok how I manage" (Canada, Woman, 34).

Many participants highlighted that they felt better after helping someone else. Helping other people included working extra hard for their clients in social work settings, doing charity work, and informally assisting individuals in solving their problems. Some participants felt especially willing to help new immigrants because they knew from personal experiences how challenging the first years in a host country can be. Participants said that helping others made them stay busy, feel happy, feel good, feel respected and rewarded.

"If you try to help other people and solve their problem, sometimes you can forget about your own. So that's why I started volunteering, I don't want to keep all the time on my own problems and feeling self-pity and everything. So I just started to help other people so I can help them and feel good" (UK, Woman, 75).

"It gives me the strength that every time I see any person who is actually a first generation here, I'm always willing to work to help them. Like to give that knowledge which nobody told me and then I suffered, I try to protect them" (Canada, Woman, 30).

Religious/Spiritual/Folk Practices

Most participants participated in some form of religious activity to help them deal with their distress, though the frequency and intensity of the activities varied. Participants primarily prayed individually in their own home. Sometimes, on special occasions, participants would go to a place of worship such as church, gurdwara, mosque or temple. Participants relied on their faith in God to help them navigate difficult periods; many felt that they could trust God's will and this belief gave them a feeling of peace, connection, strength, hope and belonging. One participant said that her understanding of Islamic faith made her "mentally different" and less susceptible to mental health conditions. Another participant thought that praying five times a day (including washing your face and hands) keeps you busy and "just change[s] your mood, it becomes better. Then you pray and you feel that something is you know…we did good thing, so change is come" (UK, Woman, 75). Another participant mentioned that praying is an outlet (i.e., a way to remove things from your heart).

"I go to temple, and I feel like theirs is a connection when I'm stressed out, when I'm worried about something, like what my father taught me, when you're worried about something really, and it's not in your hand and you tried so much, so you put it somewhere in the universe, you know. If it's in your fate it will come to you otherwise…it was not in your fate. So don't worry about it,

don't waste your energy. And you have to have faith on somebody, like go to temple and just sit there, and just pray and it helps me a lot" (Canada, Woman, 37).

"It [prayer] kind of gives you a feeling of belonging, feeling of being home, being connected to your culture" (Canada, Woman, 35).

Semi-Formal

Some participants regularly attended a South Asian women's group in a local community centre. They described it was an excellent way to meet new people as well as learn new skills (such as yoga) and visit places (such as the seaside). The participants who attended the women's group reported that while they found a lot of happiness from socialising with other members, they rarely shared their distress. Occasionally, they would share a specific difficulty they were having (if they felt that others would understand) such as having too much housework or dealing with grief after the loss of a family member.

"Here we can talk about our own problem and everything you know, matters. If you think your friends are loyal and really good and can listen to you, but not with everyone, you can't do" (UK, Woman, 75).

Formal

General Practitioner

As described previously, some participants felt like their GP could not help them with their distress for a multitude of reasons. If participants did believe a GP could help with distress, it was only for referral to a specialist service like a psychiatrist or for the prescription of medicine.

"There's no compassion from the practitioner sometimes that can also affect your well-being as well" (UK, Man, 30s)

“She has no time. She is always hurrying…I tell her my problems, what happened, why I came to her, that’s why I can’t explain to her, because a lot of patients are sitting there, they have little time, I cannot explain to her my problems” (UK, Woman, 76).

“Ya, I said once, but he started to give me some medicine, some sleeping pill, but I don’t like and I heard that this is no good for you and you get used to and all this stuff and I didn’t take. So that’s why I don’t tell them” (UK, Woman, 75).

A couple of participants mentioned that the role of the GP is limited and should be expanded to be more holistic.

“So, for me, I look to a family doctor as a person who can provide an umbrella of services, like within that clinical setup there can be a psychotherapist, there can be a human rights activist, there can be a social worker not all together at the same day, but they can have their base plan so that whoever needs those services is provided under that one umbrella because hospital is the last point to go” (UK, Woman, 35).

“So maybe I think the role of GP is very important to identify these early signs and cases, right? Maybe if it was worse then it would be very important for them to actually at least seek more direct help than like waiting for like self-referring so I think, yeah, the GPs play a very important role in this in identifying these situations” (UK, Man, 35).

In contrast, one participant described her GP as “amazing.” She went to him in an “emergency situation” (when she was having suicidal thoughts) and he immediately referred her to a psychiatrist. This participant said that the family doctor primarily helped by realising the urgency of the situation and would also talk to her about her medication and dosage. Another participant said that sharing with her GP, who she felt she could trust, gave her the confidence to begin sharing her experiences of distress with others. One participant said that she would go to the GP had she felt that her symptoms were bad enough to warrant professional help.

“I felt good actually, sharing it with other people, sharing it with my doctor. I stared my doctor, because I was confident that I could trust my doctor because they are not the one going to judge me and then slowly, I started sharing with my friends” (Canada, Woman, 37).

“You go only when you feel depressed, really feel emotional, you know, that’s why they’re there” (UK, Woman, 75).

Counselling and Therapy

The majority of participants had not been to counselling or therapy and those that had did not find it helpful. Reasons for not going to counselling included it being “too late” to receive help due to old age, believing that counselling is too focused on the past and does not provide practical skills and tools to move forward, requiring their partner to also attend (because the root cause of the distress was marital conflict) and that it is only for people who do not have friends to talk to.

“If you don't have anybody, then you go to talking therapy, but if you're surrounded with the people, then you don't need to go. And I think you are more to tell to your own friends, your own feeling, rather than to somebody you know, which you don't know. Even if they are there to help you, I'm not saying that, but you don't know them that personally “(UK, Woman, 75).

“Yes more focused on tools to go forward…. What is in the past should remain in the past, it happened, okay, it should not have. But then let’s focus on you, how you can…is one of the main reasons I don’t like psychiatrists….I talked to one a lot just to get an idea…” (Canada, Woman, 68).

In some cases, participants did find it helpful. One participant was able to become more aware of their negative and anxious thoughts after receiving cognitive behavioural therapy sessions and another participant received free counselling from her local council, which helped the participant become more resilient (after leaving an abusive relationship).

"CBT had taught me some of those kinds of like simple things I could do. I think mindfulness help me a lot just kind of being aware of the feelings that I was having. And things that I could affect and that I couldn't affect" (UK, Man, 35).

Medication

Participants felt wary of medication for distress, claiming they would become reliant on it or feeling cautious of the potential side effects.

"But I think what they will do, they will prescribe you the medicine and medicine is not always good for you. You know, like that the outcome of or the reaction of the medicine can be anything later on, you know. Any medicine has got that effect. Even with the paracetamol you know" (UK, Woman, 75).

However, one participant said that the medication transformed her and she is grateful to her doctor for prescribing it. She stated, *"no amount of counseling. No amount of words were helping. Trust me. I have went to tons of them. But only… it's the it's medication that only did the what…did the magic" (Canada, Woman, 34).*

Healthcare Professional Matching

If given a choice, most participants would prefer seeing a healthcare professional with the same or similar cultural/ethnic/religious background as them. The most cited reason was believing that a South Asian background would help the individual understand certain cultural concepts without explanation (such as arranged marriage) and that would lead to a shared understanding that you could not have with a white professional. One participant did not mind if the healthcare professional was born in Canada but came from a South Asian background, while another said that the professional would have to be an immigrant for them to truly understand.

"So my counselor even though he was South Asian, he was not an immigrant. He was born and raised here. So I could not relate much to that person. So that is why I just ended after two sessions... But the thing is, immigration adds one more aspect to your identity. Like because your values, your culture, everything was actually in your home country and not here. That is also kind

of a divide I would say, of two people of the same racial origin. And the person is not able to connect. And I understand the person who is Punjabi, South Asian, born and raised here, will not be able to connect" (Canada, Woman, 38).

One participant however, stated that she would prefer to see someone not from a South Asian background because they felt that generally South Asians are judgmental. Another participant said they do want to see someone from a South Asian background for therapy, but they would be concerned that the healthcare professional would be a "known" person if they were from the South Asian community.

"More diverse in terms of their thought, more broad, and, less judgmental than the people from our part of the world, South Asia, like Bangladesh, India, Pakistan. To be precise. So, yeah, no disrespect, but maybe that's the cultural set up that we all have brought up into" (Canada, Woman, 34).

Key Themes on Recovery

Definitions of Recovery

Participants had various definitions of recovery including feeling more empowered, confident, and independent, feeling happy or happier, feeling positive, being worry-free, being calm, peaceful, and accepting, and coping better (being more aware of tools and resources).

"Happy life…I think you have to forget your own problems and you have to help other people for their problem and always give them confidence and respect them and love them so you can solve your own problem and their problem as well. And always be friendly, responsible for your own actions. Try to teach them so good things, good manners. You can solve many problems in your life and have an easy life" (UK, Woman, 75).

Discussion

Most participants described that they aimed to manage their distress by themselves. They described that when in distress they wanted to “control it”, “rise above it” (meaning having a more positive outlook on life) and be “strong”. Self-management strategies include keeping busy, exercising, and praying solo. Social help-seeking strategies included spending time and sharing with friends and family, attending community groups, and helping other people. Most participants did not seek professional help, but those who did engage (such as speak to a GP or counsellor/therapist) only sometimes deemed it useful.

Discussion of Key Themes

The preference among first-generation South Asians to self-manage mental health problems or get support only within the family is well-established in the literature and can be attributed to various cultural beliefs. For example, a cross-sectional study with older South Asian immigrants in America found that “participants themselves were significantly more likely [than other members of their community] to discuss mental health issues with either family ($p = 0.003$) or with no-one” (Ali et al., 2021). Firstly, in South Asian culture it is seen as normal to be okay with difficult circumstances. It is often believed that if one is strong mentally and has sufficient will-power, one can overcome any circumstance. Multiple participants in the current study held this belief, stating that they would only seek outside help if they were not emotionally capable. Another widely held idea was that it was inappropriate to share personal problems (such as family conflict) with other people, even close friends, and “seeking help is not a socially accepted or socially respected means of solving one’s problems” (Singh, 2021). This sentiment was mirrored in a systematic review on self-harm and suicidal behaviours in South Asian communities in the UK; participants in the included studies felt that a “good person” or “good families” do not divulge individual or family-related matters to outsiders (Ozen-Dursan et al., 2023). Secrecy around personal and familial struggles has also been found in other non- South Asian Asian immigrant groups (Ow and Katz, 1999). We can hypothesise that this phenomenon is because South Asian immigrant families are driven by competition with one another and would like to be perceived as respectable (i.e., the South Asian concept of “izzat”) (Chew-Graham et al., 2002). Therefore, individuals do not wish to bring undesirable negative views upon themselves or their families (Singh, 2021).

Secondly, even if they did want to disclose their experiences of distress, participants reported having few people or no one to talk to. They felt as though their family and friends in their country of origin would not understand the unique challenges of being an immigrant or judge or blame them for their struggles (for example, comparing the participant to other people who are not struggling or wondering if they did something wrong). On top of that, participants found it difficult to make friends in their host country, saying the societies were different than South Asian in that you could not just drop in on someone and that people were pre-occupied with their own challenges (especially with the increasing cost of living). This double social isolation is a prominent issue for immigrants in Western countries and can act as a significant barrier to help-seeking (Aran et al., 2022). "Social support and social connection" through positive familial, friendly and neighbourly relationships can drastically improve the mental health outcomes of immigrants (Aran et al., 2022). Therefore, when raising awareness about help-seeking, shifting the dynamic between a person going through psychological distress and their friend or family member by encouraging vulnerability from the person seeking help and on the other side, improving people's ability to actively listen and support without judgment, should be considered.

Most participants did not seek help from a professional when dealing with psychological distress. An unwillingness to share personal problems outside of the family was an important explanation provided by participants when asked why they would not see a GP or therapist/counselor to manage their psychological distress. As Chew-Graham et al. (2002) astutely state, "the fundamental issue is that they [South Asian participants in their study] could not trust anyone with their personal problems." Our interpretation of this result is that in parallel to making services culturally appropriate, awareness on how formal services operate (e.g., confidentiality) and can have a positive effect on mental health problems needs to increase in the South Asian community. While religious activity (by praying alone, having faith in God's plan, and reading religious texts such as the Quran) was a significant coping strategy for most participants, they engaged in religion alone, only going to places of worship on special occasions. Therefore, while working closely with faith leaders and delivering messaging on formal services in places of worship could be an avenue to raise awareness, public health experts, community leaders and organizations and healthcare professionals must use innovative techniques to reach this population. For example, in America, a team of researchers successfully used Korean dramas (K-dramas) to teach Asian communities about precision medicine (Park et al., 2021). This strategy may work for the South Asian population; many participants in this study watched movies and TV to stay busy and distract themselves from their distress.

It is important to note that some of the help-seeking behaviours and coping strategies endorsed by the participants in this study are not necessarily unique to first-generation immigrants of South Asian origin. A large 1990 survey of a representative sample of the UK adult population found that participants used cognitive and behavioural coping strategies and that most people preferred seeking informal help (particularly from close family members) over professional help (Barker et al., 1990).

Strengths and Limitations

A strength of qualitative research is its ability to centre and privilege the voices of marginalised individuals, such as ethnically minoritized immigrants. We can also attest to our methodological rigour; we used a cross-country sample and conducted a rigorous data analysis. Also, many studies do not distinguish between immigrant generation, even though it greatly influences help-seeking behaviour for mental health conditions. The results of this study can be useful in creating culturally sensitive public health and clinical interventions targeted at settled first-generation South Asian immigrants, who we know experience higher levels of depression and anxiety than the general population.

Though we based our methodology on existing findings that most first-generation South Asian immigrants in the UK and Canada speak conversational English, there is a small subsection of the population in these locations who do not and must rely on translators to receive healthcare (Sharma et al., 2019). This study does not include those individuals due to logistical/financial constraints, which is unfortunate because communication difficulties can significantly impact one's experiences with care (Sharma et al., 2019).

We only included participants who were born in, and moved directly from, South Asia, which means we cannot speak to the experiences of smaller and often neglected South Asian sub-groups, such as Indo-Caribbean individuals (Misra et al., 2020).

Additionally, we primarily recruited participants through community organizations both in the UK and Canada, so the results may not apply to first-generation South Asian immigrants who do not contact any semi-formal services. However, our recruitment strategy included sharing information about the study at group activities, as well as at public spaces which were not mental-health related (e.g., libraries), which likely means that even individuals who are not comfortable seeking support for mental health may have known about the study and participated if they wanted to.

Finally, we must note that while the South Asian countries of India, Pakistan, Bangladesh, and Sri Lanka share many historical, cultural, and social factors, the 'South Asian' ethnic group in each study location is not homogenous and nuances between country of origin exist.

Recommendations for Policy and Practice

Based on the study results, we recommend the following six strategies to improve mental health outcomes for first-generation South Asian immigrants in high-income settings: 1) increase funding and availability for community-based groups for individuals to socialise and learn new skills, 2) raise awareness on how culturally sensitive formal services can be a helpful avenue when dealing with psychological distress, 3) create spaces for South Asian individuals to exercise (such as delivering affordable yoga classes or improving green areas for walks or gatherings), 4) enhance opportunities for volunteering and charity work, especially within the South Asian community, 5) incorporate religious teachings in mental health interventions (perhaps through engaging faith leaders, although the participants in this study primarily prayed at home rather than a place of worship), and 6) expand the presence of South Asian professionals working in the mental health field (especially those that are immigrants themselves and may better understand the unique challenges arising from migration).

Conclusion

This study adds to a growing evidence base on the influence of cultural beliefs on help-seeking and coping strategies for mental health challenges. Alongside efforts to make formal mental health services culturally appropriate for first-generation South Asians immigrants, cultural beliefs around stigma, sharing personal problems, judgment, and commentary, as well as the benefits of using primary care and specialist services to alleviate psychological distress, must also be addressed.

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SECTION A – Student Details

Student ID Number	1702879	**Title**	Miss
First Name(s)	Ruchika		
Surname/Family Name	Jain		
Thesis Title	The Cultural Conceptualisations of Psychological Distress and Help-Seeking among South Asian Immigrants in the UK and Canada		
Primary Supervisor	Dr. Abhijit Nadkarni		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

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Where is the work intended to be published?	PLOS Global Public Health
Please list the paper's authors in the intended authorship order:	Ruchika Jain, Ritsuko Kakuma, Daisy Singla, Abhijit Nadkarni

Stage of publication	**Not yet submitted**

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	Ruchika is the lead author. She was involved in conceptualisation, data curation, formal analysis, funding acquisition, investigation, methodology, project administration, validation, and writing (original draft, review and editing). Ritsuko, Daisy, and Abhijit contributed to supervision, study conceptualisation and methodology and also reviewed and edited the manuscript.

SECTION E

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Date	07/01/2025 Date: 2025.01.07 19:33:55 +05'30'

Paper #4: The explanatory models of psychological distress for second-generation South Asian immigrants in the UK and Canada: a qualitative study

Abstract

Background: Evidence suggests that second-generation South Asian immigrants experience mental health conditions at similar or higher levels than their first-generation and non-immigrant counterparts. Yet, there is little empirical research that specifically analyses how this growing and significant population group understands and experiences mental health problems.

Methods: We conducted semi-structured interviews with 21 second-generation South Asian immigrants with a self-reported experience of psychological distress within the past five years. The participants were based in London, UK and Toronto, Canada. We conducted a reflexive thematic analysis and ensured that the analysis was rigorous by hosting six public consultations with 40 members of the South Asian community.

Results: The participants attributed their distress to their bi-cultural identity, intergenerational trauma, family conflict and challenging parenting styles during childhood and adolescence as well as racism and discrimination. Reported symptoms of the distress were both psychological and physical such as overthinking, crying and lack of motivation. The participants felt that their distress impacted their relationships, work, and daily lives.

Implications: This study highlights the critical role of culture and ethnicity in shaping mental health experiences, which emphasizes the need for culturally accessible mental health services for second-generation South Asian immigrants. Beyond service design, the findings illuminate broader narratives about the immigrant experience and the intergenerational transmission of culture and mental health.

Introduction

South Asians are the fastest growing ethnic group in high-income countries such as the United Kingdom (UK), the United States of America (US), Canada and Australia—thus contributing to the largest diaspora in the world (Qureshi et al., 2023). As such, the number and importance of second-generation South Asians (an individual born in their parent(s)' host country with one or both parents born in South Asia) is also growing (Ullah, 2024). In the UK, for example, second-generation immigrants represent approximately 12-43% of ethnically diverse groups (Dorsett, 2019).

There is conflicting evidence about whether mental health conditions are more prevalent in second-generation South Asian immigrants compared to first-generation immigrants. In a cohort of Canadian-born South Asians, Islam et al. (2014) found that the prevalence of poor-fair self-perceived mental health status was higher for second-generation South Asians compared to their first-generation immigrant counterparts" (4.4% vs. 3.4%). A similar result was also seen in Hashmi et al.'s 2011 study, which found that second-generation South Asian immigrants who used services in Bolton (UK) had a higher prevalence of anxiety disorder than first-generation South Asian immigrants (40% vs. 29%). Conversely, an older study by Furnham and Sheikh (1993) found that second generation South Asian immigrants did not actually experience higher levels of psychological symptoms than their first-generation counterparts (Furnham and Sheikh, 1993).

Several factors may lead to the development of mental health conditions among second-generation immigrants. Firstly, it can be related to intergenerational conflict stemming from incongruent acculturation levels and inadequate parenting in immigrant families. (Ceri et al., 2017). Secondly, traumatic experiences—such as violence or migration—can have lasting impacts across generations. Through the process of 'intergenerational trauma,' such experiences may contribute to family conflict, low self-worth, and symptoms of anxiety and depression (Bezo and Maggi, 2015; Jeyasundaram et al., 2020). Thirdly, experiences with interpersonal and structural racism can create distress and ultimately result in a mental health condition (Bhui et al., 2018, Miller et al., 2007). Finally, second-generation immigrants also face transcultural stressors or 'general hassles', (i.e., housing insecurity, unemployment) which can contribute to distress. These stressors or hassles can affect any individual but are likely magnified by immigration status and belonging to an ethnically diverse population (Lay and Nguyen, 1998, Abouguendia and Noels, 2001).

Understanding these mental health disparities requires examining the factors that influence psychological distress. As described above, several risk factors may uniquely impact second-generation South Asians. However, cultural perspectives also play a pivotal role in shaping how mental health conditions are understood and experienced within this community. First conceptualized by Arthur Kleinman (1980), explanatory models describe how individuals or groups can hold different beliefs on health and disease based on their social, cultural, and political environments (Kleinman, 1980). Cultural factors that are said to influence mental health include emotional expression, shame, the perceived power distance between a healthcare provider and patient, collectivism, spirituality/religion, acculturation and traditionalism (Gopalkrishnan, 2018, Hechanova and Waelde, 2017, Soorkia et al., 2011). In turn, these cultural factors impact illness experience, definition, and management (Gopalkrishnan, 2018).

Previous studies on the explanatory models of mental health conditions among South Asian immigrants suggest that psychosocial understanding, collectivism, stigma, religiosity, and somatization are important cultural factors for members of this community (Kapadia et al. 2017, Anand and Cochrane 2005; Bhui et al. 2001). If we examine 'psychosocial understanding' for example, a small-scale qualitative study with first-generation South Asian women in Toronto, Canada highlighted how all ten participants believed that life and situational factors (such as gender-based violence, family conflict or financial difficulties) caused their depression, rather than biomedical factors.

Despite their unique challenges, second-generation South Asians remain underrepresented in mental health research, which primarily focuses on the post-migration experiences of first-generation immigrants (Ullah, 2024). Studying second-generation individuals separately is essential, as their mental health outcomes are shaped by different sociocultural and generational factors, such as identity struggles, racism, and intergenerational trauma. A recent qualitative document analysis on stigma among South Asians in the UK revealed differing patterns of mental health service use among first- and second-generation individuals (Shukla, 2023). Findings such as these underline how immigrant status shapes mental health experience and service use, meaning it is crucial to study these populations separately.

Moreover, there are many challenges in healthcare including "ignorance, prejudice, and stereotyping" that affect the quality of mental health care that South Asian immigrants receive (Dinos et al., 2017). Research into the cultural factors that shape psychological distress and subsequent help-seeking can help render healthcare services more culturally accessible for South Asians of differing immigrant generations (Kirmayer and Swartz, 2014). By focusing on the unique experiences of second-generation South Asian immigrants, this research aims to contribute valuable insights that can inform more effective and culturally sensitive mental health interventions.

This qualitative study explores how cultural norms and meanings influence second-generation South Asian immigrants' experiences of psychological distress in the UK and Canada. Specifically, it examines their perspectives on three key themes: the definition of psychological distress, its perceived causes and consequences, and how distress is expressed and experienced.

Methods

Study Design

Using a qualitative study design, individual semi-structured interviews were conducted with second-generation South Asian immigrants to elucidate the detailed, self-reported perspectives of participants. Intersectionality was considered at each stage of the analysis (Abrams et al., 2021, Delucio and Villicana, 2021, and Misra et al., 2021). This approach included: designing culturally specific recruitment materials, using purposive and snowball sampling, placing importance on reflexivity, and disseminating the results to ensure that it is applied to policy and practice that aims to reduce inequalities in the healthcare system. We also considered intersectionality in our study design when determining our epistemological position and define our perspective as social constructionist (Warner et al., 2017). This perspective highlights that that each individual experiences reality differently, which is important considering we used qualitative methods to explore participants' realities in their own words.

Study Sites

Data was collected in:

1. Toronto, Canada. Approximately 14% of the population in this region are reported to be of South Asian origin (Statistics Canada, 2022).
2. London, United Kingdom. Approximately 20% of Londoners are reported to be of South Asian origin (Mayor of London, 2022).

Participants

Eligibility Criteria

Participants were eligible for inclusion if they were English-speaking, adult (>18 years), second generation South Asian, and had an experience of self-reported psychological distress that impacted their daily life for a sustained period within the past 5 years. Second generation South Asians were defined as those born in Canada or the UK and had one or both parents descended from India, Pakistan, Bangladesh, or Sri Lanka. Any exceptions made are detailed in the participant demographics (Appendix).

We created a culturally informed self-reporting instrument to measure psychological distress because of existing evidence that suggests that symptoms of distress are described using culturally informed idioms rather than diagnostically (Kaiser et al., 2015). We asked six South Asian professionals with field and/or lived experience to send us a list of culturally specific symptoms they associate with CMDs in the South Asian community. We then transformed this list into a word cloud and placed it below the question "*within the past 5 years, have you experienced one or more of the following in a way that has impacted your daily life for a sustained period of time…?*"

Figure 1. Word cloud of symptoms on the recruitment poster.

Sample Size

Our predicted sample size of 20 was based on the concept of information power, which “indicates that the more information the sample holds, relevant for the actual study, the lower number of participants is needed” (Clarke and Braun, 2019). We stopped data collection when we reached ample information power, within the time and financial constraints of the study.

Data Collection

Purposive and snowball sampling were used to recruit participants. The lead researcher (RJ) established relationships with community organizations who then shared study information with their clients. Other relevant institutions and organizations circulated study information via email newsletters. RJ also visited public spaces (i.e., libraries) and religious buildings (i.e., temples, mosques and gurdwaras) to speak to potential participants and place recruitment posters. Finally, RJ asked prominent academics, clinicians, and organizations to advertise the study with their networks either in person, via email or through social media. We did not recruit from formal healthcare services (such as hospitals, General Practitioner (GP) practices or counselling services) because we did not want our sample to be over-representative of individuals who engage with formal healthcare.

The interview schedule (Appendix) was based on: 1) consultations with key experts and a systematic review (Jain et al., 2025) and 2) existing interview tools such as Kleinman's 8 Questions (Kleinman, 2006), the Cultural Formulation Interview (CFI) (Lewis-Fernandez et al., 2020) and the McGill Illness Narrative Interview (MINI) (Groleau et al., 2006). The questions were centered around the four key themes of this study: 1) perceived causes of distress; 2) experiences of distress, 3) help-seeking, and 4) recovery. The interview schedule was piloted and modified based on the feedback of four South Asians (one in the UK and three in Canada). The interview schedule was further and iteratively modified based on initial findings throughout the data collection process.

RJ conducted the semi-structured interviews and each interview lasted approximately 45 to 75 minutes. They primarily took place via Zoom^{TM}, but one interview was conducted in-person at the preferred location of the participant. Interviews were audio recorded using an encrypted recorder and stored on a secure server. One participant declined to have their interview audio recorded, so RJ took extensive notes instead. RJ and ND transcribed the audio recordings, and the transcripts were de-identified before being uploaded to NVivo 12.0.

Analysis

Analysis was conducted following the steps of reflexive thematic analysis (Clark & Braun, 2006; Campbell et al., 2021).

After transcription, we (RJ) immersed ourselves in the data to gain familiarity and begin exploring patterns and meanings. We conducted open coding. Codes could be semantic or latent. The codes were placed under pre-determined categories: *problem definition, perceptions of cause and context, expression of distress, experience of distress, coping and help-seeking and recovery.* We grouped together the codes to generate initial themes and began describing the key characteristics of the themes. We re-evaluated the initial themes and ensured that there was sufficient data to support a theme and no overlap between themes. We explored the "story" of the themes and how they answered the research question.

The transcripts from the UK and Canada were analysed as separate datasets using the same process by three coders (RJ, GV and NA). The themes and sub-themes were then triangulated. To assess the validity of the coding, random sections of two interview transcripts were coded by two coders on Excel and NVivo, respectively. A kappa score was then calculated to ascertain the level of agreement between coders, with the aim of 0.7 or higher. We have chosen not to present the interrater reliability between the three coders considering the inconsistency of this approach with our social constructivist epistemological position.

Ethics

London School of Hygiene and Tropical Medicine (UK) (ref:28173) and Mount Sinai Hospital (Canada) (ref: 23-0030-E) granted ethics approval for this study. Participants gave verbal or written consent before participating in the study. A list of support services was shared with participants who reported active distress during the interview. We gave participants a 25 GBP/$25 CAD gift card as a small token of appreciation for their time and effort.

Public and Involvement and Engagement

We invited members of the South Asian community (individuals who self-identify as South Asian, 18+, English-speaking) in the UK and Canada to provide feedback on the study. We hosted three consultations at each study site and asked participants to a) provide their perspective on emerging interpretations and themes, identify potentially missed themes, (from de-identified, analysed interviews) comment on the findings that they felt were most useful and relevant and b) provide their perspective on the final themes and identify key messages of the study. These consultations helped us determine which themes were most important to the South Asian community and should therefore be focused on.

Reflexivity

RJ kept a reflexivity journal throughout the data collection process to explore how her identity as a young, second-generation South Asian Canadian woman immigrant influenced the research, as well as how her assumptions, values, and ideas changed through her exchanges with participants. Although RJ shares aspects of her identity with the participants, she does not consider herself an 'insider' in the research, instead rejecting the insider/outsider dichotomy (Ademolu, 2023). In line with intersectional theory and a social constructionist approach, she believes that one can truly never be an 'insider' especially considering that "racially minoritized communities…occupy transformative and progressively hyphenated positionalities" (Ademolu, 2023).

Results

Participant Demographics

A total of N=21 participants (14 in the UK and 7 in Canada) consented and were interviewed for this study (Appendix). The participants self-identified from the following backgrounds: Indian (n=7, 33.33%), Pakistani (n=7, 33.33%), Sri Lankan (n=2, 9.52%), Bangladeshi (n=4, 19.04%) and a combination of Indian and Pakistani (n=1, 4.76%) backgrounds. On average, participants were 33.30 years of age (SD=10.3), and all were in full-time employment (n=18, 85.71%) or education (n=14.29%). Most participants identified as female (n=18, 85.71%).

Key Themes of Explanatory Models

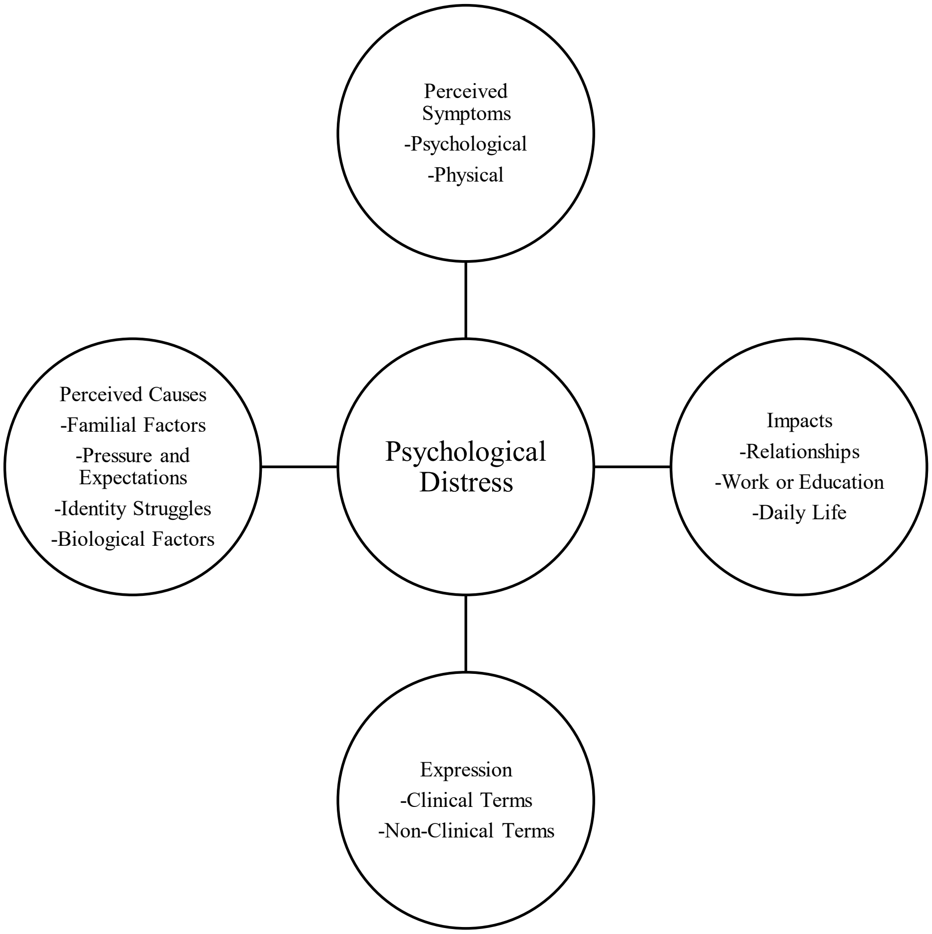

Figure 2. Explanatory models of psychological distress among second-generation South Asian immigrants in the UK and Canada.

Perceived Causes of Distress

Familial Factors

Participants mainly attributed distress to their personal relationships with family members. Family conflict was present in the lives of the participants in their childhood, currently, or both. A few participants described suffering from physical, emotional and/or sexual abuse from a parent or extended family member, leading to severe distress. Two female participants in Toronto described being sexually abused by a close family member in their childhood. The negative impact of this violence was heightened by denial and secrecy from parents. In another case, a participant was repeatedly physically abused by her father in her childhood, contributing to her diagnosis of Post-Traumatic Stress Disorder.

"So my environment from the moment I was born, pretty traumatic things that have happened have shaped my nervous system to a point where I feel like sometimes that it is like irreversible, that no matter what I do is…But that environment, in and out of shelters, being homeless, seeing so much violence…I feel like I am a veteran, I feel like I grew up in war. That's my [Post-Traumatic Stress Disorder] PTSD, that's how I can describe it. I grew up in war" (Canada, Woman, 44).

The participant attributed these experiences to intergenerational trauma, stating *"my family comes from escaping genocide, like the Sikh community in 1984, there was an attack on the Golden Temple and the Indian government attacked our church and killed our people in our church. That resulted in Sikh men being kidnapped, killed and disappearing by the police. So of course, my family, they say that they came here just to try it out, but I know that they're not sharing why they came here…they don't say that they escaped genocide. But that's why they came here. So who unpacks that trauma…' (Canada, Woman, 44).* Other participants also theorised that their fraught relationships with their parents is linked to their parents' unresolved trauma. For example, one participant said, *"they've come from a country where there's a civil war...they've gone through trauma, they've gone through their emotions, but they haven't processed it" (UK, Man, 33).*

Participants claimed that they did not receive emotional support from their parents when they were growing up because their parents were more concerned with survival post migration. As a result, participants felt like they had to dismiss their own emotions, which only worsened their distress. Additionally, participants perceived that they were not taught to be independent and make their own decisions. They cited that their parents did not communicate or explain things to them, instead just telling them what to do (e.g., following their religion, attending community events, pursuing certain careers). These parenting decisions then impacted the participants' confidence and sense of self, which they carried through to adulthood.

“Cause nobody explains to you anything about life. I just had to figure it out on my own.” (UK, Woman, 30).

"But we as South Asians, we care for you so much to the point where they smother us. And so you’re not supposed to have these feelings because we’ve given you everything in the South Asian culture” (Canada, Woman, 44).

Many participants also have a family member with a diagnosed or undiagnosed mental health condition, which was a cause of distress for different reasons. For example, one participant could not receive support for her distress because she was forbidden from revealing her mother’s bipolar disorder diagnosis to anyone outside of the family. In another case, a participant’s father hallucinated and used to become violent due to schizophrenia, but he refused to take medication, contributing to an unsafe and stressful familial environment.

Pressure and Expectations

Participants spoke about the pressures and expectations their families and wider South Asian community put on them to have successful careers (ideally in a “respectable” career such as doctor), to be “good” and respectful, especially as a girl (i.e., maintain a good reputation), and to get married and have a “normal” family. Participants thought that the pressure arose because their parents had immigrated and sacrificed for their second-generation children to thrive. Participants felt pressured to maintain a “brave face” and “smile and crack on” when battling adversity, stemming from South Asian cultural expectations. They also cited South Asian culture’s emphasis on collectivism and societal standing. Participants connected these pressures and expectations to distress in that they felt very stressed by schoolwork and culturally driven obligations (e.g., to attend community social events, spend time at home, take care of their aging parents, “people please”*).*

“I had a lot of pressure on me when I was younger…do the whole Indian girl thing. Get the good grades, become a doctor…” (Canada, Woman, 18).

"…familial expectations of you.., you navigate the world as an extension of your family, and so that puts on you stress and expectations and pressure of…have to be the good daughter, you have to be the respectful daughter, you have to be the well, high achieving daughter" (UK, Woman 29).

Struggles with Identity

Participants discussed how their unique identities as second-generation South Asians living in predominantly white Western cities contributed to distress. Participants described tension arising from the differing expectations between white Western and South Asian cultures. They spoke about how balancing contradictory cultures could be stressful at times and lead to judgment and commentary from the South Asian community. For example, one Canadian participant of Pakistani origin identified as queer and believed most members of the Pakistani community would be closed off to her sexual identity. These beliefs made her wary of attending mosque, as she did in her childhood, and connecting to her religion. She was fearful the Imam would share negative messaging around women and LGBTQ+ rights. A British participant of Bangladeshi origin expressed a similar sentiment; she was concerned with telling her extended family that she had a white boyfriend and felt judged and shamed for drinking alcohol and going to parties by her Bangladeshi co-workers.

Participants in both settings also described not fitting in at school and being victim to racially motivated bullying (e.g., for having Brown skin, for wearing an Abaya (a modest garment worn by some Muslim women)). One participant felt that growing up *"it felt like being Brown is really scary" (UK, Woman, 48).* She spoke about having her family house graffitied by the National Front, a former UK-based fascist political movement. Another participant spoke about the daily stress of being a racialized woman in predominantly white spaces and how this lowered her confidence. For example, she described having an undergraduate professor discriminate against her multiple times by insinuating that she could not speak English.

"I feel distanced from my culture, in a way. Like I love being Pakistani, but I also hate it" (Canada, 23, Woman).

"I think I feel a bit culturally homeless quite a bit of the time" (UK, 48, Woman).

Biological Factors

A couple of participants wondered whether they were more susceptible to experience distress due to history of mental health problems in older generations of their family, though this was cited to a lesser extent than other causes.

"I think a part of that must be sort of just hereditary…part of our genetic history…there must be something somewhere predisposed to some extent. The extent to which it like manifests itself or it's triggered and like things that happen in our day to day I think differs" (UK, Woman, 27).

Perceived Symptoms of Distress

Psychological Symptoms

Participants experienced a range of psychological symptoms. A commonly reported symptom in this theme was overthinking (Figure 3). Additionally, participants described psychological symptoms of crying (i.e., from being tearful to sobbing relentlessly, as a consequence of feeling extremely overwhelmed or emotional), lack of motivation (i.e., not wanting to do things you would normally do), helplessness and hopelessness (i.e., not knowing how to feel better), low mood (i.e., sadness), anxiousness (i.e., intense worry), and low self-esteem/confidence (i.e., being critical of yourself, feeling worthless or not good enough). Other feelings described included feeling hyper, frustration, irritability, and a lack of feeling/numbness.

"Caught up in my own thoughts"
"Overthinking, it's a massive thing"
"Sort of ruminating"
"Hyperactive mind"
"Really in my head"
"Spiral being in my head"
"Thoughts running through my head…rushing thoughts"
"I would overthink the situation"
"My mind would actually loop"

Figure 3. Illustration of participants' descriptions of overthinking.

Physical Symptoms

Participants identified physical manifestations of distress, such as trouble sleeping, problems with eating (over or under-eating), tiredness, exhaustion related to overthinking, and burn out. Heart-related symptoms included palpitations, an elevated heart rate, heart sinking, chest tightness, and difficulty breathing. Other reported physical symptoms include stress headaches, alopecia (hair loss), nausea and digestive issues.

Expression of Distress

Non-clinical Terms

Participants often used non-clinical terms to explain their distress. In particular, the word "stress" was commonly used. The participants said they were comfortable with using this term when speaking to others about their distress. One participant said that describing her distress as stress felt *"more acceptable to use...feels a bit more tangible" (UK, Woman, 29).* Additionally, participants sometimes relied on metaphors when asked to describe their experience; these included *"[having] a dark cloud in my head (Canada, Woman, 18)*, *"feeling…bogged down" (UK, Woman, 25),* and *"…a dam which has had cracks in it" (UK, Man, 33).*

Clinical Terms

While participants mainly described their experiences using non-clinical terms, most were also comfortable using clinical terms, irrespective of whether they had received a diagnosis for a mental health condition or not. One participant clearly stated that they were dealing with depression and anxiety but would not refer to those terms when describing their distress to others.

Inability to Explain Distress

Participants also noted that they often lacked the vocabulary to express distress, especially whilst they were experiencing it. Participants felt they were better able to describe their experiences after time had passed and they had received help.

"…[I] didn't know what I was going through myself. Like I didn't have the words for it" (Canada, Woman, 34).

"The more self-aware I've become...I have like a wider vocabulary to explain it where maybe I don't feel like I did, you know, a couple years ago, and....it's because it felt like you're sitting in the intensity of it. And dealing with it, like how distressing it is" (UK, Woman, 29).

Impacts of Distress

Impact on Relationships

Participants attributed a change in personality to distress. For example, participants complained of feeling more irritable or more reserved and low energy when around their friends. Participants also wanted to isolate themselves, avoiding socialising with their friends and family. Additionally, not wanting to share their distress with friends and family made them feel like they had distant and less honest relationships.

"Less of a trusting relationship...it probably did affect the healthiness because I wasn't…I did isolate myself so...and they [parents] probably didn't understand it...I don't think they even asked me about what was going on." (UK, Man, 33).

Impact on Work and/or Academics

Participants discussed how distress negatively influenced their work or studies. Participants described feeling unable to reach their potential in these areas due to lack of motivation, low-self-esteem/confidence (e.g., to pursue higher education) and an inability to focus. Participants' experiences of distress were also reported to lead to shame because they felt their symptoms made them waste their potential, a feeling compounded by their perceptions about their immigrant parents' sacrifices.

"...your family moves to Canada for life prosperity, and I mean, to waste that potential I think brings the family a little bit of shame I guess" (Canada, Woman, 34).

"Some days are fine, but I am not able to perform at my best self that I know that I can at my potential. I know what I'm capable of, but I can't reach that because of certain aspects of my life, such as my depression and my anxiety…" (UK, Woman, 28)

Impact on Daily Life

Participants reported many ways in which distress affected their daily functioning, including being unable to take care of their household (e.g., not cleaning their bedroom), deprioritising personal hygiene (e.g., not brushing hair or teeth), procrastinating, and not pursuing hobbies.

"When I'm in like a depressive sort of state I just…stay in bed and that's not sleeping to be honest, I'm not asleep all that time it is…I am awake in bed sometimes but it's like I just don't have the energy to get out of it. It's just…I'm so exhausted and fatigued and tired. I just feel like I don't have the energy to get out of bed or sometimes, you know, you have thoughts there, what's the point, kind of thing, getting out bed. There's no point." (UK, Woman, 43)

Positive Impact

In some cases, participants described the positive ways in which distress had influenced their lives including changing careers to work in mental health, becoming more spiritual, developing more empathy, shifting priorities from career-related goals to family, and leaving toxic relationships. For example, some participants highlighted how their relationships improved due to distress. They felt they were better able to support their friends with their own distress thanks to a shared understanding, which in turn brought them closer together.

"So that kind of shift in mental attitude…definitely more…resilient in the sense that normal kind of stresses don't really bog me down in that sense…I think to be honest with you in a weird way, it's had many positive effects in my life I see." (UK, Woman, 25)

Discussion

This study highlights the perceptions of second-generation South Asian immigrants in high-income settings pertaining to psychological distress. The participants experienced a range of psychological and physical symptoms, with overthinking being the most commonly reported symptom. Participants felt that their distress was caused by cultural conflict between white Western society and their South Asian upbringing as well as pressure, family troubles and low self-esteem. Biological explanations were rarely described, but most participants felt comfortable using medicalised terms such as depression and anxiety to describe their distress. Participants felt their distress had consequences on their relationships, productivity, and daily life.

Perceived Causes of Distress

Although participants provided a range of culturally informed explanations for their distress, the most prominent and overlapping ones are discussed below.

Parental Ethnotheories: This study highlights how characteristics of first-generation South Asian parenting play a significant role in second-generation participants' current or past experience of psychological distress. Parenting styles or parent-child relationships are complex and influenced by a wide array of interconnecting and overlapping social, economic and cultural factors. Parents with South Asian backgrounds typically endorse interdependence as their development pathway of choice due to their collectivist orientation as described in parenting ethnotheories ("parental beliefs regarding the appropriate direction of socialization for children, stemming from one's culture-specific understandings of and views on proper parenting practices") (Song et al., 2023; Harkness and Super, 2020). Collectivism can lead individuals to believe that "negative perceptions of…others will also be extended to oneself" and vice versa. Hence, parents from collectivist cultures are typically more critical of their children (Hashemi and Cochrane, 1999) and have lower levels of expressed emotion (Shaikh et al., 2024).

Some participants partly attributed their distress to familial obligation (i.e., worries of disappointing or angering their parents by, for example, choosing an "untraditional" career path). This mirrors Vaswani et al.'s 2022 study, which found a positive association between a social norm transgression (such consuming alcohol or smoking) and depression among South Asian participants because of "an increase in fear of parental negative evaluation but not through fear of own negative evaluation." This finding supported the authors' hypothesis that individuals raised in collectivist cultures are more likely to fear the impact of social norm transgressions on others than those raised in individualistic cultures. Additionally, participants felt that their parents were unable to look after their emotional wellbeing in their childhood and adolescence, causing or worsening the participants' distress. Some scholars refer to this as 'disengaged' parenting, which is emotional neglect or parents' inability to validate or emotionally support their child (Toth and Cicchetti, 1996). Choi et al.'s study on mental health among Asian Americans, who also promote collectivist and interdependent ideals within the family, found that disengaged parenting had a negative impact on Filipino and Korean American youth's mental health (2021).

Also unique to the experiences of immigrants is 'culturally disjointed' parenting or 'intergenerational cultural conflict,' which refers to acculturation gaps between first-generation immigrants and their children. For example, participants cited being forced to wear an Abaya to school and being able to socialize less than their white peers. This connection was also seen in Ying and Han's 2007 study which identified that parent-child conflict in late adolescence, which led to depressive symptoms, was related to perceived acculturation gaps in earlier adolescence. A significant element of cultural conflict is the clash between Western individualism and independence and Eastern collectivism and interdependence. As Shariff (2009) writes, "the emphasis on collectivism [in South Asian families] fosters familial interdependence throughout the lifespan; children are socialized to remain emotionally dependent on their parents well into adulthood." Gupta et al.'s 2007 study with six second-generation South Asian women in Britain found that an important factor in cultural conflict was "the meaning of adulthood." Similarly, Bose (2014) examined Bangladeshi parents' ethnotheories in the UK and found that obedience (a sign of respect) was extremely important and that giving their children choice would be "a renegotiation of parental authority and choice in a diaspora context where individual choice is highly valued." A study with South Asian mothers in London found that the participants believed that praise would lead their children to develop culturally dysfunctional traits (Paiva, 2008). Participants in that study felt a "lack of control and a desire to make their own decisions," a finding also highlighted by participants in our study, who claimed that they had lost their self-esteem, leading to distress. The link between low self-esteem and mental health problems is well established (Samuel, 2009), including for South Asian immigrants (Thompson & Bhugra 2000, Ahmed et al. 2007).

Intergenerational Trauma: In addition to South Asian parental ethnotheories, the second-generation participants in this study faced additional challenges as children in a post-migration context. Second-generation participants frequently cited that their parents' migration story played a further role in shaping their child-parent relationship, linking their experiences to intergenerational trauma. The connection between intergenerational trauma, difficult child-parent dynamics and poor mental health is established in the literature (Hill, 2017); "trauma's transhistorical potential means that a cultural group's traumatic experience in the historical past can be part of the psychic landscape of the contemporary individual who belongs to the same cultural group" (Mambrol et al., 2018; Kaur and Jaggi, 2023). According to the participants, intergenerational trauma in their lives manifested as self-sacrifice (due to traditional gender roles), toxic relationships with parents due to their untreated mental health conditions, and in some cases emotional, sexual, and physical abuse. For example, one participant described how her immigrant mother's fear of experiencing racism and discrimination in their primarily white neighbourhood made the participant feel fearful and unsafe growing up, which she felt contributed to psychological distress as an adult. Another participant reported how her grandfather had been physically abusive towards her father, positing that this was caused by her grandfather's traumatic experiences from the 1947 partition of India. She felt that this in turn led to her father becoming physically abusive towards her, causing her severe psychological distress. Such intergenerational trauma extends also to South Asian people who have not migrated; Kaur and Jaggi (2023) found a moderate level of intergenerational trauma for both the children and grandchildren of partition survivors residing in India.

Cultural Conflict and Identity Struggles: Participants noted that they often felt confused about their identities as second-generation immigrants and as racialized individuals in a White majority society. Cultural conflict is a term that describes how second-generation individuals "must choose either the constraining norms of Asian religions and lifestyles of their migrant parents, and thus maintain ethnic identity, or adopt the relative freedom offered by Western values, mediated by teachers and peers at school, colleagues in the workplace, and the images and ideas diffused by television, radio and press." However, more realistically, these individuals do not make a distinct choice between their ethnic identity and national identity, but rather have fluid identities and values that alter depending on who they are interacting with (e.g., parents versus their peers) (Ali and

Northover, 1999). Post-colonial theorist Homi Bhabha's term "hybrid," for those in a "liminal state" between two cultures, can be applied to the second-generation South Asian immigrants "who walk the tightrope of culture" and are "never quite Asian enough nor are they quite White enough" (Shariff, 2008). This "liminal state" or "tension" between two supposedly opposing cultures can lead to significant psychological distress (Moller, 2016; Bhardwaj, 2001). A quantitative study with second-generation Asian (mostly Southeast Asian) adolescent immigrants in the US found that increased levels of identity conflict correlated to increased levels of depression (Vaghela and Ueno, 2017). One possible explanation is that continuous forming and reforming of identity can lower one's sense of self and self-esteem, which in turn has negative consequences for mental health (Vaghela and Ueno, 2017).

Symptoms and Expression of Distress

Overthinking is a common symptom *and* cause of distress, though it may present differently across cultures (Hinton et al., 2015, Ehring, 2021). In their global systematic review of "thinking too much" idioms, Kaiser et al. (2015) found that "*participants themselves* related "thinking too much" to depression, though it was often unclear whether this referred to the psychiatric construct or to a more idiomatic expression." Additionally, Yang et al. (2009) explored explanatory models of psychosis in China and identified excessive thinking as a reported cause and symptom of illness.

Comparatively, this study's participants identified overthinking as a significant symptom of distress, rather than as cause or expression of distress. The concept of overthinking or "thinking too much" in regard to mental health problems in South Asian immigrant populations has been examined in the literature. For example, a qualitative study with Pakistani women with depression in the UK showed that participants linked having continuous thoughts to their low mood, meaning overthinking was seen as both a psychological symptoms and cause of sadness (Rafique, 2010). Similarly, a cross-cultural comparison of South Asian and European American women highlighted that South Asian participants would be more likely to hold negative perceptions around "thinking too much" than their European American counterparts (Karasz, 2005). Considering the commonality and importance of this symptom, language pertaining to overthinking can be incorporated into service delivery to identify individuals with, or at risk of developing, a mental health condition (Kaiser et al., 2015).

It is perhaps unsurprising that overthinking or rumination was an important psychological symptom for the second-generation participants. They mentioned that their distress partly arose from the pressure and expectations from their parents to be perfect and to achieve, which could shape them into becoming perfectionists, who “tend to perceive constant pressure in their life, focus on negative events, fear being criticized, and subsequently worry about the future and ruminate about the past” (Xie et al., 2019). For example, an American study with people of Indian descent found that perfectionism was associated with depressive symptoms and Family Recognition Through Achievement values (Methikalam et al., 2015). Interestingly, rumination acts as a mediator between perfectionism and distress (Xie et al., 2019). Therefore, we can hypothesise that the participants’ tendency to overthink may be tied to the pressure they feel to be good or perfect.

Perceived Consequences of Distress

Participants in this study believed their experience with distress impacted their lives in three significant ways: their relationships with friends and family, work or academic success and their ability to complete daily tasks. To our knowledge, there is limited literature to which these findings can be compared. A recent meta-analysis which looked at studies from 2010 on beliefs and perceptions on mental health conditions showed that most research focused on symptoms, perceived causes, descriptions, and help-seeking patterns (Choudhry et al., 2016). However, there is some indication that our findings align with existing evidence. For example, a qualitative study with Ethiopian university students experiencing mental distress found that participants were concerned about how their distress disturbed their relationships due to increased conflict and depreciated their academic success due to lack of motivation. Regarding the South Asian population, Bhui et al. (2006) reported that the Bangladeshi participants with a CMD (n=57) reported psychological consequences (100%), followed by physical consequences (59.7%) and social consequences (56.1%). Further, in a cross-cultural comparison of Australian Sri Lankans and Anglo-Australian, Antoniades et al. (2017) revealed that both groups were concerned about the social impact of their mental health problems. However, slightly more Anglo-Australians reported an inability to work because of distress than the Australian Sri Lankan group. These mixed results indicate that social consequences of distress are likely important to people of South Asian origin. However, this comparison to the literature also indicates that while culturally informed, perceived consequences of distress are unique to the individual.

Exploring an individual's beliefs about the impact of their distress is important given its probable relationship with their conceptions of recovery. For instance, when individuals perceive their distress as adversely affecting familial relationships—a perspective reported by several study participants—we can hypothesize that their ideas of recovery may involve the ability to maintain healthy familial connections. This possible relationship has implications for mental health service delivery; individuals who are most concerned with their relationships may be more inclined to pursue family therapy or individual counseling over pharmacological interventions. Therefore, future research should investigate how individuals with lived experiences of distress perceive the consequences of their condition and how these perceptions shape their recovery goals, which in turn may influence their choices in treatment modalities and the outcomes of these interventions.

Strengths and Limitations

This study used an intersectional and participatory approach to investigate the explanatory models for second generation South Asian immigrants living in cities in Western, high-income countries. It was also led by a second-generation South Asian immigrant, who was able to use her network and lived experience to inform the scope of the study and build trust with community organizations and participants. Coupled with the second part of this study, which focuses on the experiences of first-generation immigrants, we can better understand the convergences and divergences of experiences of distress between generations and how this may affect the mental health and help-seeking of each group. This study can help the development of policy and practice that is guided by medical anthropology that is applicable in clinical contexts.

There are several limitations in this study including the diversity of the participants. Due to the scope and nature of the study, we included individuals from all South Asian religions and countries

(India, Pakistan, Bangladesh and Sri Lanka), limiting our exploration of the intersectional experiences of the participants. To minimise this limitation, we asked participants to describe in their own words their education and job, ethnicity, religion, and if they felt as though they belonged to any identifying groups. Also, it is widely acknowledged in the literature that South Asian communities share many common features, especially when it comes to family characteristics (Chowdhury and Okazaki, 2020).

Men were under-represented in this study, which may partly be explained by gender norms and societal expectations for men to not share their feelings with others (Borg et al., 2024). Older adults (only one participant was 60+) were also under-represented, likely due to our recruitment style (most participants were primarily recruited via mailing lists and social media). Future research could focus entirely on the experiences of second-generation South Asian men, perhaps recruiting through men's groups or social media, or on older second-generation South Asian individuals.

Finally, this research likely cannot be applied to the South Asian diaspora in low or middle-income countries, given the different migration histories and political, economic, and social contexts.

Conclusion

'Culture' is not very well defined in healthcare research and therefore must be used cautiously. We do not wish to endorse stereotyping and create "a series of dos and don'ts that define how to treat a patient of a given ethnic background" (Kleinman and Benson, 2006). Rather, we would like to raise awareness around the importance of culture and ethnicity in the experience and management of mental health. While the study results can contribute to the development of culturally accessible mental health services for South Asian immigrants, ultimately this is a story about the immigrant experience and the intergenerational transmission of culture and mental health.

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SECTION A – Student Details

Student ID Number	1702879	**Title**	Miss
First Name(s)	Ruchika		
Surname/Family Name	Jain		
Thesis Title	The Cultural Conceptualisations of Psychological Distress and Help-Seeking among South Asian Immigrants in the UK and Canada		
Primary Supervisor	Dr. Abhijit Nadkarni		

If the Research Paper has previously been published please complete Section B, if not please move to Section C.

SECTION B – Paper already published

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SECTION C – Prepared for publication, but not yet published

Where is the work intended to be published?	PLOS Global Public Health
Please list the paper's authors in the intended authorship order:	Ruchika Jain, Ritsuko Kakuma, Daisy Singla, Abhijit Nadkarni

Stage of publication	**Not yet submitted**

SECTION D – Multi-authored work

For multi-authored work, give full details of your role in the research included in the paper and in the preparation of the paper. (Attach a further sheet if necessary)	Ruchika is the lead author. She was involved in conceptualisation, data curation, formal analysis, funding acquisition, investigation, methodology, project administration, validation, and writing (original draft, review and editing). Ritsuko, Daisy, and Abhijit contributed to supervision, study conceptualisation and methodology and also reviewed and edited the manuscript.

SECTION E

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Paper #5: The influence of culture on help-seeking for psychological distress for second-generation South Asian immigrants in the UK and Canada: a qualitative study

Abstract

Background: There is limited evidence on help-seeking behaviours and coping strategies used by second-generation South Asian immigrants due to the lack of disaggregated data. However, this population is growing sizably and likely experiences mental health conditions at similar or higher rates than first-generation and native populations. It is imperative to tailor mental health services to be culturally sensitive for this group.

Methods: We interviewed second-generation South Asian immigrants based in the UK and Canada. They all had at least one self-reported experience of psychological distress for a sustained period of time within the past 5 years. We followed the steps outlined by Clarke and Braun (2006) to analyse the data and validated it by hosting six public consultations in which members of the South Asian community were invited to comment on the themes.

Results: The participants relied on themselves to feel better, reporting they spent time with friends and family, exercised and prayed. Participants did not always speak about their distress to others, but sometimes would have conversations with individuals with shared experiences. Social media emerged as an important resource for participants – it was helpful to see other people share their mental health journeys. Most had seen a General Practitioner (GP) or counsellor/therapist but were disappointed with the support they received.

Implications: Based on the results we recommend diversifying the workforce, implementing person-centered care, training GPs to be able to treat their patients with mental health conditions holistically, boosting social media and in-person platforms to allow individuals to share their stories and 'normalise' mental health, and running culturally sensitive campaigns to address the lack of mental health awareness and stigma in the South Asian community.

Introduction

Second-generation South Asian immigrants are an important part of society in many high-income countries, including the UK, Canada, US, and Australia. Their presence is growing, partly due to increasing immigration from South Asia to high-income settings. Members of this group are considered “model minorities”, partly because of their educational and professional achievement. In reality many second-generation South Asian immigrants in these countries struggle with immense pressure and expectations from their families to succeed, racism and discrimination and their ability to straddle two opposing cultures, contributing to the development of mental health conditions, often at higher levels than local populations and compared to first-generation immigrants (Moller et al., 2016). For example, evidence suggests that second-generation South Asian immigrants experience higher levels of depression and anxiety than their white and first-generation counterparts (Islam et al., 2014).

Despite the burden of mental health conditions apparent among second-generation South Asian immigrants, these individuals tend to underuse formal mental health services. Some evidence indicates that even though second-generation immigrants are more likely to contact mental health services than first-generation immigrants, mental health service use is still low, especially for ethnically diverse second-generation immigrants (Soorkia et al., 2011). It is important to note that data on mental health service use among South Asian immigrants are generally aggregated (Prajabati and Liebling, 2022), meaning there is limited information on mental health service use specifically for second generation South Asian immigrants. Current health and social care research de-prioritise second-generation individuals in comparison to new first-generation immigrants and refugees (Lam et al., 2018). The lack of research specifically concentrating on the needs of second-generation immigrants is problematic considering how each generation’s stressors, experiences and help-seeking behaviours are unique (Mindlis and Boffetta, 2017; Hashmi et al., 2011).

While systemic factors (such as lack of awareness of available services) influence help-seeking behaviours for psychological distress (Soorkia et al., 2011), cultural factors also influence whether people want help, where people seek support (themselves, formal mental health services, family, or communities, for example) and the outcomes of help-seeking (Gopalkrishnan, 2018). Second-generation South Asian immigrants face several cultural barriers to mental health service use. The endorsement of collectivism in South Asian communities is an example of this statement. Considering South Asians tend to prioritise family over the individual, second-generation South Asian immigrants may feel concerned that seeking help for a mental health condition could negatively impact their families (Masood et al., 2009, Tummala-Narra, 2013). This phenomenon is known as ‘courtesy stigma,’ which is “the contagion effect of social stigma from the marked individual to family members” (Chaudhry and Chen, 2019). Courtesy stigma is more likely to be experienced by South Asians than European Americans (Chaudhry and Chen, 2019). It can exacerbate an individual’s distress and disconnect them from family members (Sharma et al., 2020, Bradby et al., 2007).

Though the research is limited, culturally informed barriers to help seeking for mental health conditions among this population have been discussed in other studies. For example, Moller et al.’s 2016 qualitative study examined second-generation South Asian women in the UK’s views on counselling for mental health conditions and found that there are substantial barriers to help-seeking. The participants in this study held negative views about counselling, citing racism, discrimination, and a lack of understanding from white counsellors, as well as a fear of judgment and gossip from South Asian counsellors (Moller et al., 2016). Their findings suggest that mental health services must urgently be re-shaped to be culturally accessible.

Discounting these cultural differences in healthcare services can cause and perpetuate health disparities (Kirmayer and Swartz, 2014). ‘Cultural exclusion’, in which healthcare services are tailored to fit only the majority population, can lead to delayed or misdiagnosis or referrals to inadequate services for ethnically diverse populations (Bowl, 2007). Recent efforts in the UK, Canada and beyond include the creation of culturally sensitive services, cultural adaptation of existing psychotherapies such as Cognitive Behavioral Therapy (CBT) and person-centered care, which have led to some advancement in accounting for difference in mental health service provision. However, there is still a dearth of analysis on cultural groups’ preferences for treatment (whether it be self-help, religious or formal, for example), which is required to identify which resources to invest in to improve mental health outcomes.

The overall aim of the current study was to explore help-seeking for psychological distress among second-generation South Asian immigrants in the UK and Canada. We identify facilitators and barriers to help-seeking. We then report how this group's understanding and experiences synergize to shape how an individual copes with and seeks help for their psychological distress, which is also tied to their expectations for treatment and recovery.

Methods

Study Design

We used a qualitative study design, with semi-structured interviews, taking an intersectional and social constructionist approach.

Study Sites

We conducted interviews in a) the Greater Toronto Area and b) London, United Kingdom, cities with a high proportion of individuals with South Asian origin.

Participants

Eligibility Criteria

We included second-generation individuals who were born in Canada or the UK and had both parents descended from India, Pakistan, Bangladesh, or Sri Lanka and at least one parent born in one of these countries. Additionally, they must have been 18+, English-speaking and have had a significant self-reported period of psychological distress within the past 5 years. Any exceptions we made are detailed in the participant demographics (Appendix).

Sample Size

We estimated that our sample size would be approximately 20-30 and halted data collection when we achieved sufficient information power within the constraints of limited time and resources (Clarke and Braun, 2019). We attempted to obtain maximum variance on factors such as gender, age and intensity of psychological distress.

Recruitment Strategy

We recruited participants through purposive and snowball sampling. Most participants were recruited through community organizations and South Asian networks (e.g., through newsletters and mailing lists). We also placed recruitment posters in local sites such as libraries and places of worship. We did not recruit from clinical settings because we did not want our participants to over-represent individuals who engage with formal healthcare.

Data Collection

RJ, a second-generation South Asian from Canada, conducted all the interviews individually.

We created the topic guide by consulting with experts, conducting a systematic review (Jain et al., 2025) and drawing influence from pre-existing, validated interview guides such as Kleinman's 8 Questions (Kleinman and Benson, 2006), the Cultural Formulation Interview (CFI) (Lewis-Fernandez et al., 2020) and the McGill Illness Narrative Interview (MINI) (Groleau et al., 2006). The initial draft of the topic guide was tested with four members of the South Asian community in the UK (n=1) and Canada (n=3). We also revaluated the interview schedule throughout the data collection process, revising it based on our findings.

The interviews were a duration of approximately 45 to 75 minutes and were held via videoconference (n=20) or in-person (n=1), according to the participant's preference. We recorded the interviews then transcribed and stored them on a secure server. One participant did not want to be audio recorded, so RJ took detailed notes. Participants were also asked to complete a demographic form.

Data Analysis

RJ and ND transcribed the interviews. RJ then analysed the de-identified transcripts on NVivo 12.0 using the steps for reflexive thematic analysis, outlined by Clarke and Braun (2006) and refined by Campbell et al. (2021). The steps included: data familiarisation, initial code generation, generating initial themes, theme review, theme defining and naming, and report production. We analysed the UK and Canada interviews separately and then merged the themes and sub-themes.

We calculated Kappa scores to check the validity of the coding. Two researchers with extensive experience in qualitative research coded random sections of two transcripts (NA and GV). However, after discussions, we concluded that we should not present the kappa scores because of its consistency with positivist, rather than social constructivist epistemological positions.

RJ engaged with reflexive practices such as maintaining a reflexivity journal for the duration of the data collection, analysis and writing up process. RJ is a second-generation South Asian and reflected on how her pre-conceived notions may have impacted the research process. While she shared many characteristics with the participants, she did not consider herself an "insider." According to intersectional theory, the insider/outsider dichotomy does not exist (Ademolu, 2023).

Self-identified South Asian individuals (18+) based in the UK and Canada were asked to comment on the study findings at two timepoints (n=40). It helped increase the validity of the data analysis process because we could check our initial and final results with the public (Manikam et al., 2022).

Ethics

We obtained ethical approval from the London School of Hygiene and Tropical Medicine (UK) (ref:28173) and Mount Sinai Hospital (ref: 23-0030-E). We gave participants the choice to provide either verbal or written consent. We gave all interview participants a 25 GBP/25 CAD a gift card as a token of appreciation for their time and effort. We created a list of individuals and resources who could be contacted in the case a participant became distressed during the interview process.

Results

Participant Demographics

We interviewed 21 participants (n=14 born and based in the UK and n=7 born and based in Canada) (Appendix). The participants originated from least one parent born in India (n=7, 33.3%), Pakistan (n=7, 33.3%), Bangladesh (n=4, 19.0%) and Sri Lanka (n=2, 9.5%). One participant had one parent born in India and the other in Pakistan (n=1, 4.8%). Their ages were between 18-62 (mean= 33.0 years, SD= 10.3) and the intensity of their distress was described as a little intense to very intense. 'Neutral' was not identified as a description of distress by any of the participants. The participants had received formal education (n=21, 100%), were working (n=18, 85.7%), or studying (n=3, 14.3%). The participants self-identified as female (n=18, 85.7%) and male (n=3, 14.3%).

Key Themes of Help Seeking

Facilitators to Seeking Help

When asked what made them seek help in the first place, participants gave many reasons, including worsening of symptoms (e.g., periodic sadness shifting to continuous sadness, having a panic attack), newly learning about where to go for help (i.e., through information leaflets at the library or university, internet resources, social media), and decreasing experiences of stigma (i.e., through raising their own awareness around mental health and normalising seeking help). Other reasons for seeking help included wanting to improve relationships, contribute to society, availability of low-cost therapy, and experiencing a life altering event (e.g., a car accident).

"I think I do it only when it gets worse. When things are manageable for myself, I keep them to myself…" (Canada, Woman, 28)

"I think a lot of it was actually self-taught in the sense that I went and looked for organizations. I went and looked for maybe studies or articles or personal experiences" (UK, Woman, 28)

"That kind of desperation to get out of that feeling to get rid of it and to feel happy again, to be well again, to feel like part of the social fabric and part of the world." (UK, Woman, 36)

Barriers to Seeking Help

A primary reason participants gave for delaying seeking help, was having an unsupportive family (having family members with stigmatised views of distress or a lack of awareness of how the help worked), especially when the participant lived in the same household as other family members and needed to seek permission to access professional help.

"My father…I don't think he took it seriously at all. And he would hold the therapy thing over my head a lot about how you know "we're paying money for you to be happy" and he would say things like "you get to go over there and have your therapy sessions, the rest of us have to suffer here" or he would dangle that stuff over my head because I don't think he understood what it was like" (Canada, Woman, 18)

Participants described how certain South Asian family dynamics inhibited them from seeking help inside and outside the family. For example, some participants said that they did not seek help from family members because there is no or limited focus on emotional wellbeing in South Asian families and an emphasis on "forgetting" and moving on. Also, participants felt that they had internalised their immigrant parents' attitudes about staying strong (e.g., "smile and crack on" or "put on a brave face") and that asking for help is a sign of weakness. Participants spoke about how their parents worked hard and sacrificed for them to have better lives in their host countries that the participants' complaints felt insignificant in comparison. For example, one participant felt as though he was his parents "only shot*"* and did not want to disappoint them by being weak ("it's the whole migrant story, right?").

"Don't like show too much emotion, that was like a sign of weakness and there's something about being able to just like bear it. It is like, keep it inside, and you show the world that you're quite strong because you have to...exist in a world where there is so much inequality" (UK, Woman 29)

"I mean both of my parents have been like that…I guess being able to deal with issues on your own. I would say probably growing up my dad was very like quiet, reclusive person...it was obvious he was going through shit, just leave the house for whatever reason" (UK, Man, 27)

Additionally, many participants were concerned about burdening other people with their distress. This was felt particularly strongly in relation to their parents, who they felt had already struggled a lot in their lives due to their identities as first-generation immigrants. One participant also mentioned that not burdening others is an aspect of South Asian culture.

"So I'm just that kind of person that I try…basically I try not to burden anybody…it's just the way I was brought up. That you don't put hinderance on other people – because if someone does something for you, you have to do something for them, says it's a cultural thing, the way Indian society is" (UK, Woman, 30)

"I think part of it was that I was watching my mom experience the exhaustion as a result of my situation, I was like okay it's not fair for me to put this on anyone else" (Canada, Woman, 28)

Some participants also reported that they themselves did not understand what they were going through (the distress) and therefore did not know where to go to for help.

"I felt like because I didn't understand what was happening to me, I didn't know what to do with my feelings." (Canada, Woman, 34)

Finally, other barriers to help-seeking included systemic barriers (e.g., long wait lists for therapy or counselling (especially long-term), high cost of private therapy), a dearth of South Asian professionals, and not feeling like symptoms were severe enough to warrant help.

Coping Strategies

This section describes the individual, informal, religious, semi-formal and formal ways that participants described dealing with their distress.

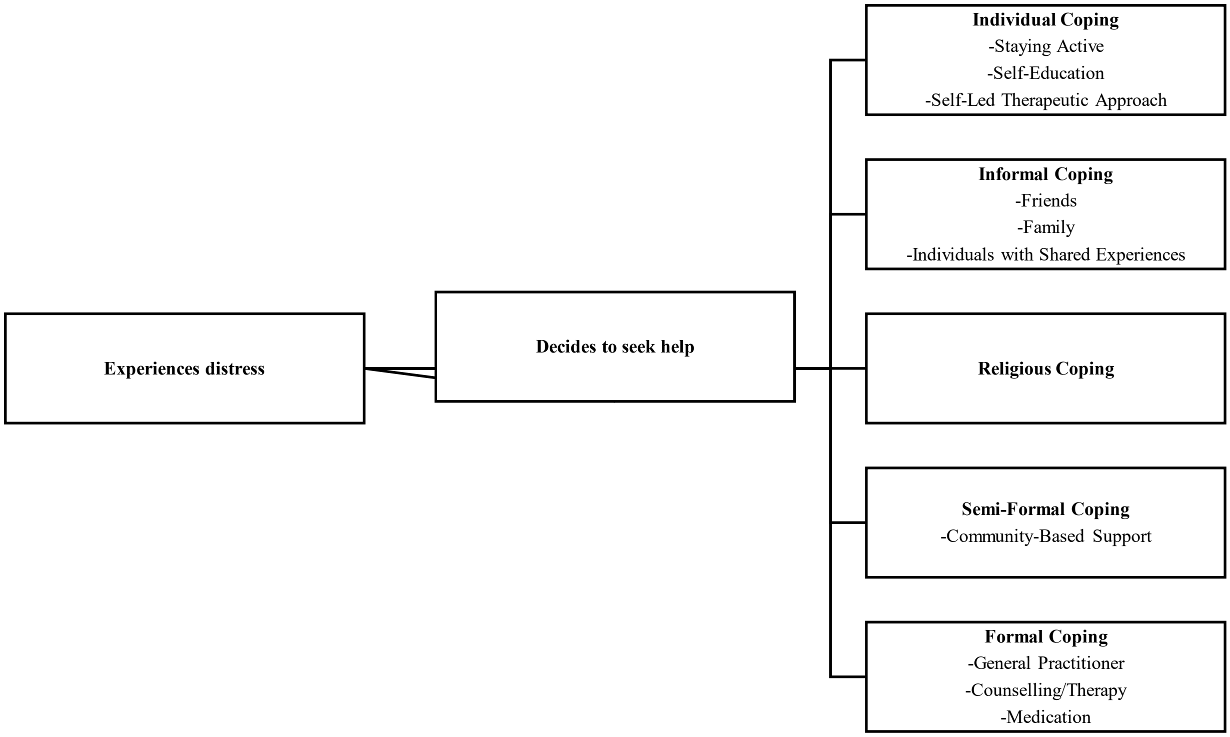

Figure 1. Participants reported coping strategies under five domains.

Individual

Individual coping strategies include those where participants primarily relied on themselves to cope with their distress by keeping busy, exercising, and using online resources.

Staying Active

Participants liked to stay busy to take care of themselves by engaging in pleasurable and meaningful activities such as cooking, cleaning, working, making to do lists, doing charitable things, and engaging with their hobbies, including watching TV/movies and listening to music.

"Making sure that my day is packed with… meaningful work. You know…where I'm like, hey, this is going to make me feel like I've done something" (Canada, Woman, 44)

Most mentioned that they engaged in some form of physical activity to cope with distress. This included walking, running, and going to the gym. Other activities included yoga, dancing, and playing sports. Reasons for engaging in physical activities included a mind-body connection, fostering a sense of achievement, boosting endorphins, facilitating calm and offering a form of distraction.

"For my mental health, [running] gave me a focus, gave me a sense… that feeling of achievement, the general sense of how you feel the serotonin levels after…a run. And it also tired me out mentally to the point where I just knocked out at night, because I had real trouble sleeping when I was…when I was really depressed, and so physically tiring myself...and then eventually that brought me out of that depression." (UK, Woman, 36)

Participants also described changing their scenery to help themselves when experiencing distress. This included spending time outdoors (walking, gardening, stepping out into the sunshine), going to a cafe, seeing friends, spending time in your own bedroom, and going to therapy in a new space.

"Sitting in a different environment that really helps also...something about a different physical space that was just as nice" (UK, Woman, 36)

Self-Education

Participants reportedly engaged in seeking and reviewing self-help resources to learn about mental health and coping strategies, by reading books, articles and tools recommended by professionals. Many participants talked about the help they received from online resources, especially social media (Youtubers, Instagram, Facebook). Participants described how seeing other people talk openly about their distress helped them learn about their symptoms, learn new coping strategies (from how the people online got through it), and empowered them to seek professional help.

For example, two participants found Muslim/Islamic groups through social media. One participant learned about prayer and learned about *'internal work'* which made her realise that she was struggling. Other participants described not understanding what they were going through and using online resources for clarification (e.g., a participant said she felt something like a panic attack, but not quite, so she went online and saw it was an emotional breakdown).

"I think that does help and just kind of seeing how people go through depressive episodes sometimes they do put that online…I think that authenticity really educated me, like personal experiences" (Canada, Woman, 25)

Self-Led Therapeutic Approach

Some participants used techniques such as mindfulness, meditation, grounding, and journaling to cope with their emotions. Conversely, one participant described just *'burying'* their emotions to manage their distress, while another said they *'ignore it*'.

Informal Care

Some participants spoke about their distress to family and friends or those with shared experiences, but mostly they preferred to spend time with these individuals as a distraction, not, or barely mentioning their distress.

Friends

Participants reported being very careful about who they share their distress with because not all friends can understand, empathise, or say the right thing. At most, participants would describe the situation that they are in or say that they are depressed but would not provide details. Instead, participants preferred to spend time with their friends as a distraction. One participant described how he had a group of other male South Asian friends who help him feel accepted: giving him an ear or a shoulder to cry on, being available, taking him into a new environment to get his mind off things, and checking in on him.

"So, you know when I'm upset I do a lot of rumination, I do a lot of spiraling into my more sad inner thoughts and talking to my friends, not necessarily about the thoughts, if I focus on them [the friends] and the conversation at hand, and I focus on the love that's in the room or whatever and I'm able to get my thoughts off of whatever it was at before and I don't have to be alone" (Canada, Woman, 18).

“So yes, I do talk to my friends, but I have learned that that's not always helpful. And that's not because they're not helpful, it's just that it's so foreign to them. Because they haven't been through what I've been through, like it’s not going to be helpful for me, you know, like they can't understand why my mom is abusive…" (Canada, Woman, 44)

Family

Sharing distress with family members was a complicated experience for many participants. Participants felt that their family members could not understand; they felt ashamed or like they would be judged, and/or that they did not want to be a burden. Some participants lived in the same household as their families or were under the age of 18 when experiencing distress, which forced them to seek permission from their parents to get formal help. In some cases, however, participants reported receiving help from a parent (usually their mother) or sibling.

“I think because we [participant and her sister] grew up in the same household and like with this similar experience, we relate lots to our struggles and I think we understand each other in a way. Like nobody else could” (UK, Woman, 27)

Individuals with Shared Experiences

Many participants spoke about the benefits of talking about their distress with people who had had similar experiences. They reflected that it was nice to speak to someone who could understand some aspects of their life that others couldn't (e.g., being a racialized woman, struggling with identity as a second generation South Asian). They could also learn about different ways people coped with the situation they were in. Participants were able to be more open and vulnerable with their situations and could feel as though what they are going through is not shameful (e.g., one participant saw a Youtuber she followed go to therapy, another spoke to people who had also experienced postpartum depression).

“It’s good to always speak to someone who can understand what you’re going through but is also not going through [it] at the same time, cause they have a different perspective that they maybe

sometimes bring. They're not caught up in the emotions as much as everyone else" (UK, Woman, 25)

Drawbacks of discussing experiences of distress with those who had similar experiences were also highlighted. One participant noted that sometimes speaking to someone who has gone through something similar can be triggering.

"Sometimes I feel like it does trigger my own because I get reminded of what I went through, like having this conversation with you, it just brings back the emotion, like "oh my god, I actually went through that" (Canada, Woman, 34)

Religious/Spiritual/Folk

Many participants, mostly those who identified as Muslim, privately engaged with religion to lessen their distress.

Religious Practices

Most participants cited prayer as the most significant way they practiced their faith. Praying gave participants peace and calmness. Most participants prayed alone, but occasionally went to a place of worship (such as the mosque) or prayed in a group setting or with their partners. However not all participants felt comfortable with going to the mosque (e.g., were uncomfortable with the Imam's messaging or was a single mother with sons she did not want to leave alone in gender segregated mosques).

Alongside prayer, some participants engaged with religious practices by listening to religious music (e.g., Christian worship music, Sikh Simran songs), reading religious or spiritual texts (e.g., the Quran or work by Eckhart Tolle), and attending religious groups either in-person or online to pray together or specifically to talk about mental health.

Participants said that using their religion/faith during their experiences of distress helped them in the following ways: to get guidance, reassurance that you are on the right path and that things happen for a reason, feeling less alone (because “there is always God to talk to”), and to find peace, calmness, and solace. One participant said if they are looking for someone to blame for their distress, they blame God.

Some participants described attempting to reconnect with their religion in adulthood, citing various motives (i.e., to combat Islamophobia, to better understand their identity, to connect with their family heritage). This reconnection was often complicated, with participants having been forced to participate in religious activities by their parents as children or feeling that they were mistreated in part due to their religion (by abusive parents, for example).

“It’s a way of speaking to God. So, it is like therapy in a way for me” (UK, Woman, 32)

“I was born into this Sikh religion, and I've tried so hard to connect. So, so hard. I think again, it's mixed with a lot of anger because of what my parents exposed me to” (Canada, Woman, 44)

Semi-Formal Care

The participants rarely, if ever, engaged with semi-formal care.

Community-Based Support

Some participants reported receiving help from community-based services. These included distress centres, mental health charities (for counselling, including Mind and smaller domestic violence charities), the case manager at a community organization, and wellbeing groups (both discussion groups and groups focussed on activities like swimming and knitting).

For example, a participant experiencing significant distress asked their case manager at a local South Asian health organization in Toronto to meet with her family “to explain to them better” what she was going through because she felt they did not understand what she was going through or how to interact with or help her.

Formal Care

Most participants had engaged in some form of formal care, with visiting the GP for support being the most frequently cited resource.

General Practitioner

Most participants had seen a GP regarding distress, primarily outlining neutral or negative interactions. Participants believed that a GP's role in mental health service delivery was currently limited to referral to specialist services and prescription of medication. Participants wanted their GP to treat their distress using a holistic rather than individualistic/biomedical approach.

"I felt very dismissed. I felt it's just such a quick process every time I meet that family doctor, she was just kind of like "oh here's some sources go do the work" (Canada, Woman, 25)

"I don't see how that's [medication] the only solution in their eyes and just say, oh well, just give me some pills and everything would be better. Or we will offer you counselling just so you don't kill yourself today but you might kill yourself tomorrow kind of thing. So they just offer you enough support for now, not for the future" (UK, Woman, 30)

In one instance, a participant described how the validation she received from her GP persuaded her to continue to seek formal help.

"Having him [GP] listen and felt heard and how much having someone else who wasn't involved in my situation tell me that my feelings were valid and I have a right to feel this way...made me seek help" (Canada, Woman, 34)

Medication

A few participants were prescribed medication to help them cope with their distress, but never took it or stopped due to perceived negative side effects such as weight gain, increasing suicidality, and feeling lethargic, as well as considering it only a temporary "sticky plaster" fix or for "extreme" situations. The participants who were on medication at time of interview commented that they would prefer to not be on it for a long time.

Counselling and Therapy

Participants primarily accessed counselling and therapy on referral from their GP. Some participants received counselling or therapy through their place of study or a charity or paid for private therapy.

Participants received various therapies, including cognitive behavioural therapy (CBT), psychodynamic and person-centered therapy, talk therapy, acceptance and commitment therapy (ACT), emotionally focused therapy (EFT), and trauma-focused therapy.

Participants described many ways in which they benefitted from therapy. Firstly, participants felt that their counsellor/therapist could provide them with a non-judgmental perspective, validation, and reassurance which a non-professional such as a friend or family member could not. Secondly, participants perceived that a counsellor/therapist could help their client identify the root causes and patterns of their distress. Third, participants felt like they could learn coping strategies and get tools and resources to respond to negative emotions. Finally, participants liked that seeing a counsellor/therapist gave them a safe space to go to mentally and physically.

"Physical space and having the space to like go [to therapy]...and that was my space. No one knew where it was" (UK, Woman, 29)

"When you talk to friends and family they can be quite judgmental and they have their own spin on things" (Canada, Woman, 30)

Healthcare professional with the same or similar cultural/ethnic/religious background

Some participants preferred speaking to a therapist or counsellor who shared some aspect of their cultural/ethnic/religious background because they would have a shared understanding and would not have to spend time explaining things like racism and discrimination and South Asian family dynamics. Others said that speaking to someone who was a Person of Colour would also be beneficial, again because of a shared understanding. Some participants mentioned some issues around privacy (given how small the South Asian community is) and fear of judgment. Some participants did not mind having a white counsellor (one participant said their white counsellor really helped her understand her race) if they used an "anti-oppressive" lens. In another case, one participant said the gender of the healthcare professional mattered more to her. Other participants described being misunderstood by their white counsellor; for example, being confused for Hindu when they were Muslim.

"I don't care about representation that harms me I care about representation that helps me." (Canada, Woman, 28)

"Quite a few people that have put in their emails to me [a therapist], I want to have someone who is racialized like me. It is quite interesting, my South Asian clients, I've got one Pakistani heritage one, one of Indian Tamil heritage, they're not the same thing as well, different religions, one is Muslim, one is Sikh but there is some shortcut of understanding that we have, that they just don't have to explain anything at all" (UK, Woman, 48)

"It [professional's religion/ethnicity] doesn't change the fact of the way the counselling is conducted" (UK, Woman, 30)

Recovery

Participants were asked what changes they would like or expect in their life after receiving help for distress and/or what being well meant to them.

Definitions of Recovery

Though participants gave answers specific to their experiences of distress, they could be categorised as the following: improved self-esteem and confidence, better relationships, increased ability to work (including feeling like they have a purpose and doing good in their community), improved management of distress (being more aware of, and using, healthy coping mechanisms) and transforming and accepting feelings of distress. They also reported wanting to feel happier, more peaceful, less anxious, and neutral.

"…because it's like trusting yourself and knowing that you have it in you to overcome something…any of those things could happen again…I have the tools to encounter them and like heal from it." (Canada, Woman, 23)

"To not keep going back to that kind of child, who is you know, feels like worthless and isn't good enough" (UK, Woman, 36)

Discussion

In this study, most participants did not see the benefits of pharmacological intervention. Instead, they preferred to cope individually, socially or by attending therapy/counselling. These findings are discussed in relation to the wider literature below.

Discussion of Key Themes

The Role of Self: Engaging in Activation

Most participants engaged in what clinicians call behavioural activation, which posits that "an increase in participation in pleasurable activities boosts levels of positive affect and that such an increase in activity and positive affect is sufficient to decrease depressive symptoms" (Jacobson et al., 2001; Chartier and Provencher, 2013), whether they had received cognitive behavioural theory or not. The activities differed by participant and included doing hobbies (cleaning, knitting, baking), exercising, spending time with friends (without speaking about their distress) or going outside. This result has also been found in South Asia. Aggarwal et al.'s (2014) systematic review and qualitative study both confirmed that self-distraction (i.e., staying busy) was a common tool employed by people with depression in India. The authors identified behavioural activation as a psychological treatment strategy that should be culturally adapted for individuals in South Asia. One such strategy was successfully tested in Goa, where a Healthy Activity Programme helped women with depression increase their activation level and decrease depressive symptoms (Patel et al., 2019). Such strategies may be beneficial for the South Asian diaspora as well.

The Role of Religion: Cognitive Coping

The three primary ways that individuals use religion to cope with distress are practicing religious activities, receiving social support through faith leaders or during religious gatherings, or "reframing stressful events in reference to their relationship with God" (Adam and Ward, 2016). Participants in the current study primarily engaged with cognitive forms of religion (such as trusting in God to remedy their pain), but also engaged with behavioural forms (such as listening to religious music) and occasionally social forms (praying in a group with other young Muslim women). This aligns with Alsubaie's 2023 study which found that Muslim refugees who had experienced trauma preferred cognitive religious coping over the others (Alsubaie et al., 2023). It should be noted that most of the participants identified as Muslim; other religions included Christianity, Buddhism and Hinduism and no religion. While there is limited research on religiosity among second-generation immigrants, some evidence suggests that second-generation Hindus and Catholics were far less likely to maintain their parents' religion than second-generation Muslims, which is important when considering the findings pertaining to religious coping in this study (Chen and Park, 2019).

The Role Social Support: Friends and Shared Experiences

Participants preferred speaking to individuals with shared experiences, fearing their close friends and family would not understand what they were going through. This preference was also described in Antoniades et al.'s study where Sri-Lankan Australian participants relied on 'compatriots', defined as "individuals who had been touched by mental illness, or even the experts 'who really understood,'" especially in the early stages of their depression. Therefore, peer groups or increasing the online presence of people with lived experience of a mental health condition, is an important care option for second-generation South Asian immigrants and beyond. For example, a scoping review on psycho-social groups in South Asia found that "trusted relationships undergirded all mechanisms, and provided a sense of inclusion, social support and of being able to manage mental distress due to improved skills and knowledge" (Mathias et al., 2023).

The Role of the Formal Care: Family Doctors

GPs were found to be an important service provider in this study; most participants had spoken to their GP about their distress. Though data about GP usage among this group is limited, there is some indication that second-generation South Asian immigrants are more likely to have contact with primary care regarding mental health than first generation immigrants (Hashmi et al., 2011). However, participants frequently commented that although GPs play a crucial role in mental health care (as often they are the first point of contact), they felt they could only prescribe them medication or refer them to services. Many participants wished that their GP could receive training to enable them to provide more listening, validation, and holistic care, enquiring about their lives and opinions on treatment strategies. In line with this finding, the British Medical Association recently recommended that "the Department for Health and Social Care must plan for and incentivise the expansion of the professionally trained mental healthcare workforce, including within psychiatry and general practice" (BMA, 2024).

Through referral from a GP, school or university, or privately, most participants attended some form of therapy or counselling such as CBT or psychodynamic therapy. They appreciated the opportunity to reflect on their lives and identify patterns in their sessions. Interestingly, the results were mixed regarding whether participants wanted to see a healthcare professional from the same or similar ethnic, cultural or religious background as them. Most importantly, participants wanted to receive help from a professional who could understand their experience as a racialized and minoritized person. The benefits of this were also seen in Singla et al.'s study which found that "explicit discussion of race and racial injustice during [telemedicine] sessions is an important and helpful aspect in psychological treatments." Additionally, Cabral and Smith's 2011 meta-analysis found that individuals had "a tendency to perceive therapists of one's own race/ethnicity somewhat more positively than other therapists" but found little to no benefit on outcomes from "racial/ethnic matching."

Additionally, participants' awareness of their parents' sacrifices and trauma due to migration made them feel guilty, shameful, and unable to share their psychological distress with others. This echoes the findings of a study with the adult children of Sri Lankan Tamil refugees in Toronto in which participants described feeling "indebted to their parents for their risks and sacrifices in coming to

Canada to start a new life. At the same time, they felt overwhelmingly afraid of failing their parents" (Jeyasundaram et al., 2020). Participants discussed how they were taught to be strong and "carry on" in the face of adversity, either explicitly or by witnessing how their parents dealt with it. The cultural rejection of emotions and weakness can inhibit help-seeking for distress which we believe is linked to the manifestation of internalized or self-stigma, occurring when individuals are *"*aware of the negative stereotypes of others, agree with them, and turn them against themselves" (Thornicroft et al., 2022). In our study, while most participants ultimately sought informal or formal support, internalized stigma often delayed them from seeking help and guided who to go to. For example, a couple of participants reported wanting to go to therapy but facing barriers because they felt like a "snowflake" and wanted to hide it from their parents. These findings align with other research that highlights how mental health is a stigmatized topic in the South Asian diaspora, though views and manifestation of stigma in second-generation immigrants specifically is scarce (Islam et al., 2014).

Strengths and Limitations

Convenience and snowball sampling was a major limitation of our study. Earlier research on this topic recruited participants from clinical settings, which likely meant those results are applicable only to those already engaged in formal healthcare. To achieve greater diversity of experience in our cohort, we recruited through various avenues in the community. Unfortunately, recruitment of men and older individuals to the study proved particularly challenging; future research must focus on tailoring recruitment strategies to target these key groups.

It must be noted that the South Asian diaspora is vast and diverse, and the findings may not be applicable to South Asian individuals in low or middle-income countries. Additionally, all countries included in the Indian sub-continent were included in the study, making sub-analysis by South Asian country impossible. Nonetheless it is widely acknowledged in the literature, in the South Asian community, and beyond that *"South Asians have a shared system of cultural values and traditions. This unifying core culture among South Asian peoples predates the modern geographical borders of South Asian countries and has been in existence since 7000 B.C. A long history of a common way of life among the peoples inhabiting the Indian subcontinent explains why a shared underlying culture continues to exist and cut across nationalities, religions, and* *geographical borders"* (Ibrahim et al., 1997, Shariff, 2009). This shared South Asian identity means that the results of the study are valid, despite heterogeneity of each participant's country of origin.

Finally, some critics argue that research focusing on culture places blame for health inequalities on individuals instead of on the wider systems that are creating and perpetuating the problems. We acknowledge that there are many systemic barriers such as racism and long waiting lists that inhibit individuals from getting help for distress. However, understanding cultural factors that shape service use is important for cultural adaptation in prevention, diagnosis, and treatment, which can include the using culturally appropriate language (such as metaphors). It is a significant strategy to address unmet mental health needs through a person-focused approach and complements work to remove other systemic barriers.

Recommendations for Practice

The following actions must be taken for second-generation South Asian immigrants to access culturally sensitive mental health care. First, the mental health workforce must be diversified to ensure individuals have the choice to see someone from a similar ethnic, religious or cultural background as them. Second, person-centered care grounded in an understanding of intersectionality to address root cultural causes such as intergenerational trauma and racism should become the foundation of service delivery. Third, GPs should receive training to provide mental health interventions beyond prescribing and referrals. Fourth, the number of platforms in which individuals with shared experiences can communicate should grow. This could include running peer groups or increasing the visibility of South Asian immigrants with lived experience of a mental health condition on social media. Fifth, public health bodies should run culturally sensitive campaigns to increase awareness about mental health, specifically targeted at older and first-generation South Asian community members. Finally, more research is required on the influence of culture on mental health experience and management, especially for men and by South Asian sub-group.

Conclusion

The study results add to a growing body of evidence that suggests that mental health service delivery must shift to be culturally sensitive and person-specific to meet the needs of minoritized individuals.

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CHAPTER 6: ADDITIONAL RESULTS

6.0 Introduction

In this chapter (Additional Results), I begin by presenting interview participants' recommendations. Towards the end of the interview, participants were asked what they think I should be mindful of regarding mental health in South Asian communities. This question was meant to elicit from participants what they felt was important to address to improve mental health care in their community. I summarise participants' answers (by immigrant generation). I then summarise the six public consultations I hosted in 2023 and 2024. I present the key findings, illustrated with participant quotes. I present the initial four consultations, which address six emerging themes, together, and the final two consultations, which focus on conclusive themes and recommendations for policy and practice, together.

6.1 Interview Participants' Recommendations

6.1.1 First-Generation Participants' Recommendations for Supporting South Asian Immigrant Mental Health

Be Mindful of South Asian Cultural Factors

Collectivism

A few participants conveyed how South Asian individuals are collectivist oriented, which is in direct contrast with the individualistic societies in Canada and the UK. Participants felt that this cultural factor should be considered by care providers.

"We have to normalize it…, we say that it does not happen with our families, it happens with them [Western white societies], they have a individualistic culture, we are a collectivistic culture. But in that collectivist culture, what we have done is we have made our relationships a burden, because

we are poking our nose in for everything and then we are evaluating success on the basis of what they [others] have, so that's like putting more pressure" (TO2005).

"So, most of the time, 80% stress give me, my husband. So, if I go alone to my family doctor, they [are] counselling me, they give me suggestion. But this is not my side problem, this is both – my husband and my life. So, my family doctor and my husband family doctor are not same. So, we need, if we need to sit together, we need both family doctor appointment and they are different, so this very not easy to see together, and I need a counselling both. But if alone I go, it's not actually very helpful" (TO2002).

"Also they have to understand like the social pressures with the South Asian community like how the family and stuff pan out" (UK1005).

Judgment

Certain participants highlighted how members of the South Asian community can be quite judgmental, which can create distress, but also inhibit people from seeking help from friends, family or South Asian health practitioners.

"I think one problem with the South Asian community is that we try to get in involved with other people's life a lot. Like not let them stay alone. I think a lot of South Asian people have a lot of opinions…which creates a lot of mental health issues" (TO2013).

"So in the South Asian community we like to guess and assume things. Maybe we need to stop that…maybe judging people from your point of view" (UK1010).

Stigma

Most participants identified stigma as an important factor delaying or preventing help-seeking. They claimed that people in the South Asian community with a mental health condition were often labelled as mad or crazy and that people assumed that those individuals with mental health problems would be unable to live independently. Some participants mentioned that people were also concerned about the potential knockoff effects of having a family member with a mental health condition, for example, not wanting to marry within that family.

“It’s got to do with society as a whole. Either they don't believe it (call it 'nakhray' (tantrums)) or having a mental issue means that you're not normal so don't marry there. Your kids will God forbid inherit it” (TO2014, via Zoom chat).

“I have close friends that they don’t know [about mental health], so having that conversation [you] have to be very mindful because it’s still like a taboo, it’s like when somebody says you have mental health illness, it’s like there’s something wrong with that person, doesn’t belong to this community. That person cannot live independently in the community and cannot live their life the way they want it” (TO2017).

Increase Awareness on Mental Health and Address Mental Health Stigma in the South Asian Community

Although participants did not provide specific recommendations on how to increase awareness on mental health in the South Asian community, many did state that knowledge about mental health was limited and stigmatised, acting as a barrier to help-seeking. Participants said that they would like members of their community to understand that mental health is no different from physical health and should be prioritised.

“Definitely we have so many other approaches in English, we need to have more representation of brown colour, or South Asian colour in those advertisements and in those videos so that they can relate to those things” (TO2005).

“I would say culture definitely plays a big role, because what we know with psychological distress or mental health, etc. it is even not known or recognized probably in the country I have come from. So the words mental health or psychological disorder, distress…We call them “they don't have capacity,” so it has a different meaning, and therefore people can be treated very badly. So that's what I'm trying to do hopefully one day, I want to do something to educate people and make people aware on the mental, psychological side of it” (UK1010).

Be Considerate of Language Barriers

A couple of participants highlighted that some members of their South Asian communities found it difficult to communicate in English. The lack of diverse languages in mental health promotion materials for example, could inhibit someone from grasping the key messages. Additionally, there is an overall lack of mental health services available in languages other than English.

"Something like having the information out there in their own language…sometimes the language could be an issue because everything is in English… but if it's not in their own language they might not be able to understand and there would be nobody telling them" (UK1005).

"We need to have I think probably more of…more appropriate linguistic services you know. That connects people, I mean we've got very few language specific community services for South Asian people. So that that becomes a big barrier" (TO2007).

Increase the Number of South Asian Practitioners

It was reported by many participants that they would prefer to see a South Asian service provider because they would have a shared understanding. They said for individuals to have the choice whether to see someone from the same cultural/religious/ethnic background as them, the healthcare workforce must be diversified.

"I know people from immigrant [backgrounds] are also doing courses and are becoming therapists...it's just that they are not the face of any therapy organization or any counselling services. So maybe you need to specify those things when you actually want to reach out to the immigrant population... It is not just limited to first generation immigrants; it goes down for second and third as well" (TO2006).

"So I think we need South Asian counsellors…we need South Asian people with lived experiences to come forward that it [mental health conditions] do exist" (TO2005).

Create Non-Healthcare Related Spaces

Isolation and loneliness were identified as a cause and consequence of distress by many participants. To prevent these issues, participants suggested creating spaces where members of the South Asian community and beyond can socialise together and potentially begin to have conversations around mental health that are not necessarily labelled as such. Participants who attended a local women's group for South Asians in London for example, cited many benefits such as taking trips, learning new skills, and making friends to support each other.

"South Asian, Indian women, most of them, they don't go to pub… the pub is a social community centre, where they can go and meet their friend, have a pint of beer and then come back. Us lot, we don't do that, isn't it? The only thing you can find like a pub…is the association [South Asian women's organization] where you can come refresh your mind, not think of anything, not get depressed and meet the people" (UK1022).

Encourage Individuals in the South Asian Community to Seek Help

Some participants felt like they wanted others to learn from their experiences. Many participants delayed help-seeking because they did not know where to go, felt ashamed or were concerned about being judged. Participants said that they would want others to begin speaking to other people about what they are going through and to get help if they need it. Participants also reported that they were aware that others in the South Asian community were dealing with psychological distress or mental health conditions but did not talk about it.

"Depending on my experience, you have to really rise high amidst all that judgment, against all that stigma that holds you back. You have to have the…the spirit. You have to develop the spirit. Probably you may be blessed with some kind of a spirit by born or take extra help but make an attempt to rise above this shackles" (TO2008).

"I think just being open would be important. You're just treating this as any other affliction of the body. And not just, you know, make into something really special or, you know, having any stigma towards it or being open with maybe your family or whoever you are comfortable with first and

then immediately trying and seeking help. Professional help. I think without like…in my case I had to wait like 3 years before I kind of like had the courage to go and seek help. So yeah, just being prompt and a bit more mindful about this would help" (UK1013).

6.1.2 Second-Generation Participants' Recommendations for Supporting South Asian Immigrant Mental Health

Be Mindful of South Asian Cultural Factors

Participants thought it was important for mental health service providers to be aware of the cultural factors that are unique to South Asian diasporic communities. Firstly, they highlighted that mental health is still not well understood or accepted in the community, particularly by older and/or first-generation individuals, so interventions targeting stigma should be a priority. Secondly, language can act as a barrier to help-seeking (not just due to some individual's limited understanding of English, but also use of diagnostic terms is not always culturally sensitive). Thirdly, participants felt that comparison and a sensitivity to what other people say and think are prominent in South Asian culture, which may inhibit help-seeking (i.e., this factor makes people less open to sharing). Fourthly, there is a dismissal of emotional wellbeing in the community, likely stemming from migratory experiences. Finally, participants discussed how South Asian families are collectivist and children are put under a lot of pressure to succeed personally and professionally, which may cause distress but also impede help-seeking. Participants therefore emphasized that service providers must consider South Asian family dynamics in care provision.

"A lot of it was "what would other people think?" or "what are other people's kids doing?" And a lot of it was a comparison game. So yeah, a lot of it was culture" (UK1006)

Increase Education/Awareness on Mental Health

To raise awareness on mental health in the South Asian community, participants suggested relating mental health to physical health (which they believed was better understood and less stigmatised), running peer support groups so that individuals have a safe space to spend time with other members of the community and share their experiences, broadcasting positive messages about mental health on South Asian TV channels and WhatsApp, and incorporating religiosity in mental health service delivery (e.g., asking imams to talk about mental health at the mosque). Many participants mentioned that any awareness/educational initiatives should be delivered through a spokesperson (i.e., a trusted member of the South Asian community). Participants also emphasised the importance of representation in the field of mental health, including having South Asian mental health practitioners.

"If you go on like South Asian community TV channels, they'll have a talk show, and they'll be like a spokesperson like a GP from that community whether they be Indian, Pakistan, Bengali. Maybe they'll be like speaking about mental health. So now I think that people within the community, generations that weren't previously aware that it was even a thing really, are aware it's a thing" (UK1001)

Deliver Intersectional and Person-Centered Care

Without directly mentioning the terms 'intersectional' and 'person-centered care,' some participants commented on how distress and its management is an individual experience and that healthcare professionals must be aware of, and willing to explore, this uniqueness.

"… knowing that the same strategies don't always work for everyone is also a key factor…for health professionals to know that it is sort of an individualised thing. So it's good to like look into what works for that specific person. Like I discovered that breathing exercises don't help me at all. What helps me is grounding." (TO2018)

"One thing is like understanding and being culturally sensitive, which is so important, but it's also understanding how unique each person is and their experiences are. The way my sister reacted to sexual abuse was wanting to cover up and like stay far away from men. The way I reacted or the way I react is like I'm going to have my hair down. I'm gonna have my tits out. I don't care." (TO2019)

"There's…kind of [a] generational gap…there's a lot of other barriers, specifically women, girls' issues in South Asian communities so we have a multi layered disadvantage as well" (TO2004)

6.2 Public Consultation Summaries

6.2.1 Participant Demographics

A total of 40 participants participated across six public consultations (full demographics can be found in the Appendix). The age of the participants ranged from 21-75. All participants were in studies or full-time employment. Participants were mostly female (91%). Please note that six participants refused to provide demographic information and that the reported demographics apply to 34 out of 40 participants.

6.2.2 Summary of Consultations #1-4 (Initial Findings)

In the first four consultations, I provided participants with a short pre-read that highlighted six themes that were emerging from my initial data analysis. I also highlighted some key questions I wanted the participants to think about prior to attending the consultation (Table 6). The full pre-reads for UK-based and Canada-based participants are available in the Appendix.

Table 6. Table of questions asked to public consultation participants.

Finding	Question
Participants mostly attributed their distress to life/situational factors (more	*Do you think this is true in the South Asian community in the UK/Canada?*

than religious/spiritual, environmental, or biological factors).	
Participants were often disappointed with their interactions with their GP regarding their mental health concerns. GPs were often only able to offer a referral to therapy or a CBT course or medication and did not provide listening support or validation.	*What do you think the role of a GP is for mental health service delivery?*
Participants valued speaking to people with similar experiences of distress as them (siblings or friends). They appreciated the level of understanding and advice these individuals could provide.	*Do you think it's important to get support from people who have had similar experiences to you? Why or why not?*
Some participants said they would appreciate it if their mental health provider was from the same cultural background as them (as they would understand the cultural factors that affected their distress), while others said they would fear their judgment or gossip in the community.	*What do you think are the benefits and drawbacks of receiving help from a mental health practitioner from the same cultural background as you?*
Second-generation participants reported that they found it difficult to communicate to their first-generation parents about their distress because they perceived their parents as not understanding mental health or not wanting to be a burden or seem weak.	*Do you think there are differences in mental health understanding between first-and second-generation South Asian immigrants?*
Participants highlighted how it was important to increase mental health awareness and understanding (and	*Do you think this is an important topic in the South Asian community? What are some opportunities for education?*

therefore reduce stigma) in the South Asian community through education.	

Theme #1: Attributing distress to life/situational factors over other factors (religious, biological, environmental)

Participants in both study sites largely agreed that this theme was relevant to their experiences and the experiences of their community. They reported that people of South Asian origin in the UK and Canada tend to attribute their distress to life or situational factors. Stressors in the South Asian community were noted as: housing, financial stress, and physical ill-health. Many participants also spoke about how South Asian individuals are taught to consider others over themselves, which could lead to suffering. They also mentioned that there is a lot of comparison in South Asian culture, which causes worry (e.g., wondering why someone else's child is married, while theirs is not, pressure/expectations to celebrate and host holidays in a particular manner). Interestingly, they noted that religion was interlinked with life/situational factors and that South Asians may believe that their difficulties are a test from God or a result of karma (i.e., their distress is a punishment from their previous life). Some participants also noted that Western influences on mental health were affecting the South Asian community. These Western influences were described as social media use and hyper individualism. In one consultation, the conversations around causes of distress mainly centred around bereavement and grief from the loss of a family member. Finally, participants noted that biological factors were not considered important for the South Asian community.

"…distress can sometimes be described due to things like housing for example, financial reasons and…I know that parents often saying 'cause their child isn't married, that's causing a lot of distress…. this person's daughter is married but my daughters is not married…I think also health is a big thing. I know for example, like diabetes…I'm just thinking about my own dad."

"I also did research with South Asian mental health. And so when I at least looked at Bangladeshi participants in Toronto…I remember one person said you know maybe once I find a good job then

I'll be okay. And it was usually oftentimes for the stressors of migration, resettlement and not having a job."

Theme #2: Role of GP in mental health service delivery

Participants overall felt the role of a GP/family doctor is very important in mental health service delivery, but these clinicians primarily screen/diagnose due to lack of specialty training. Participants noted how important the role of a GP is for mental health service delivery because South Asians have a high respect for doctors and going to see one is less stigmatising than seeing a specialist. Many participants also highlighted that GPs are extremely busy and therefore do not have the capacity to be providing mental health treatment in a holistic manner. Some participants noted that many GPs are from a South Asian background. Participants discussed how South Asian GPs would make assumptions about them due to their shared ethnic background and provide biased care (e.g., not making referral to a gynecologist).

"But I also think we might be expecting too much from our family doctors. When you have an issue with…let's say your colon… they don't do the surgery for you. You get a referral, and you go to a separate doctor. And I know that mental health is different and there's obviously different things that go into it and prescribing medication they should have a better awareness of the situation. But at the same time, how much ground are they supposed to cover?"

"…because they can often be your first point of contact in getting help for mental health issues that one may be experiencing and so probably, like inclusive language and just like sensitivity training would probably be you know, necessary. I work with a lot of providers…you know they're tight on schedules and just as a general observation usually they're like it's a quick in and out…But I think if, you know, a patient is coming for mental health concerns, then it would be better for family doctors to have more extensive training for that. I know they did increase family doctors' residency to 4 years instead of 2. I wonder if you know this extended length includes any emphasis on mental health."

"I think there are many cases, especially if you go to a GP for example who happens to be a Pakistani uncle because I am Pakistani as well. And I say I'm feeling such and such, and he has maybe a license to provide the first port of call of mental health support but I would be worried about the level of competency of support that he would provide 'cause I've been in situations before where GPs have withheld medical assessments or medical referrals for me on the basis of assuming what I need 'cause of my cultural background, so things like gynecology referrals and things like that so I would worry about the impact that that cultural similarity that they might assume onto patients who are also South Asian."

Theme #3: Speaking to someone with shared/similar experiences

Participants felt that empathy and validation from those with shared experiences is very important. They believed that talking to friends and to people with shared experiences can be helpful, if they are not providing advice (participants noted that sometimes you just want someone to listen to you). Participants felt that there was a comfort in sharing South Asian experiences with other South Asian people because sometimes individuals fear judgment from people from other cultures. Participants also shared the negative side of speaking to people with shared experiences ("negativity breeds negativity" or engaging in "the oppression Olympics"). Some participants felt that if one was to share their experiences with others who had similar experiences, it was important for the other person to be further in the process of recovery than you. Overall, participants felt that in any interaction, it is important to not feel judged.

"I think there are things in this culture that other people just won't get and we need people who understand the depth of it. I think it also normalises talking about things. But I do think on the flip side, I've seen where negativity breeds negativity and it has to be a healthy ratio of people who's gone through experiences and lived through it, rather than a group of people who are all struggling because it can have negative effects. I think the conversation needs facilitating or you need someone who is a bit further along the recovery process to help somebody else because yeah, it could go wrong."

“They're gonna give you advice based on their experiences so it's a good place to begin…but it can be a bit toxic as well sometimes…I think it's a good point to start because you have someone who has been through this, how do they deal with it? What can I do? And they are the first people who are probably going to understand you more than someone who hasn't.”

Theme #4: Benefits and drawbacks to having a service provider with the same cultural background as you

Participants reflected how choice was important for individuals seeking a service; some people may prefer to see someone from the same cultural background, while others may not. They highlighted how culture has many layers and the choice depends on the person and what is important to them (e.g., faith or gender). In some cases, participants were wary about sharing cultural taboos (e.g., sex) with a service provider who was also South Asian. Some participants also noted that people may be concerned about confidentiality breaches or seeing their healthcare provider at a South Asian community event due to the small size of the community. Some participants felt that service providers may also project their own experiences on to their patients and make assumptions if they are from the same or similar background. They also noted that there are often long waiting lists to see South Asian service providers. Noted benefits of seeing someone with the same cultural background as you were also shared. For one, individuals seeking care would not have to explain cultural nuances and spend time ‘educating’ the practitioner on their background. A participant also advocated for seeing someone who is in a similar position to you, but not the exact same (e.g., visiting a service provider who is a person of colour/racialised person).

“Drawbacks, I think, could be that the therapist might be projecting their experience on to you. That's something that I'm always very, very mindful of that just because I've had a certain experience doesn't mean that this is what it's like for you. There's a lot of inter-cultural variability.”

“My family doctor is also Sri Lankan, so I felt like whenever I was able to open up to her, she really understood where I was coming from. And she kind of understood where my stressors are coming from like parental expectations and all that…I was really being heard and validated…”

"I think when you do have someone who doesn't come from the same background, doesn't understand functions of the community or culture, you're doing a lot of the education, so there is a lot of wasted time that could've been going into healing."

"It doesn't matter how much they understand, even if they are in the exact same boat as me, what is important for me, is they don't have to understand, but to accept."

Theme #5: Generational differences in mental health understanding

Many participants highlighted that there are incongruent views on mental health between the first- and second-generation South Asians. For example, one participant highlighted that physical health was more important to first-generation individuals; they often asked their child "well, have you eaten something today?" if their child was showing symptoms of distress and were more likely to seek formal care if their distress manifested as physical symptoms (e.g., headaches, lack of sleep). Participants felt like second-generation participants had a better understanding of mental health and available resources because of their experiences going to school in the UK and Canada, whereas the first-generation had not necessarily received any formal education on mental health. In their countries of origin, they would be taught that mental health problems are "all in your head" and a mental health diagnosis would have serious consequences on marriage and work. Some participants held pessimistic views regarding the mental health views of first-generation and/or older South Asians. For example, when discussing educational opportunities, a second-generation participant stated *"...you know that generation wouldn't change,"* while another said that mental health was *"not a conversation worth having."* Another participant also echoed this in their comments. They felt like their parents and their friends were set in their ways and were therefore incapable of change: *"I don't think that people are gonna change in our community... I don't see like my mom's friends changing...[they are] very in their ways and... I don't see it happening, but I would be really happy if it did, cause I bet you their kids would probably appreciate that."*

Participants believed that the challenges faced by each generation were significantly different. First-generation participants were focused on post-migration stress such as financial difficulties and unemployment. Conversely, second-generation participants were concerned that their trauma did not "match up" with that of their first-generation counterparts, leading to a game of "top trumps" regarding generational difficulties and the younger, second-generation being seen as the "snowflake" generation. Participants believed that second-generation individuals faced many challenges including intergenerational trauma, cultural clashes between their home and outside environment (and therefore identity struggles), comparison to others, social media, pressure to succeed academically, and the housing crisis, but felt guilty and shameful for letting these issues distress them, considering the extreme challenges their immigrant parents faced.

"There was kind of this added layer of isolation where a lot of South Asian immigrants were talking about how while they don't feel at home in the outside culture, but within their culture as well. There is a feeling of well I can't talk about actually what's going on in my home…so it was this added sort of level of loneliness. And also, the family members themselves start to get isolated from each other as in the children obviously [the] accent would change…the food that they ate, the way that they dressed, the way they spoke to their parents…so they would kind of morph into a different human being. And then you know the bond…the connection that used to be there would also drift apart and so while…yes, first generation immigrants are saying that they aren't able to speak to their own family and friends about the distress they're facing but also second generation South Asians do talk about how they can't talk to their own family members anymore about the mental health challenges that they face and if they do make that decision to seek mental health care a lot of them take a very lonely road of not telling their family about it and that road to recovery is obviously very difficult as well."

"First generation immigrants experience mental health…at a greater level but the second generation also…has mental health issues. But they are different. They too feel the racism. But they also are under enormous stress. To do well, to be first in class…otherwise the parents feel it's a sense of shame because they've taken the risk to come all the way to Canada. For the sake of their children."

"But you have cultures that are very different from each other. That don't really talk to each other in some ways…they don't align. So, you grow up, and you're born in a country, you're taught one way of being but then at home you're taught one way of being. And that is very, very challenging. I think just to find out, like, where do I fit in in all of this?"

Participants also commented that alongside generational differences in mental health understanding and experience, diversity in religion, English proficiency and gender were also important characteristics to consider. Some participants highlighted how men face greater or unique barriers to mental health care because of differences in friendship, for example.

"I think that just going back to gender differences…I think what's important is, if someone does speak to someone, that feeling of not feeling judged and feeling like if I speak to this person they won't judge me and I think just thinking about different friends and family and groups. How it may differ if, let's say there is a man who is experiencing distress if he goes to people in his friendship group, who are also men, and how that might be spoken about."

Theme #6: Opportunities for education in South Asian community

Participants felt like mental health is still a "taboo" and stigmatised in the South Asian community, so interventions that aim to address stigma and raise awareness would be beneficial. Participants mentioned that the "education" needs to come from someone South Asian who is well respected in society. They mentioned that representation matters, but not necessarily representation in the healthcare/mental healthcare workforce. For example, an educational session on mental health could be held by an Imam during Friday sermons at the mosque. Other cited avenues for mental health messaging included South Asian tv channels, Whatsapp and Youtube. Participants acknowledged that the avenues would have to be different depending on age (i.e., younger adults are more likely to use social media platforms such as Instagram and TikTok than their older counterparts). Participants pointed out that even using the word "education" lowers the South Asian community- it is not necessarily that they lack education, they just have a different understanding of mental health than Western constructs. A good opportunity is for second generation children to educate their first-generation parents (e.g., one participant is encouraging her mother to seek therapy). Finally, participants highlighted how educational campaigns and awareness should not just be targeted at South Asian individuals but mental health service providers as well.

Participants found it difficult to identify 'facilitators' to mental health care for the South Asian community but suggested free phone lines so that the person seeking help can do so anonymously and without leaving their home or ensuring that therapy focuses on how to handle relationships, especially the relationships with individuals who are likely unwilling to change and therefore doing work around setting boundaries would be ineffective.

"I think the only way I was able to convince a family member to seek mental health care was because it was a free phone call line. They didn't have to go anywhere and they were able to very anonymously get help for something that they were facing."

"People are not open with it and they feel internally... they may feel something but…[it's] taboo so they won't talk about it. But they will lookout for others, and they will suffer in silence and not bring up what's troubling them, because they feel that they are, their emotions…they shouldn't be talking about themselves, they should be looking out for others."

Box 1. A summary of my key takeaways from the initial public consultations.

I documented the ways in which I felt the initial public consultations impacted my interpretation of the data. I believe the input from the participants helped me understand the following:

- ⇒ The negative aspects of sharing one's distress with an individual with a shared or similar experience.
- ⇒ The perceived role of GPs/Family Doctors in mental health service delivery.
- ⇒ The heterogeneity of South Asian culture and experience.
- ⇒ The generational differences in mental health understanding, experience, and management.

6.2.3 Summary of Consultations #5-6 (Final Findings)

For the second set of consultations, I provided participants with a table summarising the findings (the full pre-read can be found in the Appendix). I asked them the following questions:

- ⇒ How relevant and useful are the study results to the South Asian community?

⇒ Which of the cultural factors identified in the study results are important to consider when it comes to mental health service delivery for the South Asian community?

⇒ How should service providers (e.g., general practitioners (GPs), therapists/counsellors, community organizations, faith leaders) consider immigrant generation in mental health service delivery?

⇒ What does “person-centered care[1]” mean to you? Why do you think it’s important for the South Asian community?

⇒ What are the key messages from this study that should be shared with a) healthcare professionals b) community organizations c) policymakers d) academics and e) members of the South Asian community?

[1] *According to the Health Foundation, taking a person-centered approach means “focusing on the elements of care, support and treatment that matter most to the patient, their family and carers” (2016).*

Here, I present the findings altogether, because of the overlap in the participants’ answers for each question.

Overall, participants agreed that the study results were relevant, useful, and applicable to the South Asian community. Participants particularly resonated with the generational differences identified in the analysis. Participants believed the phrase “first-generation wants to survive and second-generation wants to thrive” was an accurate representation of their experiences. They commented how second-generation South Asians can become distressed due to strict parenting, intergenerational trauma, and balancing two opposing cultures. One participant spoke about how she struggled being one of the only Brown people in her school and her parents were unable to help her understand or process this experience, which led her to blame them for her struggles. Meanwhile, participants felt like first-generation immigrants were more concerned about their post-migration struggles. They struggle to adapt to an individualistic host country, which conflicts with the collectivist home country from which they migrated. Participants noted that many first-generation immigrants endorse the mental health beliefs that were prominent in their home country where mental health is less understood (at least in Western constructs), especially if they did not mix with individuals from other cultures in their host country. Second-generation participants, on the other hand, understood where to go if they were struggling with their mental health, but felt guilty for doing so. Ultimately, participants believed it was important to tailor mental health services to each generation due to their differing stressors and mental health understanding.

Participants identified religion/spirituality, collectivism, and gender as important cultural factors in the South Asian community. However, participants continuously emphasised that no two people are the same and what cultural factors matter to them will be very personal. They highlighted the need for person-centred care, where healthcare providers (and other relevant service providers) shift away from their position as the experts in the room and instead investigate their patient/client's wider context (social, familial, cultural factors as well as immigrant generation and medical history) as well as ask them what is important to them and what they think their needs are. Importantly, participants stressed that there is no '101' guide to treat South Asians dealing with mental health problems.

Participants perceived a gap in culturally appropriate mental health care for the South Asian community. They believed current standard practices were based on Western, white constructs that were unsuitable to the South Asian community. Participants reported that healthcare professionals were unaware or unwilling to engage with their patients/clients on their socio-economic-cultural context, which included the experience of being a colonised person or the descendant of a colonised person. They recommended that healthcare professionals be further trained (using a curriculum with a decolonisation lens) to further understand the known barriers to mental health care and successfully deliver person-centred care (i.e., training mental health professionals to ask the right questions to elicit important health-related information). One participant noted that more efforts need to be made to make mental health services culturally appropriate. They exemplified this statement by highlighting a therapy office that was "trauma informed," yet offered no space for their clients to pray. GPs were once again identified as important sources of care for the South Asian community, given how some members of the community may go there for physical complaints and visiting the GP may be less stigmatising then seeking specialist care. Participants did note, however, that GPs must provide holistic care, currently they mostly just prescribe medication.

In addition to improving the culturally appropriate care provided through formal means, participants felt like the government needed to invest in community resources. This could involve creating spaces and opportunities for marginalised groups, creating collectives or grassroots organizations that are led by South Asian women, disseminating research (such as the current study) to community or religious leaders as they can raise awareness.

Participants felt the perspectives of men were under-represented in the data. They highlighted how men may cope with mental health challenges differently than women and therefore must be targeted in future mental health care research. One participant spoke about how she was raised by her first-generation Tamil father, who never spoke about his issues, a sentiment which was then passed down to her (i.e., now she does not feel comfortable speaking about her issues). Additionally, participants felt that men required counselling and their reluctance for this form of support affected women as well. Participants perceived there to be clear gender roles in the South Asian community and highlighted how the impact of these defined roles must be considered in understanding mental health and service utilisation for this population group.

"One of the ways we individualize care to the youth versus culturally relevant care would be to start to engage the whole family. Can the parents participate? How do we breach stigma? These are the issues that we have to bridge the gap for when we look at services for collective communities to reduce the risk. And sell it to the government that you actually save money if you do that."

"It's like I feel that gender roles might play…[a role on] how we may reach out for mental health resources because if you're like a woman versus a man both of us have like certain stereotypes, but they're different. Like for men it would be like they're not supposed to feel emotion. For women it's like you're supposed to feel emotion but control it. You're supposed to be able to handle it. So, I feel like that may play a role in how we use mental services."

"How do you go from a collective culture where you can call on your family or you know everybody is an auntie, your neighbor is your auntie, to coming to you know Western culture which is more individualistic. Just the despair, the loneliness, the struggles. I think that yes, your…the

research is very relevant, what's come up. And I think it's just a drop in the bucket around all of the issues that really go on for people that are so nuanced unless we have more conversations like this."

Box 2. A summary of my key takeaways from the final public consultations.

From the final public consultations, I gathered these following key messages:

- ⇒ Not all cultural factors will resonate with everyone; different things are important to different people; this is the primary reason person-centered care is so important.
- ⇒ There is a perceived need for culturally responsive mental health services to address mental health concerns in the South Asian community.
- ⇒ Healthcare professionals must be trained on issues of racism, discrimination and colonization and understand that each person is unique.
- ⇒ More effort must be made to recruit South Asian men in healthcare research. How gender roles manifest in South Asian communities must be taken into consideration.
- ⇒ There are important differences in the experiences of first- and second-generation South Asians, which are important to address using intergenerational approaches.
- ⇒ Use community-based approaches to mental health care by running peer support groups, working with religious leaders to disseminate positive messages around mental health, and working with grass-root organisations and collectives.
- ⇒ The social determinants of health are crucial to understanding the risk factors for mental health conditions in South Asian communities in the UK and Canada.

CHAPTER 7: DISCUSSION

7.0 Introduction

In this chapter, I begin by bringing together the results of my systematic review, my most prominent qualitative findings relating to the manifestation of distress, perceived causes of distress, expression of distress, consequences of distress, coping strategies, the facilitators, and barriers to help-seeking and definitions of recovery and the six public consultations I hosted. Considering this thesis is presented in 'research paper style,' in this section I focus on critically discussing the following overarching topics: the convergences and divergences between immigrant generations and study sites and the potential relationship between explanatory models of distress and help-seeking attitudes, intentions, and behaviours. I use the existing literature to situate my findings. I then illustrate the strengths and limitations of my study and how they may have influenced my research. Finally, I conclude by outlining suggestions for policy and practice changes, which can help improve the mental health care that first- and second-generation South Asian immigrants in high-income countries receive.

7.1 Research Objectives and Summary of Findings

7.1.1 Recap of Research Objectives

1. To examine and synthesise the evidence about a) explanatory models of CMDs and b) help-seeking attitudes, intentions, and behaviours for CMDs among South Asians in high income countries.
2. To investigate the cultural conceptualisations of distress and help-seeking among first- and second-generation South Asian immigrants in the UK and Canada.

3. To analyse the convergences and divergences in cultural conceptualisations of distress and help-seeking among first- and second-generation South Asian immigrants and between the UK and Canada.

7.1.2 Summary of Findings

7.1.2.1 Systematic Review Findings (Paper #1)

We searched five databases and included 33 reports (29 studies) with a total of 9,030 participants. The review suggested that the participants in the included reports saw CMDs as a psychosocial issue and attributed their mental health condition to life or situational factors. It emerged that CMDs were seen as highly stigmatised issues with social consequences. The participants engaged in pluralistic help-seeking strategies, primarily relying on themselves, religion, socialising with friends and family, and visiting a General Practitioner to cope. We aimed to extract the generational differences in the explanatory models and help-seeking, but there were only a limited number of studies that reported their participants' generational status. It was clear from the review that culture plays an important role in how people of South Asian origin understand, experience, and manage their distress and that future research would need to take factors such as immigrant generation into consideration.

7.1.2.2 Qualitative Study Findings (Papers #2-5)

We interviewed first- and second-generation South Asian immigrants to better understand how individuals in these groups understand, experience, and seek help for psychological distress. First-generation participants reported symptoms such as overthinking, crying, and fatigue, primarily attributing distress to post-migration struggles, familial challenges, and systemic racism. They used non-diagnostic terms like 'stress' to describe distress and often coped individually, through religious practices, community support, and very occasionally, formal care. In contrast, second-generation participants experienced symptoms such as overthinking, sadness, and low self-confidence, citing familial dynamics, challenges forming and understanding their identity, and racially motivated bullying and discrimination as primary causes for distress. They described distress using a mix of clinical and non-clinical terms, relied on self-help strategies, and reported dissatisfaction with formal care due to perceived cultural insensitivity and non-holistic approaches. Recovery for first-generation participants was defined as feeling peaceful, empowered, and resilient, while second-generation participants sought improved self-esteem, happiness, and belonging. Stigma and cultural pressures and expectations emerged as significant barriers to help-seeking across both groups.

7.1.2.3 Public Consultation Findings

Participants (n=40) across the six public consultations I held seemingly agreed that the results of this study are interesting, useful, and relevant to the South Asian community in the UK and Canada. They spoke about how cultural factors including gender, stigma and collectivism could negatively influence how an individual of South Asian origin experiences and recovers from periods of psychological distress. Participants noted especially that efforts must be made to raise first-generation and older individuals' mental health awareness in a culturally sensitive manner; denial or misunderstanding of mental health amongst these groups reportedly acted as a significant barrier to help-seeking across generations. Participants in both the UK and Canada also emphasized that current mental health services are not working for the South Asian community. They reported that community and faith-based services, which are usually more culturally aware, are the most significant resources to improve mental health outcomes. They also noted that formal services must be transformed by diversifying the workforce, delivering holistic and person-centered care, and ensuring that healthcare practitioners are adequately trained in decolonisation and intersectional theory. They also suggested that future research aim to include South Asian men. Finally, an important finding to come from the public consultations, was that while South Asians have a common culture that binds them together, it is important to ask people what is important to them – all cultural factors will not apply to everyone.

7.2 Convergences and Divergences Between Immigrant Generations

In this section, I aim to highlight the key convergences and divergences between immigrant generations in three areas: causal beliefs, preferred coping strategies, and facilitators and barriers to help-seeking. I illustrate these points by providing readers with a case study of a first-generation mother and her second-generation daughter, both of whom were participants in this study.

Table 7. A summary of the convergences and divergences in explanatory models and help-seeking between first- and second-generation South Asian participants.

	Convergences	**Divergences**
Perceived Causes of Distress	Both groups of participants attributed familial factors to their distress, but the factors themselves differed. Both groups of participants attributed experiences of racism and discrimination to their distress.	First-generation participants cited post-migration stresses and the loss of their support system, while second-generation participants cited identity struggles, intergenerational trauma and pressure and expectations.
Perceived Symptoms of Distress	Participants from both groups reported a range of physical and psychological symptoms including overthinking, crying, lack of motivation, feeling sad or low, changes in sleeping and eating patterns.	
Perceived Impact of Distress	Participants from both groups were concerned about the impact their distress had on their relationships, work and daily lives.	Isolation was the main consequence of distress reported by first-generation participants, which was less commonly reported by second-generation participants.

Expression of Distress	Participants from both groups used a combination of medicalised and non-medicalised language to describe their distress, regardless of if they had been diagnosed with a mental health condition or not.	
Help-Seeking and Coping Strategies	Participants in both groups primarily relied on self-help to manage their distress, but the strategies themselves differed. Participants in both groups used religion to cope with their distress, primarily through cognitive methods such as prayer.	Participants from the second-generation group had all seen a GP and/or therapist/counsellor to help them manage their distress, but almost none from the first-generation group had.
Facilitators and Barriers to Help-Seeking	Internal stigma acted as a barrier to help-seeking for participants in both groups, but the forms of stigma held were nuanced.	For first-generation participants, fear of judgment, commentary or being misunderstood prevented them from seeking help. For second-generation participants, not wanting to burden others acted as a help-seeking barrier.
Recovery	Participants in both groups provided a range of responses	

	when asked what “recovery” from distress looked like to them. Responses included being there for other people, mitigating negative thoughts, having good relationships, and feeling helpful and part of society.	

A priori I believed that the primary difference between the two groups was going to be regarding their beliefs on the causes of their distress. A substantial body of research shows that the mental health stressors for first- and second-generation immigrants are different, but details on these differences remain scarce for the South Asian diaspora. The results of this study seem to indicate that existing theories on the reasons first- and second-generation immigrants may experience mental health conditions are applicable to South Asian individuals. The first-generation participants, especially those that had immigrated more recently, were principally concerned with post-migration (circumstantial/contextual) stressors, while second generation participants were primarily impacted by their bicultural identity. A cross-cutting theme across both generations was the experiences of racism and discrimination faced by individuals. These findings all chime with commonly cited explanations regarding immigration and mental health in the literature (Apers et al., 2023; Kirmayer et al., 2011).

The main domain in which there is a significant overlap between the two generations is a perceived cause of distress: family. However, the ways in which family is thought to cause distress is different for each generation. First-generation participants reported feeling isolated from their families who remained in their country of origin, believing that they did not understand the struggles associated with migration. They were also concerned with raising children in a new culture, especially without any social support and considering gender norms which meant most of the female participants had to be in formal employment alongside being entirely responsible for household chores and childrearing. Second-generation participants, on the other hand, believed that causes for their distress centered on: having a close family member with an untreated mental condition whose behavior negatively impacted them, parental values that focused on professional achievement, marriage, family honour and survival rather than emotional wellbeing, and attempts to reconcile their family's culture with that of their peers.

Considering a key cultural factor for South Asians is collectivism, in which the *we-self* is endorsed over the *my-self,* it makes sense that issues pertaining to family played such a significant role in participants' experiences of distress in both generations. In South Asian families, respecting elders, responsibility for izzat (honour) and prioritisation of the family's needs over the individual's needs are some of the ways in which collectivism is played out (Sharma et al., 2020). After considering these collectivist values and their applicability to the study results, I was left with the following question: how can conflict be so pervasive in families where the cohesion of the unit is so important? One possible explanation is acculturative family distancing in which conflicting cultural values between first-generation immigrants, who value "hierarchical and authoritarian parenting models" and their second-generation children, who are learning about individualism through their contact with Western society (Patel, 2024) create stress and communication difficulties (Hwang, 2006). Ultimately, the tension between these two opposing schools of thought may make family cohesiveness, or harmony, challenging. This finding is detrimental considering family cohesiveness is a protective factor against mental health conditions (Harker, 2001). Evidence suggests that this protective factor, however, does not persist in families with first-generation parents and second-generation children because their values and beliefs are more likely to misalign (Montazer and Wheaton, 2011). For the same reasons, family conflict is also more likely in these inter-generational families than families in which everyone is born in the same country (Phinney et al., 2000). Finally, the transmission of mental health conditions, particularly those related to trauma such as post-traumatic stress disorder, from first-generation immigrants to subsequent generations has been partly attributed to "psychosocial mechanisms within the parent–child attachment and intra-family communication style" (Apers et al., 2023).

These cultural clashes within families were more commonly cited as causes of distress by second-generation participants than first-generation participants. Prior to my analysis, I hypothesized that these interfamily tensions would be brought up equally across both generations. I cannot say for certain if this is because they were less impacted by these clashes, if most participant's children were too young for these issues to have come up or in the case of older participants, if too much time had passed for them to recall. Another possible explanation is that the first-generation participants were genuinely more concerned about their socioeconomic environment and lack of family and friend support in their host country and subsequent isolation than due to acculturation differences with their children.

Interestingly, interpersonal challenges such as these are established as common stressors that can lead to mental health conditions for most people- irrespective of culture (Sheffield et al., 1995; Stewart-Brown, 2005). This recognition has even led to the development of an entire discipline in psychotherapy- interpersonal psychotherapy (IPT). IPT "focuses on stressful life events of grief, interpersonal disputes, life transitions, or social isolation or deficits that are associated with the onset, exacerbation, or perpetuation of current symptoms, while helping patients to connect with social supports and to improve the quality of their relationships" (Cuijpers et al., 2016). Through a meta-analysis and empirical testing, IPT has been shown to be an effective treatment to address multiple mental health conditions (Cujipers et al., 2016).

Though generally there is mixed evidence (primarily from meta-analyses) regarding the success of culturally adapted psychotherapy interventions across diverse settings and populations (Benish et al., 2011, Hall et al., 2016, Cuijpers et al., 2016), I posit that culturally adapted IPT could be potentially useful to my study population because participants mostly attributed their distress to familial factors such as conflict and intergenerational trauma. The first-generation participants tended not to use or be satisfied with formal care services such as therapy due to the lack of understanding in how these services could actually help them address the causes of their distress (e.g., social isolation, interpersonal challenges). This finding is not unique to my study; Yasmin-Qureshi and Ledwith's 2021 qualitative study with women of South Asian origin who accessed Improving Access to Psychological Therapies (IAPT) services in the UK found that there were significant issues with cultural and religious exclusion. Therefore, demonstrating the benefits of IPT in improving relationships, for example, would be necessary in parallel to upscaling the availability of IPT.

For example, in a South Asian context, a research team successfully delivered culturally adapted group based IPT to adolescents in Nepal, with the aim of helping participants improve their most significant relationships and decrease depressive symptoms (Rose-Clarke et al., 2020). The adaptation involved delivering the intervention in school settings, using culturally acceptable terminology regarding mental health, reframing the intervention as a training programme to address stigma, encouraging parental involvement, and utilizing non-specialist staff such as lay community workers. Dutifully, the authors note that while the intervention is promising, further evidence (generated from a randomised control trial) must be conducted to fully ascertain the feasibility and validity (Rose-Clarke et al., 2020). This evidence suggests that IPT, delivered in a culturally safe manner (i.e., with a therapist shedding their Eurocentric lens in which they have likely been trained), could potentially offer a valuable option for improving mental health outcomes among first- and second-South Asian immigrants.

Related to family dynamics was participants' perceptions of their social support. Furnham and Sheikh proposed in 1993 that the correlation between social support and mental health would be different between first- and second-generation South Asian immigrants. They base their hypothesis on the idea that the challenges faced by each generation are different (Furnham and Sheikh, 1993). As previously discussed, first-generation South Asian immigrants arrive to their host country with developed identities and feelings of belonging to the culture in their country of origin, but must leave behind their networks of friends, family, and neighbours. As Tummala-Nara (2013) astutely states in their review article, "several studies with South Asian women, most of whom are immigrants, indicate that family/marital stress and lack of access to extended family are strongly associated with mental and physical health problems." Meanwhile, for second-generation immigrants, social support networks are complicated because they may find their family and community's support "restrictive", negating the benefits of social support. Interestingly, participants in both generations in my study found social support to be restrictive. A theme relating to barriers to help-seeking for distress was first- and second-generation individual's perception that their family members or friends offered unsolicited advice, judgment, and commentary when they shared their problems. Vaux and Harrison (1985) refer to this phenomenon as "intrusive involvement." Participants claimed that they would rather rely on individual or religious coping strategies to avoid others' intrusion in their personal lives. For first-generation participants, this was coupled with the idea that it was culturally inappropriate to share personal problems and for second-generation participants, it was coupled with the idea that most people did not understand their unique experiences of distress. Participants in both generations were still keen to socialise with other people, primarily as a form of distraction, even if they did not share their distress.

Perceived social support (size of social network and feeling satisfied with one's support) is well-established as a universal predictor of wellbeing as well as a coping resource (Sarason et al., 1983; Akhtar et al., 2010). Approximately 30 years ago, Winefield et al. (1992) measured social support and psychological well-being among young adults using the Multi-Dimensional Support Scale (n=483). Their regression analysis revealed that perceived social support was strongly associated with psychological wellbeing. Particularly "the frequency of supportive behaviors toward the respondent by close family and friends" was strongly associated with wellbeing (Winefield et al., 1992).

Research indicates that the meaning of social support can vary across cultures, potentially affecting coping mechanisms and psychological well-being in diverse ways. Notably, social and cultural differences become especially evident when comparing South Asian cultures with those of Western Europe. Wiggins et al. (2004) who conducted a randomised control trial and economic evaluation of social support interventions for mothers with depression in London emphasize the importance of creating culturally relevant and standardized tools for assessing social support, as existing measures often fall short in this regard. Similarly, Akhtar et al.'s review of the literature revealed a lack of widely adopted culturally specific instruments designed to evaluate social support within South Asian contexts (2010). Hopefully, my study results can help elucidate how perceived social support is connected to wellbeing and preferred coping strategies drawing out the nuances between two immigrant generations.

Along with socialising, other distraction techniques (i.e., "keeping busy") were frequently reported from individuals across both generations. The actual strategies differed slightly across generations (i.e., how each individual chose to distract themselves), but they were all forms of behavioural activation. It is interesting to note participants engaged in behavioural activation activities intuitively, without guidance from a therapist or counsellor. A global systematic review on interventions to combat depression among first-generation immigrants found that interventions employing behavioural activation strategies were successful in reducing depressive symptoms, especially if they had been culturally adapted (Antoniades et al., 2014). While most of the studies included in the review focused on Latin immigrants in the US, based on this evidence and the results of my study, perhaps culturally specific behavioural activation interventions should be available to those individuals who are interested in seeking formal care for their distress.

These findings also support recent efforts to utilise behavioural activation strategies to improve mental health outcomes in the South Asian community. Dr. Farooq Naeem and his team are advocating to implement culturally adapted cognitive behavioural therapy (CaCBT) for South Asians in Canada, which they claim is acceptable to the community and can improve community mental health services for this underserved group (Naeem et al., 2024). Naeem et al. do not specify the immigrant generation of the participants who tested the pilot intervention but suggest that South Asians in Canada are more likely to engage in formal care if cultural factors such as family dynamics and language preferences are incorporated. I believe this study highlights a limitation of the widespread implementation of CaCBT, which is that it may only be an option for second-generation South Asians who are willing to engage in formal care, as opposed to first-generation South Asians who rarely seek help from formal care.

Another important convergence in help-seeking between generations was the use of religious coping strategies such as praying, reading religious texts, or listening to worship music. Religion is an important mediator in the relationship between distress and help-seeking in all South Asian religions. In some cases, religion can deter those experiencing mental health conditions from seeking professional care (Karasz et al., 2016). While this deterrence was seen among first-generation participants, who often said they only found solace through prayer, second-generation individuals were still willing to receive professional help, alongside their religious coping strategies. Though there has not been extensive research on this topic, it is thought that religious identity is likely to decline with second-generation immigrants versus the first. An exploration of religious attachment across generations in Muslim groups in the Netherlands found that second-generation individuals engaged less with religious practices than first-generation individuals

(Maliepaard et al., 2011). However, other research suggests that religiosity may be equally important to first and second-generation individuals, claiming that second-generation Muslims maintain their religious attachment (Beek and Fleischmann, 2019. It is important to note that the maintenance of religion across generations is dependent on the religion; these patterns have not been observed for those of a Hindu faith, for example (Robinson, 2009). These differences are worth exploring in future research to allow for more nuanced recommendations on how to incorporate faith in mental health service delivery. I should also note that while I acknowledge religiosity in formal care is a prominent call to action in the field, it may have limited consequences on help-seeking for the participants in my study considering they mostly participated in cognitive forms of religion, rather than social forms. This indicates that we must explore options for increasing the role of religion in mental health that goes beyond hosting events in places of worship.

I did not find medical settings to be important sources of care for first-generation immigrants, while for second generation immigrants, using formal care was acceptable, but relatively unhelpful. Such differences in medical service use between immigrant generations has also been noted in another recent study: second-generation South Asian participants with a history of self-harm in the UK noted that their parents and grandparents were not aware of mental health in their country of origin and were more distrustful of medical services due to their experiences of racism and crime (Ozen-Dursun et al., 2023).

Most first-generation participants did not view biomedical intervention as a means of easing their distress. This is a finding consistent with Arthur Kleinman's popular theory that individuals' distress is intrinsically linked with their everyday suffering and they therefore look for resolutions that are related to this suffering- "everything that really matters" (Kleinman, 1997). In the current biomedical framework in the UK and Canada, the psychosocial needs of patients are largely ignored, which may be why the participants in my study did not see attending formal care as a solution to their distress. We can see these results paralleled in multiple other studies (Prajabati and Liebling, 2022). For example, although the generational statuses of the participants were unclear in their study, similar findings were seen in Kai and Hedges 1999 examination of Pakistani and Bangladeshi individuals' beliefs around distress. Participants in that study attributed their distress to social factors such as racism and disadvantages, as well as issues in familial and marital relationships. They felt that GPs' role was to deal with physical health problems and as such, the participants preferred not to engage in this form of care. It is particularly interesting to note the consistency in these findings considering my study takes place 25 years later. Similarly, an analysis of national register data in Norway revealed that although Pakistani immigrants experienced mental health conditions at higher rates than the general Norwegian population, they were less likely to consult a GP for help (Straiton et al., 2014).

Conversely, second-generation participants often saw GPs as their 'first port of call' and were willing to go to counselling or therapy. This finding makes sense considering that second-generation immigrants, who have been born and raised in the UK or Canada, would be aware that mental health service delivery is an important pillar of primary care. Disappointingly, most reported negative or neutral experiences with GPs when seeking help for distress. Underpinning both generations' views on primary care is the idea that GPs are not well equipped to provide holistic care that can tackle the social, economic, and cultural factors impacting their distress experience. This finding suggests that action taken to expand the role of primary care in mental health service delivery could be beneficial for both first- and second-generation individuals, though more effort would likely have to be made to encourage first-generation individuals to seek help from this source. I believe a more successful strategy for first-generation individuals would be to shift to a community model of health, where most mental health care is delivered by informal services. I will discuss this further in the recommendations section.

Although only a few facilitators to help-seeking were identified in this study, one that was apparent across generations was that increasing awareness of existing mental health resources often led individuals to seek help. What is different is *where* individuals in each generation learned about these resources. First-generation individuals reported increasing their awareness through discussions with their second-generation children, through their work at community organizations (especially if it was in the mental health field), and through community spaces (e.g., brochures at the library). Conversely, second-generation individuals' mental health knowledge often came from their schools or universities or from the internet – some participants were encouraged to seek help because they saw people on social media share their mental health journeys.

Across both generations, internal stigma acted as a barrier or delayer to help-seeking, though the ways in which it manifested differed. First-generation participants felt as though it was culturally frowned upon to share personal problems and doing so would be an invitation for unsolicited commentary. Second-generation participants were more concerned that seeking help would mean that they would be perceived as weak or ungrateful from family and non-family members (especially in the context of witnessing of their parents' post-migration stresses). Experiences of external stigma were mainly spoken about when participants were asked about the South Asian community's views on mental health. Only in some instances did a participant relay that they had personally been externally stigmatised against (e.g., one male participant said that after he disclosed his distress to his father-in-law, he was told to be strong and "be a man").

The findings pertaining to the ways in which stigma can manifest and shape attitudes towards help-seeking among South Asian immigrants specifically, also aligns with previous research (Chew-Graham et al., 2002; Kapadia et al., 2017; Ozen-Dursun et al., 2023). For example, Moller et al.'s 2016 qualitative study, which explored second-generation South Asian British women's perspectives on counselling, participants felt it was both stigmatising to experience psychological distress in the first place, but also to go to counselling. Further, a recent document analysis with South Asian communities in the UK found that "stigma is socially constructed within cultural groups, and heterogeneously across generations." The author found that second-generation South Asian immigrants were more likely to use mental health services than their first-generation counterparts. They ascribed these generational differences to acculturation, speculating that second-generation individuals were less likely to ascribe to South Asian values, which could reduce stigma levels (Shukla, 2023).

While my study can help decipher how stigma manifests across different cultural contexts, which is still arguably an under-researched topic (Chaudhry, 2016), not all forms of stigma which have been found in previous research to be prominent in South Asian communities will be highlighted. We can examine 'label avoidance' for example, in which individuals with a mental health condition and/or their families avoid hospital or in-patient treatment due to fear of being socially outcast in their communities. A 1998 study showed that approximately 40% of families in a population-based sample did not disclose their family member's hospitalization due to mental health problems or only told a limited number of people (Phelan, Bromet and Link, 1998, p.120). A study in the UK with individuals of Pakistani origin found that hospitalization was perceived as a last option due to fears of being ostracized in the community (Tabassum et al., 2000); a result also mirrored in a study among Muslim immigrants in the US (Amri and Bemak, 2012). However, this form of stigma was not particularly salient in the current study. I would posit that this is because that though many participants self-described their experience as "intense" or "very intense," no first-generation participants and only one second-generation participant had sought or received hospital-based care for their distress.

Generally, stigma is a well-known predictor of help-seeking attitudes; a large-scale systematic review found that "shame/embarrassment, negative social judgement and employment-related discrimination" was reported as a significant barrier to help-seeking by 21-23% of 90, 189 participants (Clement et al., 2014). In fact, the link between stigma, refusal of mental health service, and poor outcomes has led to the development of key publications such as the Lancet Commission Report on Stigma and Discrimination as well as the 2024 WHO Mosaic Toolkit to End Stigma and Discrimination in Mental Health. These publications as well as other research highlight anti-stigma strategies including education (i.e., increasing knowledge), contact (i.e., combating prejudice and discrimination by increasing contact time with an individual with a mental health problem) and protest (i.e., discouraging representations of negative attitudes towards mental health) (Gronholm et al., 2017). There is little empirical evidence that has assessed the acceptability, validity, and efficacy of these strategies in the South Asian diaspora, especially when accounting for immigrant generation. Perhaps, the results from studies such as these can inform the development of anti-stigma interventions that employ such strategies in a culturally sensitive manner. While we can turn to evidence from campaigns that have been run in South Asia itself (Kaur et al., 2021), we must be careful considering first- and second-generation South Asian immigrants face unique challenges due to their immigrant and ethnic minority status.

Case Example

I will now highlight two participants' interviews to further illustrate the convergences and divergences in the experience of distress and help-seeking by immigrant generation.

I recruited these two participants at a South Asian women's group in Toronto and coincidentally these two participants were mother and daughter. The mother was in her 70s and was born in Pakistan and her daughter was in her 30s and was born in Canada. They contacted me separately and as far as I know, were not aware that the other had also consented to do an interview.

Both discussed the hardships they had faced in their lives thus far. The second-generation participant attributed her distress (which had been diagnosed as severe anxiety and depression, for which she was hospitalized during the COVID-19 pandemic) to not fitting in with her peers in adolescence, dating difficulties and having parents who did not focus on her emotional wellbeing. She was also sadly abused by a close relative, and subsequently alienated from her family abroad after disclosing the abuse, causing further trauma. Her first-generation mother was having a hard time financially and, in the past, had gone through a divorce, which she said was culturally frowned upon. She felt like her children did not respect their elders, which she said was important to her culture, especially in Islam (for example, her daughter refuses to visit her biological father). She also reported that her distress was stemming from feeling as though her husband, son and daughter always blamed her for their pain.

While she accepted that her daughter was dealing with mental health conditions, the mother felt like it was not "proper" to share these types of personal matters with others and reported finding it difficult when her daughter would reveal these things to others soon after meeting them. She was also wary of counselling/therapy and psychiatrists. She felt that these professionals focused too much on the past, which was not helpful in moving forward. She also did not like sharing her difficulties with other individuals, like her sister, because she felt that she was always taking a side and blaming her for her difficulties. To deal with her own distress, she preferred doing "mechanical" activities to shut off her brain, which included doing chores and playing computer games. Conversely, her daughter sought specialist help and her most important source of care came from a mental health case worker at a community organization. At the time of the interview, the daughter was working with her case worker on trying to invite her family to speak about her distress- she felt like her family had toxic communication techniques and having a case worker help them mitigate family conflict would likely improve her experiences, especially since she was still living in the family home.

To summarize, while both mother and daughter attributed their distress to life circumstances, rather than biological reasons, the actual perceived causes were different, with neither party being able to understand each other. Their misaligned views on where to go to for help then furthered this tension, with the mother believing that disclosing a mental health diagnosis or seeking professional help was inappropriate.

This case study demonstrates how crucial it is to address the cultural factors (e.g., the inconsistency between how second-generation individuals want to be parented versus how their first-generation want to parent them, opposing views on mental health, toxic communication) that shape family dynamics and ultimately impact the wellbeing of South Asian families.

This study suggests that an individual's immigrant generation is a significant factor that influences mental health experience, management, and recovery. Consequentially, my suggestions to improve mental health service delivery differ by immigrant generation.

7.3 Cross-Country Comparison

From the outset of this study, I wished to explore if the cultural factors influencing psychological distress and help-seeking converged or diverged for South Asian immigrants located at two distinct, but comparable, geographical locations of the diaspora. I hoped this methodological decision would help me shed light on the theory that diasporas are underpinned by shared cultural understandings and help inspire policy and practice in each country. However, as I analysed my data, it became apparent that the themes emerging from each country were the same, meaning between-country differences were minimal. This finding led me to collapse the geographical category and choose to present my results by immigration generation, rather than country of residence.

My study indicates that despite distinct migration patterns to the UK and Canada, there seems to be a significant degree of similarity across these two countries regarding how South Asian people experience and seek help for their distress after their or their parents' migration.

This supports a view that the long historically shared culture of South Asian individuals is more important for how they experience and seek help for psychological distress than the specifics of their migration route, story, and destination. From these findings, I postulate that the cultural factors affecting mental health experience and management for South Asian immigrants are more likely to be *universal* across the diaspora, rather than shaped by *local context.*

However, we must be careful when making such generalizations because of the similarity between the UK and Canada. They are two majority English-speaking and white high-income countries. Does a host country's socio-political-cultural context act as a confounder? Unfortunately, there is a lack of literature exploring the mental health of South Asian immigrants in other host country contexts (e.g., East Africa), making it challenging to determine if the similarities found between South Asian immigrants' mental health in the UK and Canada extends to the wider South Asian diaspora.

There is no singular definition of culture, but at the core of its many definitions is the idea that culture represents a group with shared histories. These shared histories are then shaped by the dominant social-economic conditions at various points in time. Groups will receive cultural traits and practices from past generations and "its acts of reiteration or repudiation, its everyday interactions and its ritual practices will serve to select, modify, and transform these institutions" (Brah, 1996). Hence, culture is dynamic and evolving.

To highlight this point, sociologist Avtar Brah points to the sub-continent of South Asia. In South Asia, factors such as religion, gender, caste, and capitalist forces manifest differently in religious, class and caste groups, which then shape these groups' "social norms, values, customs, and lifestyles." However, Brah argues that common historical experiences result in these various groups sharing cultural values. It is this powerful shared history that separates "South Asian cultural systems from the cultures of those peoples whose historical experience have been significantly different" (Brah, 1996).

The concept of culture becomes even more complex when examining how it forms and persists in diaspora. Historically, diaspora was mostly used to describe the experiences of Jewish individuals and was characterized by "displacement, victimisation, alienation, loss*"* as well as the desire to return to a homeland. Later, the term began to be applied to other groups such as Armenians (Vertovec, 1999). Now, diaspora describes transnational communities that dispersed from a single geographical area (such as South Asia) and "whose social, economic and political networks cross the borders of nation-states or, indeed, span the globe" (Vertovec, 1999). This definition supports the one put forward by Brah, which also points to how a combination of socio-economic factors and cultural understandings allows us to frame the diaspora as one entity:

> *"…diasporas are composite formations with members of a single diaspora likely to be spread across several different parts of the world. What enables us to mobilise the word diaspora as a conceptual category in analysing these composite formulations, as opposed to using it simply as a description of different migrations, is that the concept of diaspora specifies a matrix of economic, political and cultural inter-relationships which construct the commonalty between the various components of a dispersed group."*
>
> -Avtar Brah in Cartographies of Diaspora (196; 1996)

Overall, my study supports the argument that the South Asian diaspora situated in similar locations likely share a cultural understanding despite varied migration histories. Thematic findings were remarkably similar between the UK and Canada. Nonetheless, as discussed in previous sections, key factors such as gender, religion and generational status intersect to shape how each individual experiences psychological distress. The South Asian diaspora's shared cultural understanding does not mean it is a monolith.

Most studies that investigate the mental health needs of the South Asian diaspora are in the UK, Canada, Australia and the USA. Future work must focus on the diaspora in other locations (such as East Africa, Mauritius, United Arab Emirates) to better understand any similarities and differences between host country contexts.

7.4 The Relationship between Explanatory Models and Help-Seeking

It is interesting and important to discuss how the study findings can contribute to existing evidence on the connection between an individual's explanatory models and their help seeking intentions, attitudes, and behaviors. As seen by my conceptual paradigm (provided for recap purposes here), I have based this study on the idea that the ways in which someone understands and experiences their distress will influence when and where they go for help and how successful that help is. This idea is well-established in the literature: Saint Arnold's 2009 Cultural Determinants of Help Seeking model, for example. This model, based on extensive literature reviews and qualitative and quantitative work, highlights how an individual's culturally based interpretations of the meaning and consequences of their distress shapes help-seeking. However, more empirical work on the realities of this pathway is required.

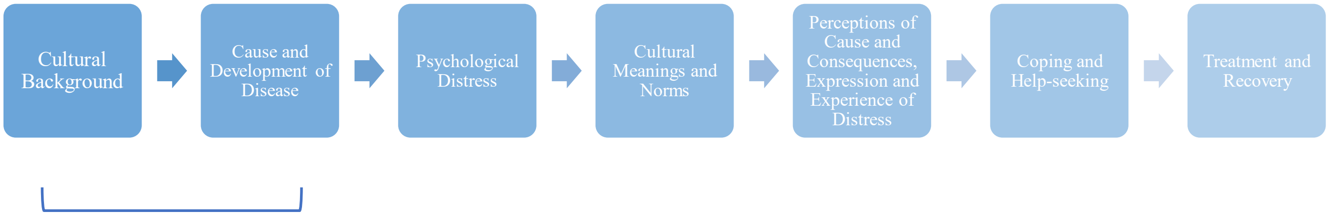


Figure 3. Conceptual Paradigm: the influence of culture on mental health.

In this next section, my intention is to assess if the results pertaining to the four aspects of explanatory models I have explored in the study (the manifestation of distress, the perceived causes of distress, the perceived consequences of distress, and the expression of distress) are at all related to the findings on help-seeking, and how these findings compare to the wider literature. While I am unable to make firm conclusions, I hope to contribute to an ongoing conversation on an important question in culture and mental health research: are explanatory models predictive of help-seeking?

Perceived Causes of Distress and Help-Seeking

One area of explanatory models had a particularly strong connection to participants' help-seeking patterns—perceived causes of distress. Across both generations, participants mostly did not relate their distress to classic monocausal biological theories (i.e., neurochemical imbalance), which may contribute to their reluctance to engage with formal mental health care. For example, first-generation participants who attributed their distress to the negative situations in their life (housing and financial insecurity, hostile familial relationships, or bereavement) saw the distress as normal, circumstantial, and fleeting, meaning that they did not see the benefit of classical mental health interventions such as medication or counselling. In one case, a participant reported that when she did finally share her experiences of distress with her GP, the GP had referred her to counselling. However, the participant did not see counselling's purpose because nothing in her life would change if her husband's behaviour did not. Furthermore, participants' attribution of distress to factors such as intergenerational trauma explains why most participants who sought support from their GP for their distress were disappointed by the care they received. Instead, they desired holistic care that addressed the roots of their distress and rejected 'temporary fixes' such as medication.

The connection between perceived causes of mental health conditions and help-seeking behaviours and care pathways is mostly consistent with current research. Bhikha et al. (2015) found that British South Asians' explanatory models of psychosis influenced their help-seeking behaviours; the participants attributed their experiences to supernatural causes and therefore engaged faith healers in their care. Similar findings also appear in other settings: in Singapore, university students' personality-based causal beliefs about mental health influenced help-seeking attitudes (Tan et al., 2019) and a literature review of research in India on help-seeking for mental health found that culturally determined causal attributions shaped decisions about help-seeking in both treatment and non-treatment seeking samples (Sanghvi and Mehrotra, 2020). However, evidence around this topic is not straightforward. A study showed that causal explanations of CMDs among Bangladeshi individuals in the UK did not uniformly predict help-seeking practices; the participants who held physical explanations for their CMD still did not seek clinical care. (Bhui et al., 2006). These contradictions highlight the need for more research in this area.

Perceived Consequences of Distress and Help-Seeking

Another important aspect of explanatory models which linked to participants' help-seeking behaviours was the perceived consequences of distress. First-generation participants reported that the main outcome of their distress was feeling lonely and isolated because the distress led to a lack of motivation, fatigue, and a change in personality. To cope, many engaged with community services, such as community groups for South Asian women. They felt like these groups helped them prevent and manage distress because it was an opportunity to spend time with other people and combat isolation. I can therefore reason that how an individual believes their distress is impacting their life likely influences where they go to for help.

However, I am careful not to overstate the significance of this finding; the first-generation participants were primarily recruited from community organizations. There may be individuals who feel lonely and isolated due to their distress but are still unable or unwilling to socialise. These individuals were therefore missing from community organisation-based recruitment, which would indicate that perceived consequences of distress are not always predictive of help-seeking. Ultimately, this recruitment strategy means that while I can connect first-generation South Asian individuals' perceived consequences of distress with their help-seeking behaviours in this study, this connection may not be generalizable to other populations or contexts. However, a population-based study looking at the entire Canadian population found that intense loneliness (in this case due to the COVID-19 pandemic) was correlated to mental health help-seeking (Lin, 2023).

The pathway between perceived consequences of distress and help-seeking is less clear for the second-generation participants in this study. They had more diverse answers when asked how the distress affected their lives than the first-generation participants, but they could be broadly categorised into: impact on their daily lives, relationships and perhaps more significantly, their work and academics. Due to the rising visibility of mental health on social media and increasing awareness in schools and universities, second-generation participants knew that their GP was the first port of call for mental health care in both the UK and Canada but did not think that the GP's actions (e.g., prescribing medication) were going to make a difference to the areas that they felt their distress impacted. So, the connection can be described as the following: second-generation participants did go to formal care, even though this help-seeking behaviour misaligned with their perceived consequences of distress, but their post help-seeking attitude (i.e., their dissatisfaction with the care they received) *did* align with their perceived consequences of distress. Instead, these participants endorsed pluralistic help-seeking behaviours such as self-care, speaking to someone with a similar shared experience, or praying. Overall, these findings are supported by the theory that one is more likely to seek alternative forms of care if formal care does not align with one's "values, worldview, or beliefs regarding the nature and meaning of health and illness" (Astin, 1998).

NOTE: Second-generation participants concern with the impact their distress would have on their work and academics, is likely closely related to the pressure they reported being under to meet their parents' expectations in this domain. This finding differs from a report included in my systematic review, which found that Sri Lankan-Australian immigrants were more considered about the social impact of their distress than work, compared to their Anglo-Australian counterparts (Antoniades et al., 2018).

Manifestation of Distress and Help-Seeking

While my analysis shows that causal beliefs and perceived consequences of distress and help-seeking were predictive of help-seeking, this correlation was not apparent for reported manifestation (i.e., symptoms) of distress and help-seeking. Fundamental to help-seeking theory is the idea that the help-seeking process begins once an individual experiences a symptom and recognises it as a problem (Scott and Walter, 2010). This connection between symptoms and help-seeking is also described in Kessler et al.'s help seeking model for psychological symptoms (Kessler et al., 1981; Rickwood and Braithwaite, 1994). For example, most participants described experiencing a range of physical symptoms that they recognised as resulting from their distress such as headaches, heart palpitations, over- or under-eating, and insomnia. Therefore, one could postulate that if symptom experience and recognition was truly predictive of help-seeking, we would expect that more participants would seek medical treatment to manage their symptoms, but this was not the case for the study participants. The only aspect of 'manifestation of distress' that related to help-seeking was regarding why participants sought help in the first place. Some participants mentioned that the reason they wanted to receive self, social, informal, or formal care was because their symptoms were worsening, which has been commonly reported in the literature across different populations (Rickwood and Braithwaite, 1994; Doll et al., 2021). The severity of symptoms was a more significant driver of help-seeking than the ways in which the symptoms manifested themselves.

Expression of Distress and Help-Seeking

Participants primarily relied on non-diagnostic vocabulary, particularly using metaphors to explain their distress. However, participants were mostly comfortable using medicalised vocabulary to describe their experiences, even though the majority had never received a diagnosis. In fact, one first-generation participant noted that they felt that "depression" had become a commonly used term in the South Asian community, which suggests a potential decrease in stigma associated with using these terms as awareness on mental health increases due to social media, public health efforts and second-generation individuals engaging their first-generation parents on discussion on mental health.

The diversity of language used by the participants makes it difficult to determine if there is a connection between how one expresses their distress and where they go to for help, but it does indicate a need to shift away from a purely diagnostic model of care. In general, the limitations of psychiatric diagnoses have been well described in the literature, including their inability to hold any form of explanatory power (Timimi, 2014). The study findings support the idea that we must shift away from diagnostic models, use culturally specific language in anti-stigma work and boost engagement in different forms of care.

Case Example

These above discussions make it apparent that I cannot make definitive statements regarding whether explanatory models are predictive of help-seeking behaviours. These complex results do indicate, however, that there is a strong likelihood of a connection between the two for my study population. I would like to use a first-generation participant's story to exemplify this finding. When I asked this participant what they thought caused their distress, they outlined that daily hardships, difficult familial relationships (particularly a tense spousal relationship), and the lack of a support system in their country of residence were responsible. When I asked them what the symptoms of their distress were, they reported fatigue and a lack of motivation, resulting in them not wanting to go out and socialize. They also felt like it was shameful to share personal problems with other people and preferred using ‘stress’ to describe their experiences. Ultimately, due to their distress, they felt lonely and isolated. Using common sense, we can ask ourselves: why would a person who believes that the cause of their distress is normalised life and situational circumstances, who is tired and unmotivated to socialise, and who labels their experience as ‘stress’ rather than using medicalised vocabulary, see a doctor or healthcare professional, who they think can only prescribe them medication, for help? While it may not aid them in addressing the root causes of their distress, one can understand why they would instead join a South Asian women’s group where they can leave the house to socialise with like-minded people and not be expected to disclose their mental health problems. This participant clearly stated that this coping strategy could help them combat the main consequence of their distress- isolation- but they were unable to address the root causes of the distress through this help-seeking action.

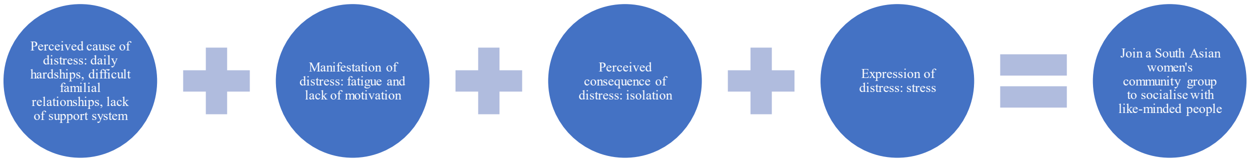


Figure 4. An exemplary conceptual framework describing the possible pathway between a first-generation participant’s explanatory model and their help-seeking behaviour.

In this section, I have established that explanatory models seem to have a nuanced but definitive relationship to help-seeking behaviours for my study population. My work also highlights the theory that explanatory models are unique to individuals who hold intersectional identities shaped by characteristics such as immigrant generation and gender. It is therefore unlikely that any two people would share the *exact* same explanatory model, though some beliefs may be similar due to a common binding cultural background. These findings can be used to determine how services can account for diverse explanatory models, especially considering how fundamental they are to help-seeking and therefore, mental health outcomes.

7.5 Study Strengths and Limitations

7.5.1 Strengths

I believe that this study has four key strengths.

Advocating for Structurally Competent and Person-Centred Care

A strength of this study is that it adds to a growing and necessary evidence base on the cultural influences on mental health in ethnically diverse and migrant populations. It is well established that mental health services are inadequate in high-income countries (despite relatively large economic investment and a sizeable specialist workforce), but most global health efforts have been concentrated on low- and middle-income countries. An important avenue to improving mental health services is through the development of culturally sensitive services and the delivery of person-centered and structurally competent care. In order to advocate for these changes, research on how an individual's or group's culture may influence their mental health understanding, experience and help-seeking, is vital.

Engagement with the South Asian Community

I ensured that I worked closely with the very people I was hoping to improve mental health outcomes for in the first place. I used qualitative methods to centre the voices of individuals within the South Asian community, especially those with lived experience. Of particular importance, and not typically discussed with individuals with lived experience, is that we asked participants about their ideal recovery outcomes.

I also had numerous informal conversations with South Asian community leaders and organizations and hosted six public consultations with lay South Asian people to guide the study's conceptualisation, recruitment, data collection and analysis, and recommendations. Additionally, I believe it was a significant strength that this study was conducted by me, a second-generation South Asian from Canada because it conferred access and insight into the community.

Differentiating by Immigrant Generation

As I established in my systematic review, there is a dearth of literature that separates 'South Asians' in high-income countries by immigrant generation. By recruiting both first- and second-generation South Asian immigrants and analysing the data separately, I have been able to determine how immigrant generation impacts an individual's mental health beliefs and propose specific recommendations on how to improve mental health service delivery for these distinct groups, rather than treating the South Asian ethnic group as homogenous.

Cross-Country Comparison

As far as I am aware, this is among the first studies that explore the similarities and differences between South Asian immigrants in two different, but comparable, countries. Cross-country comparisons allowed us to explore whether certain cultural factors influencing mental health are universal across the South Asian diaspora, even when accounting for diverse migration histories, or are determined by local context.

7.5.2 Limitations

Despite my efforts, this study was not perfect and has several limitations, which I considered when assessing the validity and usefulness of the results.

Using Ethnicity as a Proxy for Culture

As I have previously discussed in the Introduction, there are valid criticisms for focusing on the cultural factors that impact mental health experience and management, rather than the structural factors. However, considering poor and inconsistent definitions of culture in academia and beyond, I felt that using country of origin and parents' country of birth as a measure of an individual's cultural background, was my only choice. I validated this decision by determining what researchers have previously done to address this issue and by having frank conversations with South Asian community leaders. Ultimately, this limitation means that I cannot really account for the heterogeneity between immigrants from different South Asian countries (the economic disadvantage of Bangladeshi and Pakistani individuals compared to Indian individuals in the UK and Canada is a good example of this heterogeneity). There are also well-founded criticisms of the term 'South Asian' – some scholars argue that this classification could possibly "forge some kind of post-national social justice collective that escapes territorial, xenophobic, and political conflict rooted within the sub-continent itself" (Walton-Roberts, 2013). However, the sub-continent of South Asia has a long and shared history pre-dating British Imperialism, which has led to many cultural commonalities that bind South Asians. I have attempted to limit the impact of this decision by clarifying that I am discouraging the stereotyping of South Asian individuals and instead am using this research to promote the delivery of person-centered and structurally competent care.

Limited Sample Variation

I found that it was (unsurprisingly) challenging to recruit men (n=7) in this study, which is a limitation common to many mental health studies. I was able to explore some gender-specific issues from the female participants (such as sexual, emotional, and physical abuse, domestic roles, and motherhood), but was unable to do so for the male participants due to the small sample size. The findings pertaining to the male participants, though limited, do indicate that men find it difficult to seek help for psychological distress, partly due to their gender (which comes with the underlying culturally based assumption that a man must be strong, independent, and stoic) (Jullierat et al., 2023). These findings warrant further exploration in future research.

Additionally, most participants identified themselves as Muslim, which inhibits how much I can speak about the influence of other South Asian religions on understanding, experience, and help-seeking for psychological distress. For example, it is clear from the Muslim participants that daily prayer and the Quran were their primary coping strategies for psychological distress, but the ways in which Hindu, Sikh, Christian, Buddhist, and Atheist participants engage with religious coping remains unanswered and must be researched specifically.

Eligibility Restrictions

A primary concern from members of the South Asian community was the pre-determined criteria for 'South Asian' in this study. Individuals from community organizations that I worked closely with were disappointed about the exclusion of newcomer South Asian immigrants, those originating from East Africa as well as neglected South Asian sub-groups such as Indo-Caribbean and Indo-Mauritian sub-groups. While I seriously considered these concerns, I decided it was important to restrict the eligibility criteria based on length of residence in host country, country of origin and migration route to allow for some similarity between participants.

Due to logistical constraints (such as lack of financing) and ethical concerns around using family members or translators while studying sensitive subjects, I decided to only include individuals who could communicate in English. This decision resulted in first-generation participants being unable to describe their experiences in their first language and not including perhaps more underserved South Asian individuals. I attempted to give individuals who spoke English as their second language ample time to answer questions. In some cases, I was able to help translate short phrases due to my own Hindi language skills or was able to ask a community organization staff member for assistance (with permission from the participant). Additionally, since an eligibility criterion was having lived in the UK or Canada for five years or more and the relatively small number of South Asian immigrants who do not speak at least basic English in both sites, I believe the impact of this decision is negligible.

Recruitment Styles

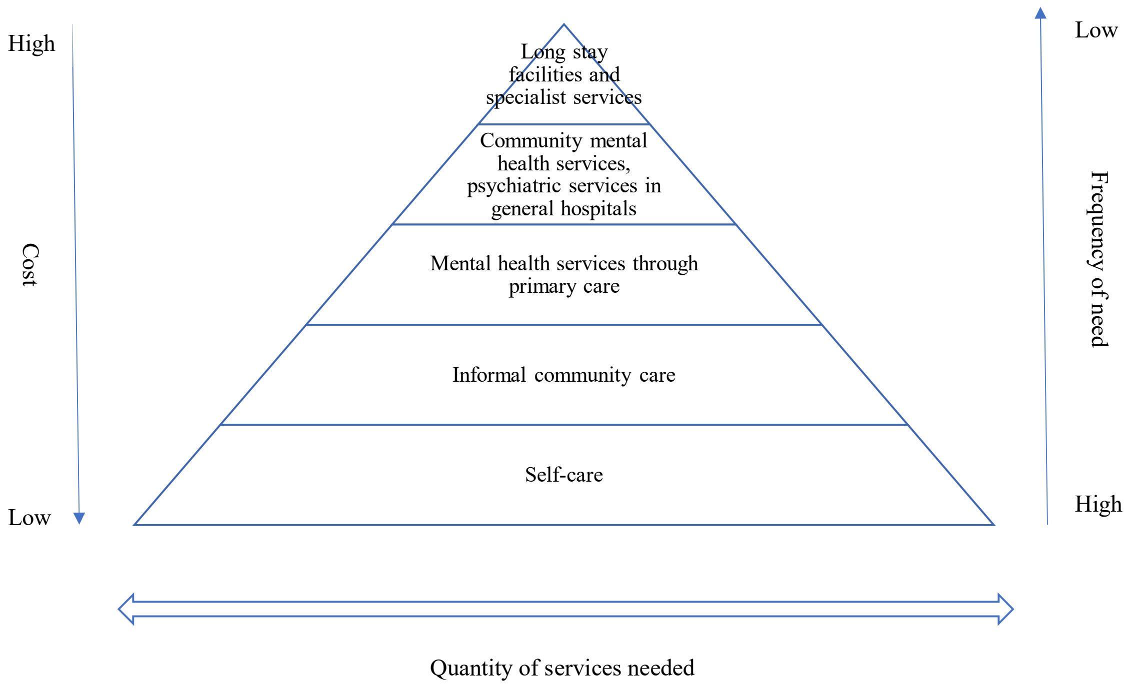
I used varied strategies to recruit participants. For first-generation participants, working with community organizations such as Punjabi Community Health Services, Indus, and Access Alliance in Toronto, and Henna Women's Group in London, was the most successful strategy. For second-generation participants, asking organizations that are more targeted towards younger and second-generation South Asian immigrants to post my recruitment poster on social media (particularly Instagram and Twitter) allowed me to recruit participants. While I also went to community spaces such as libraries and places of worship to spread information about my study, it is likely that my study sample is over representative of those who are educated, employed and that engage with, or work at, community services. It is therefore important to not exaggerate the usefulness of community services as mental health service providers for the South Asian community.

7.6 Implications for Research, Policy and Practice

Overall, these findings support well-established explanations that connect South Asians' explanatory models to their lack of engagement with formal healthcare services in their help-seeking practices. These culturally based explanations are primarily framed around the endorsement of socio-cultural-spiritual frameworks, collectivism and stigma (Bowl, 2007; Prajabati and Liebling, 2022; Hussain and Cochrane, 2016). Despite the consistency, what I believe this study can help change, is how we interpret, and see the significance of, these findings. I have noticed from conversations with academics, my systematic review, and field experience, that previous discourse around this subject often placed South Asians as a monolith (e.g., 'South Asians somatise mental health problems, hold supernatural causal beliefs and prioritise the family over the individual'), which, as astutely stated by a public consultation participant, "lowered" and "othered" the South Asian community as a group unable to understand supposedly superior Western ideologies on mental health. Therefore, efforts were concentrated on culturally unspecific educational campaigns designed to address stigma (Goel et al., 2022) and culturally competent care, which recently has been widely criticized (Melino, 2022).

Addressing ethnic differences in mental health is an old and much-debated subject, however, there are recent factors that have led to substantial change. Factors responsible for this change include the de-colonisation of the field of global mental health coupled with the increasing profile of public mental health, heightened interest in migrant and ethnically diverse populations due to anti-immigration and anti-Muslim rhetoric, widening health inequalities due to the COVID-19 pandemic, and the expansion of research that centers the voices of people with lived experience. Now, we must seize this opportunity and join new and fundamental conversations about how to improve mental health outcomes for this sub-group, while resisting making sweeping generalisations about individuals of South Asian origin. Arguably, the greatest contributions of this study are the unpacked nuances on generational differences and the fact that despite the substantial amount of work done in high-income countries and beyond to address the influence of culture on mental health, the need for culturally appropriate care persists.

The World Health Organization's "Optimal Mix of Services for Mental Health" pyramid framework illustrates how mental health services should ideally be distributed based on a population's need and the cost of the service (World Health Organization, 2003). At the base of the pyramid there are two levels: self-care and informal community care. Both levels are highlighted as services which are both high need and low cost. As you travel up the pyramid, one



can see that primary care services, hospital and community-based psychiatric care and specialist and long-term in-patient care are lower need and higher cost options.

Figure 5. WHO Service Organization Pyramid for an Optimal Mix of Services for Mental Health (2003) (World Health Organization, 2003).

My findings suggest that it is the delivery of self-care and community care that must be prioritised moving forward. Bolstering self-care and informal community care could involve:

a. creating opportunities for volunteering,
b. running groups for South Asian women and men that are not necessarily labelled as mental health groups, but allow attendees to learn new skills, travel, socialize, and strengthen their perceived social support,
c. increasing the availability of community spaces where individuals can engage in activities, they enjoy such as playing computer games, exercising, or doing yoga
d. deliver family-based interventions such as group therapy.

These services could be delivered in parallel to community-led, culturally sensitive campaigns to raise mental health awareness. The goal of these campaigns would be to help individuals learn how to manage their mental health problems by themselves or with the support of friends or family members, rather than encourage them to seek help from formal care.

The options I have mentioned above are important for the second-generation participants in my study as well, but there are some nuances that must be considered. First, only a few second-generation participants attended any community services as a coping strategy for distress, meaning that they may be unlikely to attend in-person groups, especially if they are mixed with first-generation and/or older South Asian individuals who they may feel misunderstand them. As a result, the community groups should exist on online digital spaces and be specifically tailored to the unique challenges that second-generation individuals face. Additionally, the second-generation participants were more aware about mental health because the increasing visibility of the topic in educational settings and prominent influencers openly sharing their distress on social media.

Raising first-generation parents' mental health awareness will likely positively impact second-generation individuals especially in childhood and adolescence. Firstly, participants reported that their distress partly stemmed from a first-generation family member with an undiagnosed or unmanaged mental health condition, and secondly, first-generation family members' differing views of mental health often meant that they acted as barriers to help. For example, South Asian youth in Toronto, Canada "recommended that prominent leaders within the South Asian community like religious leaders, politicians, celebrities and others take a more active role in facilitating mental health awareness and combating mental health stigma within the parental generation" (Islam et al., 2017).

Importantly, second-generation participants in my study also used medical strategies to cope with their distress, with the most common strategy being speaking to their primary care practitioner. Therefore, another service level on the WHO's pyramid that is important for second-generation South Asian individuals is increasing the quality of care delivered by primary services. Kirmayer suggests that along with basic care practices, which are also important for the general population, primary care can address the specific needs of individuals with immigrant backgrounds "through specific enquiry into social and cultural context, the use of interpreters and culture brokers, meetings with families and consultation with community organizations" (Kirmayer et al., 2011). The second-generation participants in my study desired holistic approaches to mental healthcare from their GP. Therefore, Kirmayer's first point, about encouraging primary care physicians to ask their patients about their social and cultural context, is particularly meaningful.

Recommendations

I have written these recommendations based on my systematic review, informal conversations with South Asian community leaders, my reflexive thematic analysis and direct suggestions from interview and public consultation participants. Our efforts must concentrate on the reform of universal services, in parallel to the development of specific services for South Asian communities. While I acknowledge that the reform of universal services will benefit people from all ethnic groups in high-income countries and beyond, I focus on how these changes can benefit my study population specifically.

Reform of universal services must include:

Challenging dominant Western ideologies, which "other" and "minoritize" ethnically diverse populations and endorse clearly failing diagnostic models of care.

To address the challenges facing mental health care for South Asians in high-income countries today, we must acknowledge that "mental health practices are fundamentally situated within systems of power and colonial hegemony and continue to be used as tools of neocolonialism in relation to Asian mental health" (Millner et al., 2021). Then we must take action to address social, economic, and political factors that intersect to cause and worsen mental health conditions in ethnically diverse populations including anti-immigrant public policies and systematic racism. In parallel, efforts must be made to abandon biomedical theoretical perspectives and proceed to a post-colonial lens, which "draws our attention to the historical, economic, cultural, and social contexts of health and healthcare" rather than the affordability, distance, and availability of services (Horrill et al., 2018). To me, adopting a post-colonial perspective means that the cultural values and beliefs of disadvantaged groups are not only considered, but prioritised. For South

Asian communities, this transformation would involve accounting for factors such as collectivism and religion and spirituality, rather than demonising them.

Addressing the wider social determinants of health.

Many participants, especially first-generation participants, attributed their distress to factors such as racism, gender-based discrimination, inadequate housing, and employment insecurity. These findings are consistent with growing evidence in the literature that suggests that mental health conditions are determined by social and cultural, environmental, neighbourhood, economic and demographic factors (Lund et al., 2018, Oswald et al., 2024). These findings signify the importance of addressing the social determinants of health to prevent and manage distress.

Though there is an established research gap on how gender shape mental health (Rose-Clarke et al., 2020), my study indicates that there is some relationship between gender norms and the manifestation of distress. Therefore, of particular importance to my study population when it comes to mental health are interventions targeted at helping the recipients of gender-based discrimination. For example, advocacy and housing interventions have been shown to reduce depressive symptoms in women who have experienced intimate partner violence (Yakubovich et al., 2022, Oswald et al., 2024).

Even after living in their host country for at least five years, first-generation participants often attributed their distress to the trials and tribulations associated with moving to a new country, even if the decision to immigrate was voluntary. Therefore, boosting support for newcomers by ending racism and discrimination in employment practices, the provision of safe and welcoming housing, opportunities to build social networks, and increasing awareness of existing healthcare services is essential.

Social prescribing, which is currently being widely employed through the UK's NHS, could act as an important intervention to address some of these key issues and improve immigrant mental health and wellbeing. Formal and semi-formal services can connect immigrants with 'link workers' who are then able to refer them to relevant organizations that handle the social determinants of health. Social prescribing has been described as a holistic approach to care and has been shown to boost self-esteem and confidence and social connectivity (though as Zhang et al. (2021) point out in their systematic review on social prescribing for migrants in the UK, these positive outcomes are anecdotal rather than statistically significant). A crucial part of delivering social prescribing for migrants, however, is ensuring that it is culturally and linguistically sensitive (Zhang et al., 2021).

Norming person-centered, structurally competent, and culturally sensitive care across all forms of service delivery.

Participants in my study widely agreed that adopting these forms of care was essential to improving mental health care for the South Asian community. There is widespread acknowledgement that healthcare providers must be equipped to handle their diverse patients' healthcare needs. For example, in a qualitative exploration of clinicians' perspective on their South Asian patients' mental health care needs, the participants "emphasized that clinicians need to pay attention to and respect pertinent cultural influences and religious values" (Rastogi et al., 2014).

In line with intersectional and postcolonial theory, person-centered and structurally competent care would involve clinicians shifting away from their position as the 'experts' in the room to them being genuinely interested in their patient's life stories, cultural and religious context, and family relationships (Akhtar et al., 2022; Melino et al., 2022). A 2013 systematic review (including 13 articles) found that person-centered care models (referred to as patient-centered care in the study), "increased practitioners' knowledge about and awareness of dealing with culturally diverse patients" (Renzaho et al., 2013). Importantly, the authors noted that there is little empirical evidence that connects this increased knowledge with improve health outcomes.

Studies highlight the benefits and limitations of exploring explanatory models in clinical settings. Keys et al. (2012), for instance, investigated culturally informed understandings of mental health (termed "idioms of distress" and "ethnopsychological frameworks") in post-earthquake Haiti. Patients affected by trauma, bereavement, and economic instability commonly reported somatic symptoms centred on the head and heart. Ideally, clinicians would elicit patients' explanatory models through in-depth interviews to uncover the psychosocial dimensions of distress. However, the study found that such practices were rarely implemented. Although clinicians recognized local idioms of distress and their interrelations, they "attributed their reluctance to explore potential mental distress to the severe shortcomings they face in their professional training and resources… [they had limited training in mental health]." As a result of inadequate training and resources, patients were often prescribed medication rather than appropriate psychosocial or religious/spiritual interventions, such as referrals to social workers or church leaders. This study reinforces that there is still a gap between the theoretical value of clinical interviewing and its practical application in resource-limited contexts and beyond (Keys et al., 2012)

At a similar time to the Keys et al. (2012) study, Arthur Kleinman reflected on the limitations of the use of his eight questions to elicit explanatory models in routine practice in clinical settings (Kleinman, 2013). As he witnesses these questions being taught in medical school and utilized in hospitals across the USA, he realized that these questions "reduced complex, vivid lives" into stereotypes, made patient's narratives into stories that were separate from the social determinants of health and was disappointed by the way in which these questions became part of the cultural competence wave, which made healthcare providers believe they could be competent in another person's culture. Then, after his wife's diagnosis with early-onset Alzheimer's, Kleinman became his wife's primary caregiver. This experience made him aware of the apparent disconnect between the things that "mattered most" to clinicians and what was "at stake" for him and his wife (i.e., their careers, family, hopes and fears). After 40 years of work on culture and health, he believes that healthcare practitioners must return to the moral core of medicine and see the relationship and communication between healthcare providers and patients as "gift giving and receiving among intimate others". He writes that "caregiving [must be] central to health care…enduring practices of caring as the laying of hands, the expression of kindness, the enactment of decency, and the commitment to being there for those who need them" (Kleinman, 2013). Perhaps more central to the exploration of a patient's explanatory models is this return to the moral and emotional core of medicine, along with the considering of people's everyday suffering (driven by structural racism, bleak socio-economic conditions, and conflict).

Employing person-centered, structurally competent, and culturally sensitive care would also involve providing individuals with options regarding treatment that go beyond short-term counselling and medication. One such treatment option relevant to my study population are intergenerational approaches to mental health, which aim to address cultural conflict within South Asian families. The need to include family in service provision, especially for South Asians, was confirmed in a recent qualitative study. A youth programme coordinator in the Peel Region in Canada with experience working with South Asian youth in mental health stated "I think systemic family therapy really works; I find that working with South Asian families, youth, CBT, [dialectical behaviour therapy] DBT are really useful to reduce mental health symptoms and harmful behaviors but you also have to do some family work" (Islam et al., 2022).These approaches may include family-based and parenting mental health interventions, group therapy and support, and cultural brokers, which have shown effectiveness in South Asian communities and other immigrant populations (Sharma et al., 2020; Bunn et al., 2022; Shah et al., 2023). For example, in their clinical review, Sharma et al. (2020) advocate for the use of Attachment-Based Family Therapy (ABFT) to improve mental health outcomes among South Asian American youth. In ABFT "the provider has to recognize the differing goals and values of the parent and child, and then negotiate a middle path of parental understanding rather than rejection or conditional support." The idea is to translate parents' conditional support into unconditional support, which would allow their child to create "a culturally integrated identity that aligns with the youth's sense of self." The authors look to culturally adapted family therapy as evidence to support this; a family therapy intervention for Hispanic families was found to be very successful because the provider worked with the family as a unit (Sharma et al., 2020, Santisteban et al., 2006).

Given its relation to the current study, it is also important to reflect on the recent ROSHNI-2 randomized controlled trial, in which the researchers tested the efficacy of a culturally adapted CBT group-based intervention called the Positive Health Programme (PHP) (Husain et al., 2024). Participants included British South Asian women who met the DSM-V definition of depression and had a child under the age of one year. The intervention was delivered by non-specialist (but NHS trained) workers and culturally adapted based on previous research such as the study by Masood et al. (2015). The intervention "educated participants about depression and addressed nine culturally specific topics, including the challenges of being a British South Asian woman, the role of religion and spirituality in mental health, issues affecting self-esteem and their management, exercise, relaxation, assertiveness, self-confidence and tackling social isolation" and was offered in multiple South Asian languages. At the 6-month follow up, recovery from depression was higher among the intervention group than the control group. However, there was no sustained effect reported. At the 12-month follow up, the difference between the intervention group and control group was insignificant. While promising, clearly, evidence from this trial indicates that further research is required to determine how culturally adapted interventions such as these can result in sustained effects for South Asian individuals. Generational status was reported (57% of participants in the intervention group were first-generation, 33% were second-generation and 10% were third-generation) but the authors did not present disaggregated results based on this characteristic. Considering my study results indicate that the cultural barriers to service use and its effectiveness differ by generational status, I would postulate that this should be accounted for designing mental health services.

Diversifying the workforce so that all ethnic and cultural backgrounds are represented in the healthcare field and beyond.

Whether to consult a healthcare profession with the same ethnic or cultural background was very personal to participants. Many participants preferred to see an individual with a South Asian background because it would give them a ‘short-cut of understanding’ and guaranteed culturally sensitive solutions. Therefore, a barrier is an insufficient number of South Asian healthcare professionals, especially in counselling and therapy. The lack of workforce diversity was identified as a provider-level barrier to visible immigrant population’s mental healthcare needs in a qualitative study and a scoping review in Canada (Sim et al., 2021; Salam et al., 2022). One potential way to increase South Asian representation in the mental healthcare workforce is to accept overseas educational and professional accreditation (Sim et al., 2021).

This result has implications for efforts around “racial, ethnic, or cultural matching.” Studies have shown that this form of matching does not improve mental health outcomes; for example, a meta-analysis of 53 studies showed that there was virtually no benefit of matching individuals to therapists (effect size=0.09) (Cabal et al., 2011). Similarly, in this study, it is evident that representation is not the solution for everyone. Some participants preferred to see a white professional because they were a ‘blank slate’ and would not impose their cultural values onto their client or assume to have a common experience with their client when there was not one. There is a common thread in what qualities participants desired from their healthcare professions: being non-judgmental, confidential, and culturally responsive.

Therefore, this study suggests that efforts to bolster service providers ‘cultural competence’ or racial, ethnic, or cultural matching are not key solutions. Rather, the results once again indicate that the principles of person-centered care are fundamental to delivering culturally sensitive care, regardless of the service provider or service user’s background. As Epner and Baile (2012) argue a person-centered approach “focuses on foundational communication skills, awareness of cross-cutting cultural and social issues, and health beliefs that are present in all cultures…[and] relies on identifying and negotiating different styles of communication, decision-making preferences, roles of family, sexual and gender issues, and issues of mistrust, prejudice, and racism, among other factors.”

Though efforts to incorporate cultural sensitivity in healthcare delivery have intensified, research demonstrates that service providers are nonetheless struggling. For example, a team in Canada and America aimed to deliver culturally sensitive psychotherapy for perinatal women dealing with depression and anxiety and found that all the healthcare providers (n=19) did not feel as though they had enough training to discuss culture with their clients (Singla et al., 2022). To better facilitate the delivery of culturally sensitive psychotherapy, Singla and colleagues recommend bolstering training and supervision for the providers, explicitly mentioning culture and diversity in patient materials, and incorporating elements of the CFI (a validated set of questions meant to extract the social and cultural factors that are important to the client/patient) into behavioural activation treatments (Singla et al., 2022).

Existing and incoming mental health service providers (especially clinicians) should continue to be trained on how to deliver person-centered approaches which are not considered an afterthought. These practices would allow service providers to elicit their patients’/clients’ explanatory models and frame them as the experts of their lives. Evidence suggests that if patients perceive their healthcare provider to be culturally sensitive, they are more likely to be satisfied with their care, feel comfortable, adhere to treatment, and improve their outcomes (Tucker et al., 2011). In parallel, actions must be taken to increase the number of South Asian individuals in mental health work so that South Asian individuals have a choice in who to seek help from.

The following recommendations are important for the South Asian community in particular:

Using culturally sensitive initiatives to shift attitudes around mental health, particularly for older and first-generation South Asian individuals.

Many participants clearly stated it is crucial to consider *who* delivers the messaging around mental health. They suggested increasing the visibility of people of South Asian origin who were prominent within the community or had lived experience of mental health conditions. Important cultural leaders such as Imams, Bollywood stars, or local politicians could centre awareness campaigns that take place online or in South Asian community spaces.

We must also consider *what* the message is that is being delivered. Participants mentioned that it is important to address stigma in the South Asian community without lowering the community or shaming people. They suggested comparing mental health to physical health or connecting it to religion or spirituality.

For example, a mixed-methods evaluation of an anti-stigma mental health campaign in rural South India found that such approaches are successful in improving attitudes on mental health, but likely do not impact mental health knowledge or increase service use (Maulik et al., 2016). This campaign employed a wide variety of elements from the distribution of brochures to video testimony of a person of lived mental health experience to a live theatre performance. The most successful parts of the campaign, which echo the suggestions from participants from this study, were those that employed a ‘social contact’ strategy (e.g., the video and the play). Social contact strategies, in which an individual with lived experience of a condition interacts with someone who does not, are generally considered the best option to improve mental health attitudes (Thornicroft et al., 2016).

Seemingly, to positively shift attitudes in the South Asian community, the aforementioned prominent individuals could share their own personal experiences of mental health or highlight someone else with lived experience on common internet-based platforms (Kim, 2024) or through television or movies (Corrigan and Gelb, 2006). Content can include vignettes and information about signs and symptoms of mental health, similar to physical health conditions (Thornicroft et al., 2016).

It is important to not overplay the influence of stigma on low mental health service utilization among South Asian immigrants. Some scholars have argued that over-relying on culturally-informed stigmatized attitudes towards mental health problems can deter us from discussing all forms of racism. As Kapadia argues, *"the narratives assert that due to certain religious, spiritual and cultural beliefs held by ethnic minority populations, there are greater levels of mental illness stigma in these populations that deter help-seeking, and ultimately lead to more severe mental illness and poorer mental health outcomes…however, there is little evidence that ethnic minority people's poor mental health outcomes are mainly due to the apparent greater stigma felt by ethnic minority people…the way in which racism may shape stigma narratives about ethnic minority people has not been considered"* (Kapadia, 2023).

Bolstering the voluntary sector (i.e., community and faith-based services) to deliver mental health care outside of, or in parallel to, formal care through task-sharing.

The findings from this study, along with systemic factors such as short GP appointment times, long waiting lists for therapists and counsellors, and an overreliance on diagnostic models of care, indicate that formal services are not well equipped to deliver mental health care. In fact, researchers estimate that only 10% of individuals experiencing a mental health condition will ever require medical care (Patel, 2014). It is therefore necessary to bolster the delivery of mental health care from the voluntary sector through "task-sharing," which for the most part is a successful strategy used in low resourced countries. High-income countries can also benefit from task-sharing; certain aspects of mental health services can be delivered by individuals with less specialised skills or creating a new workforce that has been trained in specific skills (Sashidharan et al., 2018).

Task-sharing must be done differently for each generation. Alongside self-care, two coping strategies emerged as very important to many first-generation participants: religious activities (such as praying and reading religious texts) and attending South Asian community groups. It then becomes important for most mental health care to be delivered by trusted community organizations and faith leaders. Individuals already working in these settings could be trained to be community-based workers who promote mental health. These individuals have been shown use "social, cultural, and psychological skills in forming trusting relationships and in-depth knowledge of the context of their client's lives and family dynamics." They can clearly address the wider determinants of mental health and deliver culturally sensitive care (Jain et al., 2024).

Second-generation participants mainly did not attend any community-based services, but they did find communities on social media specifically for South Asians or Muslims to be rewarding. For this generation then, mental health services should be hosted online. Social media can be a powerful tool to create virtual support networks for these individuals because it gives them an opportunity to connect emotionally with other people. A scoping review found that social media-based interventions can positively effect adolescents and young adults with mental health problems. These interventions included posting educational content and encouraging dialogue so individuals with shared experiences could support and learn from each other (Kruzan et al., 2022).

Ensuring future research efforts use intersectional and co-production methods and focus on leadership and engagement within the South Asian community.

Clearly, future research must concentrate on under-represented groups such as racialized men, Indo-Caribbean, and Indo-Mauritian people and those experiencing multiple disadvantages due to their gender, sexual orientation, ethnicity, immigration generation or status or disability.

This research must use co-production methods, which are becoming best practice in global mental health. Co-production, though often operationalised and defined differently by different researchers, is based on the principles of involving service users and other relevant stakeholders all stages of the research process (i.e., "nothing about us, without us") (Albert et al., 2022). For true co-production to occur, "shared power" is essential; all stakeholders must have equal say in decision-making processes (Smith et al., 2022). It is important to recognise that outcomes of co-production (such as "improved trust, shared responsibility, levels of influence and ownership over projects") can be hard to evaluate due to their complexity. Therefore, researchers must aim to present how they are using co-production methods and which values they perceive are the foundation of their chosen methods (Albert et al., 2023). Beyond exploratory research, co-production or community engagement can be used to design mental health interventions. Evidence suggests that co-production in intervention development can be an effective strategy to reduce health inequalities. Of relevance to this study was that a meta-analysis signified that community engagement informed interventions for disadvantaged communities increased individuals' perceived social support (O'Mara-Eves et al., 2015). This recommendation mirrors those of prominent leaders and organizations. For example, recently CareIf and the Ethnic Inclusion Foundation brought together professionals to discuss how to improve mental health outcomes for South Asians in the UK. One of their key suggestions was to ensure that any mental health research or interventions involve co-production approaches (Gnanapragasam and Menon, 2021).

To engage important stakeholders in the South Asian community, beyond individuals with lived experience, we can also borrow from research which focuses on Indigenous leadership to develop culturally appropriate constructs around mental health services in Canada. Like South Asian communities, Indigenous communities in Canada have been subject to colonial violence, racism and discrimination in healthcare, and a lack of culturally safe mental health services. To address some of these issues, researchers have utilised collaborative and consensus-based approaches. For example, Montesanti et al. (2022) carried out a nominal group technique, which is a "structured meeting which seeks to provide an orderly procedure for obtaining qualitative information from target groups who are most closely associated with a [health-related] problem area" (Van de Ven and Delbecq, 1972) and a participatory community visioning exercise, which formalises vision-building and involves "a) developing the vision, b) defining the guiding principles and c) identifying strengths and the components of an action plan" (Montesanti et al., 2022). These approaches allowed the researchers to successfully work with members of the Indigenous community in Alberta to contribute to the development of an Indigenous mental health strategy. Adapting such approaches to the South Asian context could offer a valuable pathway to co-develop strategies that prioritise the community's perspectives and foster culturally responsive mental health solutions.

7.7 Conclusion

In this study, I investigated the ways in which culture influences how first- and second-generation South Asian immigrants in the UK and Canada understand, experience and seek help for psychological distress. I conducted a systematic review to examine the existing evidence base on the explanatory models and help-seeking for CMDs for South Asian living in high-income countries. I then interviewed first- and second-generation South Asian immigrants (n=38) with a self-reported experience of psychological distress residing in London, UK or Toronto, Canada. I analysed these interviews using a reflexive thematic analysis. I assessed my interpretations of the initial and final analysis and garnered what was important to the South Asian community by hosting a total of six public consultations (n=40) in both study sites.

My intention from the beginning of this study was never to create a list of dos or don’ts for working with the South Asian community. In fact, this study reveals how the South Asian diaspora is vast and diverse. Nonetheless, there are many cultural factors that are common across each individual’s explanatory models, coping strategies and help-seeking. Participants primarily attributed their distress to life or situational factors, with almost no participants correlating their distress with biological explanations. Participants were concerned about the impact the distress had on their work/academics, character, daily life and relationships. They used a mix of medicalised and non-medicalised terminology to describe their distress, regardless of a formal diagnosis. They reported a range of psychological and physical symptoms such as overthinking, crying, sadness, a lack of motivation and disordered eating and/or sleeping. Participants used self-help strategies to cope with their distress and many relied on cognitive religious practices (i.e., praying) to feel better. Participants mostly kept their distress to themselves, occasionally sharing with individuals who had similar experiences to them. If they did use formal care, it was to visit a GP or go to therapy or counselling. These participants were mostly dissatisfied with the formal care they received.

My analysis highlights that there are clear generational differences in how first- and second-generation immigrants perceived the cause of their distress as well as their help-seeking behaviours and coping strategies. Therefore, generational status must be accounted for when designing mental health interventions and services. The analysis also reconfirms that there is a substantial need for culturally appropriate mental health care for South Asians and other ethnically diverse populations.

In order to meet these needs, we must invest in community resources, run culturally sensitive anti-stigma and awareness campaigns, and employ person-centered and structurally competent care. Also, while this study focused on culture, the social determinants of mental health cannot be ignored in service delivery. More empirical evidence led by and in engagement with the South Asian community is required.

Even in high-income countries, the rising prevalence of mental health conditions and widening treatment gap is evidence of insufficient investment in mental health services and research. Ethnically diverse individuals and immigrants are more likely to develop mental health conditions, face particular systemic and cultural barriers to care, and exist within an increasingly xenophobic and racist environment. These groups therefore deserve special consideration, without ‘othering’ them. The South Asian diaspora is an important part of the fabric of UK and Canada. It is time to address their mental health care needs.

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