

Factors influencing beliefs about mental health difficulties and attitudes towards seeking help amongst Nepalese people in the United Kingdom

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Definition of Terms

Help-seeking

This term will be used throughout to refer to attempts made by an individual experiencing mental health difficulties, to find support or help. This may be in the form of professional help via mental health services or informal support e.g. from family or friends.

Intention (or Intention to seek professional help)

These terms will be used interchangeably throughout to refer to intention to seek professional help for mental health difficulties in the event of experiencing such difficulties.

Mental health difficulties

These terms will be used interchangeably to refer to psychological difficulties which have a significant impact on one's daily life including difficulties with working, communication, relationships, and learning. These difficulties may include reactions to stressful life events e.g. trauma or stress and anything which is referred to in the literature as a 'psychiatric condition or disorder' e.g. depression, anxiety, bipolar disorder.

Mental health professional

This term will be used to refer to an individual who has been trained to work with individuals with mental health difficulties. This includes psychiatrists, psychiatric nurses, psychotherapists, counsellors, psychologists, general practitioners and social workers.

Mental health services

This term will be used to refer to professional mental health services which are statutory (i.e. National Health Service) or privately run. These services will usually be staffed by mental health professionals (as described above).

Nepalese people living in the UK (NLU)

This term will be used to refer to any individual who identifies themselves as 'Nepalese'. This may include individuals of Nepalese nationality or individuals who identify themselves as Nepalese but were born in the UK (or not in Nepal).

Professional help/support

These terms will be used to refer to a professional mental health service provided by one of the mental health professionals described above.

South Asians

This term will be used to refer to individuals who identify themselves as being from Afghanistan, Bangladesh, Bhutan, India, Iran, Maldives, Nepal and Pakistan.

Abstract

Research shows that in the UK, individuals from black and minority ethnic backgrounds are significantly less likely to access mental health services than the general population. In the absence of literature or robust mental health service access figures for Nepalese people living in the UK (NLU) there is little understanding of the mental health needs and help-seeking preferences of this group. This study aimed to examine factors which are associated with professional help-seeking for mental health difficulties in NLU. The Theory of Planned Behaviour (Ajzen, 1985) was used as a guiding theoretical framework to examine the strongest predictors of intention to seek professional help. Potential predictors, shame/izzat, acculturation, beliefs about the causes of mental distress and demographic variables were measured. The sample were 65 NLU recruited from community centres, health events and online groups across the UK.

Results indicated that although a significant number of NLU reported having experienced mental health difficulties, very few had sought professional help. A number of variables significantly correlated with intention to seek professional help, including level of acculturation, non-Western physiological causal beliefs and izzat. According to a multiple-regression analysis of the whole sample, izzat was the most strongly related to intention to seek professional help. A number of barriers to help-seeking were identified such as hoping problems would go away or not wanting to burden others.

A significant strength of the study was the use of both Nepalese and English language questionnaires which ensured that a large non-English speaking section of the NLU population was not excluded from the study. Limitations include methodological considerations such as the use of one measure which appeared to have limited validity. Furthermore, the exclusion of illiterate individuals by merit of using a self-report questionnaire limits the generalisability of these findings to the NLU more widely.

Low mental health service access rates were identified within this sample relative to the prevalence of mental health difficulties. The clinical implications of this study highlight the need for policy and service level strategies to increase service access rates and the need for mental health services which are sensitive to the culturally specific issues within the population.

1. Introduction

This literature review aims to examine the existing research relating to mental health and barriers to accessing mental health services for Nepalese individuals living in the United Kingdom (NLU). Firstly, an epistemological discussion and examination of the terminology to be used throughout this thesis will be detailed. A review of the mental health needs and mental health service access of South Asian populations will then be described and related specifically to the native Nepalese population and to NLU.

The various models which have been used in the literature to explain help-seeking behaviours will be examined in order to understand the mental health service accessing behaviours of this population. The theoretical framework used in this study to examine help-seeking in the target population will then be discussed. Subsequently, the literature relating to factors likely to influence help-seeking for mental health difficulties in this population will be reviewed. A description of the literature searches conducted for each section of the review can be found in Appendix 1. Finally, the rationale, research hypotheses and aims of this study will then be discussed in the context of this literature.

1.1 A cultural perspective and use of terminology

A vast wealth of literature in the field of mental health uses terms such as 'race', 'ethnic minority', 'culture', 'Western' and 'ethnicity'. These words are often used without qualification and the definitions and implications of the use of these terms are not always considered. In this thesis, the terms 'culture', 'South Asian', 'ethnic minority', 'Black and Minority Ethnic (BME)' and 'Nepalese individuals living in the UK' will be used. However, a number of important caveats must be stated in using these terms.

Various attempts have been made to define 'culture'. However, most of the definitions of this term are in agreement that culture consists "*primarily of the symbolic, ideational, and intangible aspects of human societies*" (p8: Banks & McGee-Banks, 1989). Banks and McGee-Banks go on to state that "*the essence of a culture is not its artefacts, tools, or other tangible cultural elements but how the members of the group interpret, use, and perceive them. It is the values, symbols, interpretations, and perspectives that distinguish one people from another in modernized societies; it is not material objects and other tangible aspects of human societies. People within a culture usually interpret the meaning of symbols, artefacts, and behaviours in the same or in similar ways*" (p8). Thus, in this thesis, culture will not be considered as a static or linear entity, rather as complex and evolving.

'Ethnic minority' or 'BME' are a somewhat contentious terms, for a number of reasons. For example, they may imply similarities between ethnic groups which do not in reality exist. There is a certain level of agreement in more recent psychological research that ethnicity is based on a sense of belonging to a particular group. For example, Bhopul (2004) defines ethnicity as *"the social group a person belongs to, and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including language, diet, religion, ancestry and physical features traditionally associated with race"* (p.443). Whilst the terms 'ethnic minority' and 'BME' will be used throughout this thesis, it is acknowledged that 'ethnic groups' will vary over time, along with cultural beliefs and practices.

Two specific 'ethnic' labels will be used throughout this thesis. The first, 'South Asian', is often used within the mental health literature to refer to individuals originating (or descendants of those who originate) from the Indian subcontinent i.e. Pakistan, India, Bangladesh, Sri Lanka, Bhutan, Nepal and Tibet. This label will be used with caution throughout this thesis. Anand and Cochrane (2005) suggest that the use of this 'catch-all' term ignores the high variability in demographic variables, such as religion and cultural factors and may serve to limit understanding of mental health issues within these populations. At their worst, collective terms such as these may essentially be used to perpetuate racist stereotypes. Again, it is acknowledged that the use of this term may imply homogeneity and that individuals who are included in this definition may not self-identify as belonging to this group.

The second ethnic label which will be used is 'NLU'. This is a short-hand term to denote individuals either originating in or descending from Nepalese citizens and who are currently living in the UK. While this nationality itself may not be contentious, referring to 'Nepalese individuals' in a catch-all term may also lead to misconceptions of a potentially heterogeneous population. In reality, the population of Nepal is hugely diverse, in terms of socio-economic status, cultural practices, religion, language etc.

1.2 Access of immigrants originating from South Asia to Mental Health Services in the UK

Considerable strides have been made in improving access to mental health services for ethnic minority groups, propelled by equity-driven health policy which prioritises the provision of appropriate mental health services for ethnic minority groups in the UK (e.g. Department of Health, 2005). However, there is a growing body of literature attesting to the greater burden of illness in immigrant ethnic minority populations and the underuse of health care services (e.g. Hwang, Myers, Abe-Kim, & Ting, 2008). In the UK, ethnic minority groups continue to be overrepresented in inpatient mental health

and forensic settings and under-represented in community mental health services (Friedli, 2009). Research has suggested that ethnic minority groups have poorer outcomes and experience lower service satisfaction than dominant white groups (Sashidharan, 2003). In order for ethnic minority groups to access appropriate mental health services, a number of difficulties must be overcome. For example, Hwang et al. (2008) suggest that the use of non-ethnic minority populations in the majority of research regarding 'evidence-based treatments' limits the ability of services, commissioners and policy makers to understand how best to treat individuals from ethnic minorities.

Hwang et al. (2008) developed a conceptual framework to explain cultural influences on mental health. They suggest that cultural factors permeate all aspects of the diagnosis and assessment of mental health difficulties as well as help-seeking behaviours and treatment pathways. An increasing number of research studies have focused on mental health in South Asian groups, perhaps due to the huge number of South Asians immigrating to the UK (Pilkington, Msetfi, & Watson, 2011). As with other ethnic minority groups, numbers of South Asians presenting at mental health services appear to proportionally be significantly lower than the general population (Sheikh & Furnham, 2000). Moreover, demographic data for mental health services has indicated that this population is significantly less likely to present to services than other ethnic minority groups (Sheikh & Furnham, 2000). In recognition of this, the National Service Framework for mental health identifies performance indicators specifically related to the mental health needs of Asian groups (Department of Health, 1999).

A number of explanations for the low access rates for South Asian populations can be found in the literature. For example, some early studies claimed that the low levels of service access in South Asian populations could be explained by lower levels of psychological distress, which meant that service access was not necessary (Cochrane & Stopes-Roe, 1977). However, more recent studies have suggested that the risk of mental health difficulties is particularly high in South Asian women (Fazil & Cochrane, 2003; Sonuga-Barke & Mistry, 2000). Attempts to explain this increased prevalence have suggested that risk of mental health difficulties in immigrant populations may be explained by factors such as language barriers, homesickness and social discrimination (Sher, 2010). However, Hwang et al. (2008) suggest that methodological failings in the research such as not controlling for the socio-economic status may account for higher prevalence estimates in ethnic minority populations. After controlling for such demographic differences Cochrane and Sashidharan (1996) found that South Asians had significantly lower inpatient admission rates for 'non-psychotic' mental health difficulties

than native British populations (although admission rates for schizophrenia were found to be similar for both groups). Further factors which may potentially influence service access in South Asian communities are considered below.

1.3 Mental Health access for individuals of Nepalese origin

Nepal is one of the world's poorest countries, with a population of around 30.4 million (UNO 2011). The country has a very limited mental health structure, with roughly one percent of the government's total health budget (itself less than three percent of the gross domestic product) spent on service provision for mental health difficulties (Regmi et al., 2004). There is currently no Mental Health Act and the National Mental Health Policy developed in 1997 has not yet been fully implemented (Jordans, Luitel, Tomlinson, & Komproe, 2013; Regmi et al., 2004). A recent study suggests that there are eighteen outpatient and seventeen community inpatient mental health units in the country, all in urban areas (Halder & Mahato, 2012). Records of mental health service utilisation show that services are largely accessed by individuals of high socio-economic status (Tausig & Subedi, 1997).

Estimates of the number of mental health workers in Nepal are varied, although it is clear that the number per person is extremely low (e.g. .59 workers per 10,000,000, Halder & Mahato, 2012). Estimates of the numbers of psychiatrists working in Nepal range between thirty (Jha, 2007) and forty (Kohrt & Harper, 2008) and between six and fifteen clinical psychologists (Halder & Mahato, 2012; Kohrt & Harper, 2008).

The lack of professional provision for individuals with mental health difficulties appears to have a profound impact on their treatment within society and views about mental health difficulties. For example, in the relative absence of mental health inpatient units, many individuals with severe mental health difficulties are incarcerated without having committed an offence (National Planning Commission and Ministry of Health, 1995). Whilst work is being undertaken to develop the mental health infrastructure of Nepal (National Planning Commission and Ministry of Health, 1995) the difficulties caused by a lack of resources and the huge stigma surrounding mental health difficulties is documented in much of the literature in this area (Jha, Ranjan, Pradhan, & Jha, 2011; Jha, 2007; Khattri et al., 2013; Kohrt & Harper, 2008).

Despite the bleak picture painted in much of the literature, there are a few studies reporting areas of progress in mental health treatment in Nepal. For example, Jordans, Keen, Pradhan, and Tol (2007) conducted a study in Nepal of the views of 'culturally sensitive para-professional psychosocial counsellors' and their clients. In qualitative semi-structured interviews, many

of the counsellors and their service managers reported feeling that the counselling approach was culturally relevant and appropriate and that they had noticed significant improvements in their clients. Furthermore, the majority of clients who were interviewed reported feeling that the counselling approach fitted well within their cultural setting. However, notably, clients were selected to participate by their counsellors, meaning that a positive bias towards counselling may have been introduced. Jha et al. (2011) also report the success of a setting up a voluntary and private sector mental health project in a town in Nepal. The merit of this project was the low running costs which the authors state must be central to the set-up of any mental health service initiatives in one of the poorest countries in the world.

1.3.1 Mental Health access for individuals of Nepalese origin in the UK

A growing number of Nepalese citizens are now moving to and settling in the UK. The UK Census in 2011 estimated that the non-UK born population in England and Wales was 7.5 million, a 62% increase on the 2001 figure. Of these, an estimated 41,000 were born in Nepal (Office for National Statistics, 2011). A community study of NLU which attempted to describe the different groups of Nepalese immigrants concluded that the main groups living in the UK were Gurkhas, overseas students, professionals and refugees and asylum seekers. Of these, the Gurkhas (and their families) were found to represent the largest proportion (Sims, 2008). She suggests that older NLU and individuals with limited knowledge of the English language (particularly the families of ex-Gurkhas) are especially likely to struggle to access to health care services.

Figures relating to the mental health service access activities of NLU are hard to find and present a major stumbling block for anyone attempting to policy make or research in this area (Casey 2010). However, referral figures obtained by the researcher for 2011 from Berkshire Health Care Trust Improving Access to Psychological Therapies indicated that fewer than 1% of referrals in Reading were for Nepalese individuals, despite 3% of the population being Nepalese (Centre for Nepal Studies UK, 2008). Similarly, the Count Me In Census (Care Quality Commission, 2011) suggests that .9% of mental health patients were included in the 'Other Asian' category which would include NLU. Demographic data collected regarding ethnicity does not usually include a 'Nepalese' category specifically and this limits the ability to specify the exact numbers of NLU who are accessing mental health services. However, the figures available suggest that a very small percentage of the total number of mental health patients accessing services are Nepalese and a very small proportion of NLU ever access mental health services.

Despite the figures suggesting that NLU are proportionally underrepresented in mental health services, research in the area of mental health amongst NLU is sparse. To the researcher's knowledge, there is only one published report addressing mental health issues in the NLU population. Amani (2012) conducted a project investigating the 'Mental Health Awareness' of Nepalese individuals living in Rushmoor, East Hampshire. The results of a survey addressing this issue suggested that NLU had low mental health awareness, were rarely accessing mental health services and had a preference to seek community help such as support from family, friends and community leaders. However, although suggestions are made in this report as to the possible reasons for this low access, there is no evidence in this report as to whether NLU intended to access services but are unable to, or whether there are other factors which influence these individuals' intentions to access services.

1.4 Models of help-seeking for mental health difficulties

Developing an understanding of the factors which influence help-seeking behaviours can be useful in improving the provision of culturally appropriate mental health services and increasing access to these services (Mo & Mak, 2009). There is good evidence in the literature that attitudes and intentions predict behaviours such as accessing mental health services (Ajzen, 1988; Leong, Wagner, & Tata, 1995; ten Have et al., 2010). However, much of the research is exploratory and has been criticised for not using theory-based models to facilitate understanding of attitudes which may be related to help-seeking behaviour (Phoenix & Winnie, 2009).

A systematic review of the literature relating to the extent and nature of help-seeking behaviours for common mental health difficulties (e.g. depression, anxiety) concluded that the focus of much of the literature has been on three constructs: attitudes towards help-seeking, intentions to seek help and actual help-seeking behaviours (Gulliver, Griffiths, Christensen, & Brewer, 2012). With this in mind, the three most widely cited and applied theoretical frameworks relating to attitudes, intentions and behaviours will be critically discussed, including the theoretical framework chosen for this study.

The Health Belief Model (HBM; Becker, 1974; Hochbaum, 1958; Rosenstock, 1966) is a cognitive model which posits that five factors: perceived susceptibility and severity of an illness, perceived barriers to taking action, beliefs about the effectiveness of taking action, and cues to action (i.e. incidents which remind the individual of the threat of illness), predict the likelihood of engaging in a health related behaviour. The HBM has been widely used as a guiding theoretical model to explore health related behaviours, with a number of studies exploring mental health care utilization and treatment

compliance (e.g. Henshaw & Freedman-Doan, 2009; Kelly, Mamon, & Scott, 1987). The model has received a number of criticisms including comments on its lack of structure (Norman & Conner, 1996) and questions about whether the theory is 'disconfirmable' (e.g. a review of studies using the HBM concluded that many of the studies had found one or more of the proposed variables to be insignificant in predicting behaviour, Ogden, 2003). Furthermore, a comparative systematic review of predictive models of behaviour change concluded that due to its poor predictive power the HBM was "*in essence a list of variables rather than a theory based on adequately specified relationships between its core components*" (p11 Taylor et al., 2006).

Another model which has been commonly used in this field of research is the Health Service Utilisation Framework (HSUF: Andersen & Newman, 1973; Andersen, 1995). The HSUF was initially devised in an attempt to understand the service utilisation behaviours of families. Individuals within the family are used as the unit of analysis to allow for heterogeneity within family members, Andersen & Newman, 1973). The model purports that '*predisposing*' factors (e.g. health beliefs, demographics, education, social networks etc), '*enabling*' factors (e.g. personal or family means and know how to access health care services and the availability of services), and '*need*' factors, both perceived (i.e. an individual's view of their health and healthcare needs) and evaluated (i.e. professionals' opinions about the individual's need) are determinants of an individual's health service use.

A number of studies examining health service utilisation have used the HSUF (e.g. Tomiak, Berthelot, Guimond, & Mustard, 2000; True et al., 1997). However the model has been criticised as being overly general (Mackenzie, Knox, Gekowski, & Macaulay, 2004) and not accounting for the complexity of attitudes and factors which may impact upon service use. The model also has limited scope for the inclusion of culture and social influences and has not been used widely in cross-cultural research. This model was therefore considered to be of limited merit in helping to understand the population of this study.

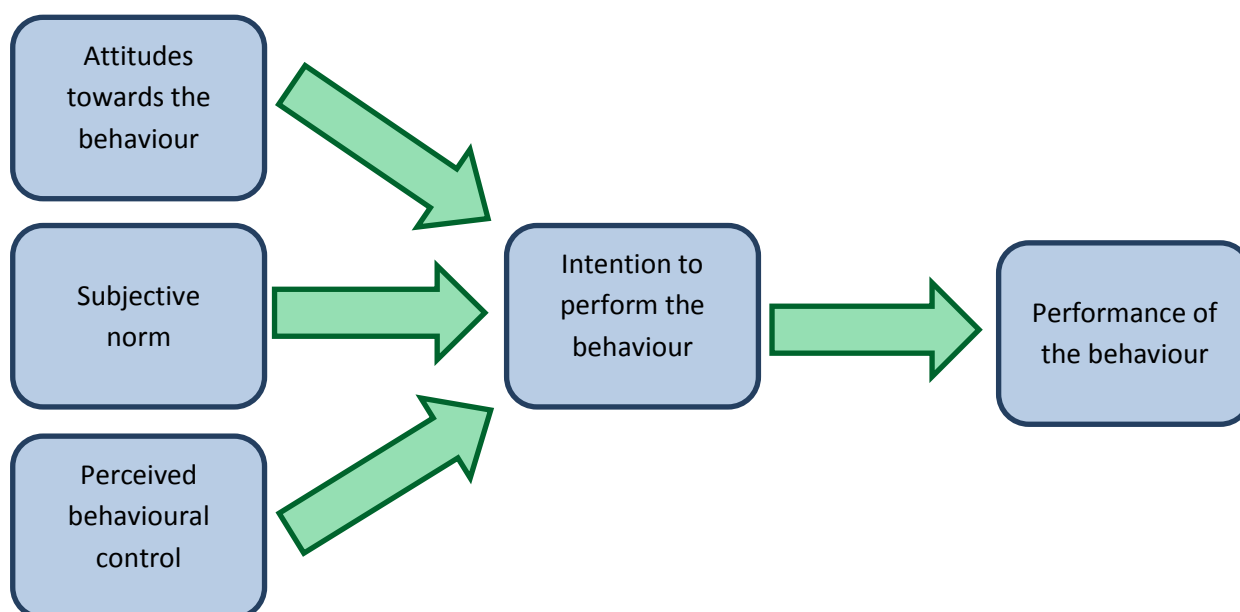
1.5 Theoretical framework for this study

The model which will be used as a guiding theoretical framework for this study is the Theory of Planned Behaviour (TPB; Ajzen, 1985). The TPB is an influential model which is a revision of the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975). The TRA purports that an individual's '*intention to perform a behaviour*' can be predicted by his or her '*attitude towards performing the behaviour*' and '*subjective norms*' (i.e. an individual's perception about the expectations of significant others in his or her social network and his or her intention to comply with these expectations,

Fishbein & Ajzen, 1975). The relative strength of behavioural intention is then seen as a good predictor for actual performance of the behaviour. Fishbein and Ajzen (2009) suggest that the relative weight of the components which predict intention are likely to vary dependant on both the behaviour and the population under consideration.

The TRA has been criticised for being unable to predict behaviours which are not within an individual's volitional control (Hale, Householder, & Greene, 2002). In order to account for this, Ajzen further developed the model to include the additional concept of '*perceived behavioural control*' as a further predictor of intention to perform a behaviour (Ajzen, 1985). This refers to an individual's perception of the ease or difficulty which may be faced in performing a particular behaviour. Put simply, the TPB model states that behaviour within an individual's volitional choice can be predicted by his or her attitude towards that behaviour and the perception of others' views about the performance of that behaviour. This model is presented in Figure 1.

Figure 1. Theory of Planned Behaviour (Ajzen, 1985)



The TPB incorporates aspects of cognitive theories such as Self-Efficacy Theory (Bandura, 1977a), Learning Theory (Bandura, 1977b) and Attribution Theory (Heider, 1958) and has become one of the most widely applied behavioural theories. A number of good quality reviews concerning the application of the TPB have been conducted (see Armitage & Conner, 2001; Godin & Kok, 1996; Hardeman et al., 2002; see also Rutter & Quine, 2002; Taylor et al., 2006; Webb, Sniehotta, & Michie, 2010). These reviews suggest that the TPB has use for both predicting behaviour and application to

retrospective analysis of health related behaviour. Various estimates of the predictive power of the TPB suggest that between 20–39% (Armitage & Conner, 2001; Godin & Kok, 1996; Taylor et al., 2006), of the variance in behaviour following an intervention can be explained by components of the TPB. Much of the literature reports strong correlations between performance of a behaviour and the ‘attitudinal’ and ‘perceived behavioural control’ elements of the model (see Taylor et al., 2006). A large meta-analysis of 185 health related behaviour studies reported weaker correlations between the behaviour and subjective norm components of the model (Armitage & Conner, 2001). However, a possible methodological explanation for this, given by Armitage and Conner (2001) is the inappropriate measurement of subjective norm in many studies i.e. using single item measures, rather than multiple item measures. They suggest that weak correlations are moderated by the type of measure used.

A variety of criticisms have been levelled at the TPB. For example, Mullen, Hersey, and Iverson (1987) voice a common criticism, that the TPB emphasises rational and deliberate processes, neglecting behaviours which are carried out impulsively or spontaneously and does not account for the emotions and affect which may influence behaviour. A number of studies which have examined the influence of affective beliefs as well as the instrumental aspects of the TPB (e.g. French et al., 2005; Perugini & Bagozzi, 2001). These studies have supported the notion that affective variables explain additional variance in the TPB. Fishbein and Ajzen (2009) accept these criticisms, stating that they recognise and welcome the huge number of studies using the TPB which have included additional factors such as age, gender, religion etc. (e.g. Pilkington et al., 2011; Rose, 2010) which are likely to contribute to behavioural intention.

The TPB and TRA have been widely used in research relating to the prediction of health-related behaviours in areas such as smoking cessation (Guo et al., 2007), dental hygiene (Syrjälä, Niskanen, & Knuuttila, 2002), condom use (Albarracin, Johnson, Fishbein, & Muellerleile, 2001) and diabetes management (Didarloo et al., 2012). The TRA and TPB have also been used as theoretical frameworks in a number of mental health studies examining the relationship between intention to access professional help and actual behaviour (e.g. Bayer & Peay, 1997; Mackenzie, Gekoski, & Knox, 2006; Rose, 2010). Moreover, the TPB has been applied to a number of ethnic minority populations (Phoenix & Winnie, 2009; Pilkington et al., 2011; E. Rose, 2010). It has been described as particularly appropriate for use studying diverse and multicultural populations by a number of authors (Ajzen, 1985; Armitage & Conner, 2001). The cultural appropriateness as described by Ajzen (1985), include the ability of the model to account for cultural attitudes and subjective

norms relevant to the target population. The model can also include the influence of cultural and religious factors on positive behavioural control, which may, for example forbid particular attitudes and subjective norms towards particular behaviours. Das and Kemp (1997) suggest that in South Asia, collectivist cultures may emphasise the needs and integrity of family groups or wider groups over individual needs.

1.6 Factors influencing access to mental health services

In this study, the primary focus will be on the first half of the causal chain of the TPB, namely factors which are likely to predict intention to access professional help for mental health difficulties. The relative contributions of the constructs of the TPB are likely to be variable across different cultural groups (Hagger et al., 2007; Walker, Courneya, & Deng, 2006). A number of key factors have been identified as influencing these constructs in South Asian populations and specifically Nepalese populations, including beliefs about the causes of mental health difficulties, levels of acculturation, and stigma. These factors will be considered in turn in relation to help-seeking for mental health difficulties.

1.6.1 Beliefs about the causes of mental health difficulties

The notion of ‘explanatory models illness’ was first introduced by Kleinman, Eisenberg and Good (1978). They proposed that an individual’s understanding and experience of his or her illness is socially constructed, meaning that individuals from differing cultural backgrounds may ascribe different labels to their experiences of illness and may experience and interpret them differently (Kleinman et al., 1978). Extensive research has demonstrated that ‘explanatory models of illness’ have an impact on the type of help which is likely to be sought, attitudes towards mental health services and the likelihood that help will be sought at all (Hill & Bale, 1980; Lynch & Medin, 2006).

In the field of mental health, a wealth of research has examined the impact of culture on explanatory models of mental distress. For example, Hwang et al. (2008) suggest that culture impacts not only on the manner in which distress is expressed, but this in turn impacts upon the type of help an individual seeks or whether they seek help at all. Within a TPB framework, an individual’s explanatory model could be viewed as impacting upon attitudes towards help-seeking and thereby upon intention to do so.

There is a wealth of literature on the ‘somatic expression’ of mental distress in South Asian populations (e.g. Chun, Enomoto, & Sue, 1996; Tabassum, Macaskill, & Ahmad, 2000), compared with the verbal and emotional expression of distress in ‘Western’ cultures. This is also known as

somatisation. The literature provides an example of how 'cultural factors' might impact upon the help which is likely to be sought for mental distress and the types of beliefs which might be held about the cause of mental health difficulties. For example, an individual experiencing somatic symptoms and being influenced by a culture which places a significant stigma upon mental health difficulties may seek help from a GP for physical problems. Conversely an individual believing their experiences to have a psychological aetiology may seek help from a psychologist. However, the term 'somatisation' itself is somewhat contentious, with debate about whether the under-diagnosis of actual physical illness (Kohrt et al., 2005) accounts for the prominence of somatisation diagnoses, or whether 'psychiatric illness' is under-diagnosed in South Asian populations (Hsu, 1999). There have been a number of studies (e.g. Bhatt, Tomenson, & Benjamin, 1989) which have found equivalent rates of somatisation in English and South Asian groups. Furthermore, Belliappa (1991) suggested that South Asian participants of a mental health study were able to recognise the psychological nature of their difficulties. An increasing amount of literature has focused on the stereotypes and racism which may be perpetuated by viewing South Asian populations as not being 'psychologically minded' or somatising instead of reporting psychological distress (see Webb-Johnson and Nadirshaw, 2002, for a review).

Religion is also thought to influence explanatory models of mental distress. For example, Al-Krenawi, Graham and Kandah (2000) suggest that Muslims commonly believe that mental distress is a punishment from Allah, sent to test their faith. Furthermore, Pilkington et al. (2011) suggest that religion may serve to forbid a behaviour despite the subjective norms or attitudes which endorse it. There is limited research examining the impact of religious belief in NLU or native Nepalese communities on mental health difficulties or beliefs about the causal of these difficulties. However, there is literature which links religious activity to mental health outcomes, such as a study by Gautam, Saito, and Kai (2007) which found that older adults in Nepal who engaged in religious activities e.g. saying prayers, experienced significantly lower levels of mental health difficulties.

Research examining the causal beliefs of South Asian groups about mental health difficulties has varied. McCabe and Priebe (2004) found that individuals of Bangladeshi origin were significantly more likely to ascribe mental health difficulties to supernatural causes than White British individuals. However, this study is somewhat reductionist in its fixed categorisation of explanatory models (despite acknowledging that participants expressed causal beliefs in multiple and non-fixed ways) and provides no explanation as to how potentially confounding socio-economic factors were accounted for, therefore the results must be interpreted with caution. As

previously stated, Tabassum et al. (2000) described the tendency of South Asian individuals to describe mental health difficulties as medical or biological problems (i.e. physical symptoms).

Literature relating specifically to the causal beliefs of Nepalese groups is again sparse and where it does exist, tends to be anecdotal. Tausig and Subedi (1997) state that *“traditional cultural institutions continue to dominate the explanations of the causes and care of persons regarded as “mentally ill” (p444)* and suggest that narratives such as the *‘possession by demons, ghosts or spirits’* are commonly given as aetiological explanations for mental distress. The authors argue that mental health providers must carefully consider the ‘fit’ between these causal explanations and ‘modern’ therapeutic techniques. Kohrt and colleagues have also conducted a number of studies relating to the causal beliefs and attitudes of individuals in Nepal towards mental health difficulties. For example, Kohrt and Hruschka (2012) conducted a small but rigorous medical anthropological study of survivors of trauma. They describe the explanations of mental distress given by Nepalese participants as often relating to bad *karma* resulting from past sins which have been transformed into personal loss and suffering. In a qualitative study in Nepal, Kohrt and Harper (2008) examined the role of beliefs about the relationship between the mind and the body and its impact upon the understanding of mental health difficulties. They suggest that these beliefs then influence the type of help sought by Nepalese individuals and the stigma attached to ‘mental illness’. Whilst the findings of these studies may provide a framework upon which to understand the causal explanations of some sections of Nepalese society, to the researcher’s knowledge there is no existing research which examines the causal beliefs of NLU specifically.

In relation to the TPB which is used as a theoretical framework in this study, beliefs about the causes of mental distress are considered to be related to the attitudinal predictor of intention. As discussed, causal beliefs are likely to influence the type of help sought because they will influence beliefs about the type of help required and thereby individual attitudes towards seeking help. For example, it could be hypothesised that Individuals who are exposed to Western models of distress who develop ‘Western-physiological causal explanations’ will have different attitudes towards seeking help from UK mental health services that those who hold more traditional supernatural or non-Western physiological causal beliefs.

1.6.2 Shame/Izzat

Mental illness has historically and continues to evoke shame and stigma in the majority of cultures (Hinshaw & Stier, 2008; Ng, 1997). Levels of stigma also appear to be related in many cultures to mental health service access

(Gilbert, 2000) and in South Asian populations have been found to be a significant barrier to service access (Gilbert, Gilbert, & Sanghera, 2006; Pilkington et al., 2011). The term izzat is used in much of South Asia to describe *“a complex set of rules that must be adhered to in order to protect family honour and maintain position within the community”* (p5, Pilkington et al., 2011). This concept has been explored in a number of studies of help seeking for mental health difficulties in South Asian populations (Anand & Cochrane, 2005; Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002; Gilbert et al., 2006; Pilkington et al., 2011). One study, which used the concept of izzat to explore intention to access mental health services, using the TPB as a guiding framework, concluded that for migrant South Asians, levels of izzat significantly predicted intention to access mental health services (Pilkington et al., 2011). However, this study, which used a questionnaire design to understand participants’ intentions to access psychological services, is significantly limited by its use of only individuals able to complete a questionnaire in English; this is likely to bias the sample collected.

Whilst there appears to be no literature regarding the impact of izzat on mental health in Nepal or for NLU, the term is frequently referred to in the Nepalese literature (e.g. McHugh, 1998; Poudel, 2011) and is a commonly understood term. Within Nepalese culture, there appears to be significant stigma towards mental health difficulties, with fear and shame that ‘mental illness’ may impact on status within a community, marriage prospects and bring shame and dishonour upon the family (Jha, Kitchener, Pradhan, Shyangwa, & Nakarmi, 2012). A significant number of individuals identified as ‘mentally ill’ are thought to experience discrimination and marginalisation and in some cases physical violence (Kohrt & Harper, 2008).

Using the framework of the TPB, the concept of izzat may be seen to closely link to the concept of subjective norms, that is, the individual’s perceived beliefs about the views of others in relation to mental health which will impact on the intention towards help seeking for mental health difficulties. Given the research documenting the impact which mental illness may have on a Nepalese individual’s family, including educationally, socially, economic marginalisation and difficulties in getting married due to views about the ‘contagiousness of madness’ (Kohrt & Harper, 2008; Raja et al., 2012), it would seem to follow that within NLU populations, izzat (or subjective norms) are likely to be a significant predictor of intention to access mental health services.

1.6.3 Acculturation

Acculturation is thought of as a multidimensional construct which describes the extent to which the dominant culture impacts upon the behaviours, attitudes, and values of an individual from an ethnic minority group and the degree to which the individual or group adapts to this culture (Berry, Trimble, & Olmedo, 1986). Instruments used to measure acculturation tend to focus on factors such as identity, food preferences, use of media, friendships and language use (Cabassa, 2003).

Hwang et al. (2008), suggest that 'acculturative stress', that is stress resulting from the process of adapting to a new environment, such as experience of discrimination, intergenerational conflict, language barriers and pressures to conform to dominant culture norms, increases the risk of developing mental health difficulties. Studies have variously shown that particularly for populations of recent immigrants, these types of 'adaptational stressors' may have a significant impact on mental health (Hovey, 2000; Mui & Kang, 2006; Oh, Koeske, & Sales, 2002; Schrier, van de Wetering, Mulder, & Selten, 2001, see Bhugra, 2001 for review). However, there are individual differences in response to and experience of these stressors and the acculturative process as a whole. Williams and Berry (1991) suggest that factors such as educational status, local support networks and ethnically diverse neighbourhoods and linguistic ability mediate the impact of these stressors.

South Asian groups represent the largest ethnic minority group in the UK. However, there is a huge amount of disparity in the level of acculturation within these groups (Palmer et al., 2007). A number of studies have documented the relationship between acculturation and help-seeking preferences in South Asian populations. For example, in a study of Asian Australian students, South Asian individuals with higher levels of acculturation were found to indicate significantly greater willingness to access professional psychological help than those who indicated lower levels of acculturation (Hamid, Simmonds, & Bowles, 2009). However, limiting the sample only to students significantly impacts on the generalisability of these findings. In the UK, studies have found mixed results. For example, in a study of the factors relating to mental health in British South Asians, Furnham and Sheikh (1993) found that acculturation did not appear to be significantly related to mental health difficulties. However, in line with a multidimensional view of the acculturative process (Williams & Berry, 1991) it is likely that the relationships between these variables are complex. For example, for an immigrant, having parents living in the UK could be linked with possible increased social support

but also could potentially increase intergenerational stress as a result of conflicting or different cultural values or behaviours.

The relationship between acculturation and mental health also appears to be linked to beliefs about the causes of mental health difficulties (i.e. explanatory models). For example Furnham and Malik (1994) examined the beliefs of South Asian women in the UK about depression. They found that the beliefs of older South Asian women were not only significantly different to native British people but also to younger South Asian women (whose views were more similar to those of native British people). The authors concluded that while causal explanations and reporting of depression did appear to be culturally determined, acculturation played a significant role in differences within South Asian populations, which may thereby influence help-seeking preferences.

Within the TPB framework, the impact of acculturation on service utilisation could be viewed as being linked to both the attitudinal and perceived behavioural control variables. Acculturation is likely to be linked to attitudes towards help-seeking in the sense that it will be linked to the alignment with cultural attitudes about the treatment of mental health difficulties. For example, a less acculturated individual is likely to have attitudes aligned with more traditional methods of treatment (e.g. faith healers) and may therefore have less positive attitudes towards seeking help from Western mental health services. Acculturation may be seen as linking to the perceived behavioural control element of the TPB in the sense that it is linked to factors such as language ability, knowledge of existing services and integration into the dominant community, which may influence an individual's perceived ability to access services if they wished to do so (Ajzen, 1985).

1.7 Conclusions and future research

Individuals of Nepalese origin who live in the UK, along with many other ethnic minority groups are significantly less likely to seek professional help for mental health difficulties than the general population. However, it is unclear whether this is due to not accessing services when mental health difficulties arise, whether this population experiences lower prevalence of mental health difficulties, or whether some other factors influence the low service-access rates of this population. Despite the large numbers of Nepalese individuals who have immigrated to the UK, there is a stark paucity of health care utilisation data and research related to the mental health and help-seeking preferences of this group. This makes it difficult to gauge the extent and form of mental health need in this population and to begin to implement culturally

appropriate service provision by addressing the unique cultural issues of this group.

A number of factors have been found to impact upon the likelihood of South Asian populations and native Nepalese individuals accessing support for mental health difficulties. For example, the prevalence of traditional methods of support for mental health difficulties and widespread physical causal explanations for mental distress may affect the types of support which may be sought if an individual experiences such distress. Furthermore, for immigrants from ethnic minorities, levels of acculturation have been linked both to the risk of developing mental health difficulties (related to the level of acculturative stress experiences) and the perceived ability and intention of individuals to access mental health services should mental health difficulties arise. It would seem pertinent to explore these and other potentially relevant factors to begin to develop an understanding of the service needs of this group.

The TPB is a widely used model which offers a framework upon which to measure the extent to which the factors discussed above, influence and predict intention to access help for mental health difficulties and in turn predict actual behaviour. This information could then be used to begin to build an understanding of the help-seeking behaviours of NLU.

1.8 Aims of this study

There is a stark paucity of research into the factors which influence help-seeking in Nepalese populations. To the author's knowledge, there are currently no published studies specifically relating to the factors which contribute to or predict the intention of NLU to seek professional help for mental health difficulties. There is also very little data as to the actual service-access figures for this group in the UK and no research exploring the relationship between the intention to access service and actual attempts to do so.

This study will attempt to address this gap in the research by using a modified version of the TPB (Ajzen, 1985) as a guiding framework to identify the factors which are most strongly related to intention to seek help for mental health difficulties for NLU. The study will also seek to understand how these intentions relate to actual levels of psychological distress.

As discussed, one method of studying help-seeking behaviour is to measure intention to carry out this behaviour, as studies have demonstrated that intention to seek services for mental health difficulties significantly predicts a decision to seek such support should mental health difficulties arise

(Ajzen, 1988; Leong et al., 1995). If the NLU who participate are willing to provide information about their experiences of help-seeking, this study will also explore which factors predict actual help-seeking behaviour.

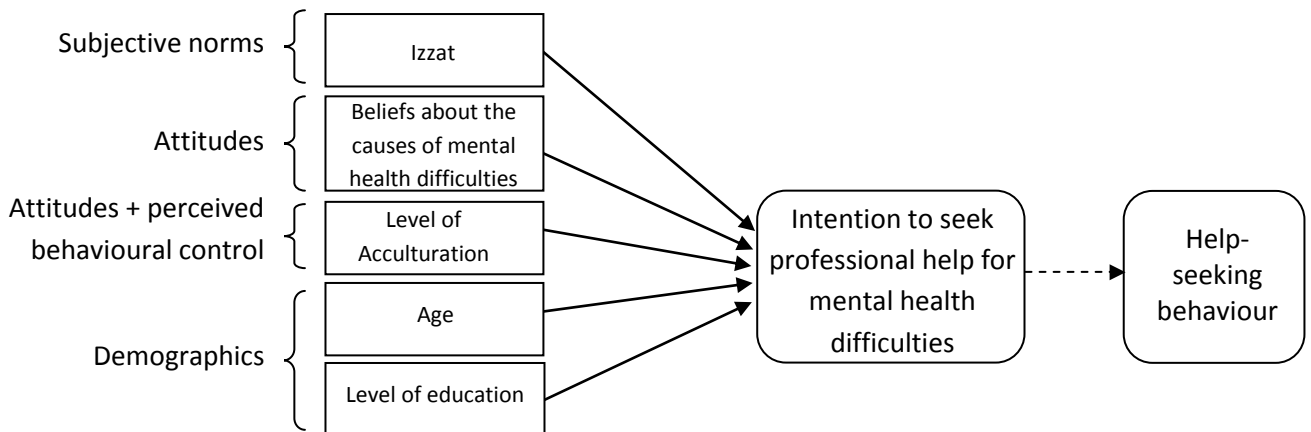
It is hoped that gaining an understanding of the relationships between these variables will be useful in helping mental health services and clinicians to develop the most appropriate care for this population.

1.8.1 Research aims

This study aims:

- To examine how factors relating to attitudes, perceived behavioural control and subjective norms influence intention to seek help in the event of experiencing mental health difficulties (see figure 2 below). The factors to be examined will be:
 - Beliefs about the causes of mental health difficulties - which are thought to be related to attitudes towards the type of help which is required to be sought.
 - Levels of izzat (influence of community and close others i.e. family/friends) - which closely links to the 'subjective norms' element of the TPB.
 - Acculturation - which relates both to the attitudes and perceived behavioural control elements of the TPB.
- To establish how many participants have attempted to access mental health services, and where services have been sought, to explore participants' views about these services.
- To establish, using a modified version of the TPB as a theoretical framework, which of the above factors are the strongest predictors of intention to seek help.
- To establish whether, in line with the TPB, actual help-seeking is predicted by intention to seek help.

Figure 2. A TPB based initial model of the potential predictors of intention to seek professional help for mental health difficulties.



1.8.2 Research Hypotheses

On the basis of these research aims the following hypotheses will be made using the framework of the TPB, which suggests that attitudes, subjective norms and perceived behavioural control can be measured to predict intention to seek professional mental health support:

- 1. The following variables will be positively associated with greater intention to access mental health services:
 - a. Greater acculturation – it is anticipated that more acculturated individuals will have greater perceived behavioural control because they have increased dominant language skills, are more integrated with Western society and will therefore attitudes more in line with Western beliefs about seeking support for mental health difficulties.
 - b. Western physiological and stress-related causal explanations of mental health difficulties – it is hypothesised that individuals with these types of beliefs about the causes of mental health difficulties are likely to have attitudes more aligned with values of the dominant culture about seeking Westernised support for mental health difficulties.
 - c. Level of education – a demographic variable which has been shown in the literature with South Asian populations to be positively related to intention to seek help for mental health difficulties (Pilkington et al., 2011).
- 2. The following variables will be inversely associated with intention to access mental health services:
 - a. Non-Western physiological and supernatural causal explanations of mental health difficulties – it is hypothesised that individuals with these types of beliefs about causal explanations are likely to have attitudes

less aligned with values of the dominant culture about seeking Westernised support for mental health difficulties.

- b. Izzat i.e. higher levels of negatively oriented social influences towards help-seeking will be inversely associated with intention – given the concept of izzat is closely linked to the TPB concept of subjective norms which has been shown in the literature to influence intention to seek help for mental health difficulties. Therefore it is hypothesised that high levels of shame and izzat related to help-seeking will be inversely related to intention to seek help.
- c. Age - a demographic variable which has been shown in the literature to be inversely related to intention to seek help for mental health difficulties (Mackenzie et al., 2006).

3. In line with the TPB it is expected that any reported attempts to access mental health services will be predicted by intention to seek help for mental health difficulties which is itself predicted by the many study variables, izzat, causal beliefs, acculturation, age and education.

4. Of those individuals reporting having suffered from mental health difficulties a low proportion will have accessed mental health services.

2. Method

2.1 Design

This study employed a non-experimental research design which involved the use of a cross-sectional questionnaire survey consisting of a number of pre-existing and purpose designed measures. The research questions which inform the structure of a questionnaire for this type of study mean that the data collected is limited to existing concepts in the research literature.

Much of the literature which exists in the field of mental health amongst Nepalese communities focuses on the stigma and shame associated with mental health difficulties and mental health service access (Jha et al., 2012; Regmi et al., 2004). Research has shown that individuals are more likely to disclose experiences which may be viewed as stigmatised in self-report questionnaires than in face-to-face interviews e.g. intimate partner violence (Kataoka, Yaju, Eto, & Horiuchi, 2010) or HIV status (Siegel, Krauss, & Karus, 1994). The researcher acknowledged the potential difficulties which might arise in asking Nepalese individuals to speak openly about mental health difficulties in a face-to-face interview, both in terms of fear of stigmatisation and fears about a lack of confidentiality. A self-report questionnaire design which ensured anonymity of respondents was therefore favoured in order to facilitate disclosure by potential participants.

In addition, the use of attitudinal measures was considered an appropriate method of data collection for this study, due to the aptitude of these measures to collect scaled data pertaining to an individual's beliefs or attitudes about the target research questions. Attitudinal surveys have been widely used in research relating to attitudes towards mental health difficulties and help-seeking across a variety of populations (e.g. Al-Krenawi, Graham, Dean, & Eltaiba, 2004; Hall & Tucker, 1985; James & Buttle, 2008; Kovandžić et al., 2011; Mackenzie, Gekoski, & Knox, 2006; Mo & Mak, 2009; Sheikh & Furnham, 2000). Furthermore, a number of attitudinal surveys relating to beliefs about and attitudes towards mental illness have been used in South Asian and migrant South Asian populations (Fung & Wong, 2007; Pilkington et al., 2011). However, to the author's knowledge there are no existing studies examining these beliefs and attitudes within the UK Nepalese population.

A questionnaire design was therefore selected because it allowed for the maximum number of data to be collected within the timeframe available, was less likely to be influenced by investigator-bias and allowed the researcher to access participants more widely, hopefully collecting a more representative sample.

2.1.1 Questionnaire design

A number of purpose-designed and pre-existing validated measures were selected and compiled into a single fourteen page questionnaire.

2.1.2 Questionnaire translation and back-translation

In order to ensure that the study did not exclude individuals who were not able to read and write in English, participants were given the option to complete the questionnaire in Nepal's most commonly spoken language, Nepalese. The translation and back-translation of this questionnaire into Nepalese was carried out by a research group at the BP Koirala Institute of Health Sciences, Nepal, consisting of a Clinical Psychologist, English and Nepalese Teachers, a methodology expert and a statistician, using a protocol developed by Gjersing, Caplehorn, and Clausen, (2010).

2.1.3 Questionnaire Pilot

The questionnaire was given to three Nepalese people (two living in the UK and one in Nepal via email/Skype) in order to pilot it. The feedback from these individuals mainly included queries about the way particular items were worded. All three individuals who piloted the questionnaire reported that they felt it was lengthy, but were able to complete the full questionnaire in twenty minutes.

In light of the feedback provided by the individuals who piloted the questionnaire, amendments were made to items where possible, these changes are referenced in the relevant sections on each measure used. In order to ensure that the reliability of validated measures was not compromised, suggested changes to items within pre-existing measures were not made. In two of the expert interviews, comments were made about the complex language used in the information sheet and consent form. The researcher therefore attempted to simplify the language used in both with the assistance of the expert interviewees.

Expert interviews were conducted with these individuals to ensure that the information sheet, debrief sheet and consent forms were understandable. Sources of confusion or misunderstanding or areas of contention were addressed. Useful feedback was given by these individuals about ways of approaching this potentially very stigmatised topic with the target population and changes were made to the wording accordingly.

2.2 Procedure

2.2.1 Participants

A non-clinical population of Nepalese people living in the UK was accessed. Participant inclusion criteria specified that in order to participate they must be over the age of 18, currently living in the UK and identify themselves as Nepalese. The cross-sectional convenience sample included participants from across the UK recruited via a number of methods including community and online organisations (see section 2.2.2.). The sample was 71% male, with a mean age of 46.36 and included participants from a range of socio-economic and educational backgrounds. A full description of the sample is presented in Table 1 below.

2.2.2 Recruitment

Questionnaires were completed either online or via a paper questionnaire pack. Each pack included an information sheet (Appendix 2) which explained the purpose of the study and what involvement would entail, a consent form (Appendix 3), a questionnaire (Appendix 4a - g) and a debrief sheet (Appendix 5) which provided some further information about the study and potential sources of support. Participants were recruited by the researcher through a number of sources:

- a) Social networking sites – the study was advertised via social networking sites and online groups for Nepalese communities. This advert provided a small synopsis of the study and a link to an online version of the questionnaire. Due to the technical limitations of the online survey platform, this was only available in English. Readers were advised that they could contact the researcher to obtain a paper copy of the Nepalese version of the questionnaire. It is not possible to ascertain how many people viewed the adverts or accessed the link to this study.
- b) Health events for Nepalese individuals – the researcher made contact with an organisation which runs regular health events for Nepalese individuals (e.g. education about Diabetes, blood tests etc.). This organisation agreed to help with recruitment by allowing the researcher to attend three health events each with up to 50 Nepalese in attendance. Volunteer translators and the researcher approached individuals in the waiting room of these events and a brief explanation of the study was given. These individuals were informed that participation in the study was voluntary and that their data could be removed at any time without needing to give a reason. They were given some time to consider whether they wished to participate and those who wished to do so were asked to read the information sheet carefully, before deciding whether to give consent to participate. Individuals who agreed to participate either completed and returned the questionnaire in the waiting rooms or were provided with a pack including an information sheet, consent form,

questionnaire, debrief sheet and stamped address envelope to return the completed questionnaire. Approximately 30 paper questionnaires were given out to people at these events.

- c) An organisation for ex-Gurkhas and their families – the research made contact with a Gurkha organisation in Berkshire which helped to promote and ask members to complete the survey. A link to the online questionnaire was provided and 40 paper questionnaire packs were given to the head of this organisation to distribute.
- d) Nepalese organisations listed on the Nepalese Embassy website – The UK Nepalese Embassy website lists a number of Nepalese organisations operating in the UK. Each of these organisations was contacted either via email or telephone to inform them of the study and ask whether they would be willing to help with recruitment by emailing the organisation's members with a link to the online questionnaire. Organisations were also offered paper copies of the questionnaire, with stamped-addressed envelopes in both English and Nepalese languages. It is not possible to ascertain how many of these organisations emailed their members.
- e) Snowballing – individuals who had completed the survey in person with the researcher and a number of personal contacts known to the researcher were approached to ask them for help with recruitment. This included requesting them to approach their own contacts about taking part in the study. Approximately 50 questionnaire packs were provided to these individuals and emails detailing the online questionnaire link were sent to 35 individuals.

2.3 Questionnaire Measures

The questionnaire comprised seven measures (Appendices 3a – g) which aimed to collect demographic data, data related to the constructs under investigation and information about experience of mental health difficulties and help-seeking. The various sections and reasons behind the selection of particular items and measures are described below:

2.3.1 Demographics

There is a wealth of literature demonstrating the interaction of various demographic variables on psychological help-seeking behaviours such as age, gender and level of education. For example, many studies have suggested that women in many cultures are more likely to have positive attitudes towards accessing psychological services (e.g. Ang, Lim, Tan, & Yau, 2004; Fischer & Farina, 1995). The first section of the questionnaire (Appendix 4a) therefore asked participants to provide personal background information such as their age, gender, length of time spent living in the UK, religious affiliation, level of education, marital status and occupation.

2.3.2 Measure of intention to seek professional help for mental health difficulties.

The mental health help-seeking intentions of individuals have been widely researched across many settings and cross-culturally. The intentions of individuals towards professional help-seeking was measured using the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS: Mackenzie, Knox, Gekoksi, & Macaulay, 2004), Appendix 4b). The IASMHS measure consists of 24 items rated on a five-point Likert scale with response options ranging from 0, “disagree” to, 4 “agree”. Items are combined to provide a score indicative of an individual’s intention to seek psychological help in the event of experiencing mental health difficulties, with higher scores indicating greater willingness to seek professional help. Furthermore, items can be combined into three scales indicating help-seeking propensity, psychological openness and indifference to stigma respectively.

The IASMHS was originally developed as an adaptation of the Attitudes Towards Seeking Professional Psychological Help questionnaire (ATSPPHS: Fischer & Turner, 1970), a 29-item measure which consisted of four subscales relating to attitudes towards help seeking, “interpersonal openness”, “stigma tolerance”, “recognition of the need for psychotherapeutic help” and “confidence in a mental health practitioner”. The ATSPPHS has been widely used in research relating to attitudes towards seeking psychological help for mental health difficulties (e.g. Al-Krenawi et al., 2004; Fung & Wong, 2007; Hall & Tucker, 1985; Sheikh & Furnham, 2000). However, it was criticised for both methodological and conceptual failings including firstly the use of old-fashioned language and secondly detailing a limited range of health care professionals (namely psychologists and psychiatrists) to denote professionals who provide psychological services, rather than recognising the full range of mental health professionals e.g. social workers, occupational therapists, nurses etc. (Mackenzie, Knox, Gekoksi, et al., 2004).

For this study, the use of the ATSPPHS was felt to be limited. Mackenzie et al. (2004) suggest that the centroid factor extraction methodology used to develop the four subscales has been shown to be less accurate than the more recently developed exploratory factor analysis used in the development of the IASMHS and indeed Fischer and Turner (1970) recognise the poor to moderate subscale reliability. The development of the IASMHS as an adaptation of the ATSPPHS attempts to account for these limitations in order to include items relating to the Theory of Planned Behaviour (TPB) model. The language is also amended e.g. the terms ‘psychiatrist’ and ‘psychologist’ are substituted with ‘professional’ with a short paragraph informing the respondent of the various professional disciplines that this is referring to (Mackenzie et al., 2004).

Furthermore, the rating scale was increased from a 4-point to a 5-point scale in order to minimise the susceptibility to type-II errors (Rasmussen, 1989).

Since the development of the IASMHS, the scale has been widely used in attitudinal research related to psychological help-seeking (e.g. McClure, 2010; Munson, Floersch, & Townsend, 2009) and has been used in various studies of immigrant Asian population samples (e.g. David, 2010; Pilkington et al., 2011). Mackenzie et al. (2004) using Cronbach's alpha analyses reported that the overall scale and three subscales demonstrate strong internal consistencies, help-seeking propensity (.76) psychological openness (.82), indifference to stigma (.79) and overall (.87). In this study, Cronbach's alpha analyses revealed acceptable internal consistencies: help-seeking propensity (.72), psychological openness (.74), indifference to stigma (.64) and overall (.71).

2.3.3 Measure of Izzat (shame)

The Attitudes Towards Mental Health Scale (ATMHP: Gilbert et al., 2007, Appendix 4c) was used to measure the construct of izzat or shame related to mental health difficulties. The Attitudes Towards Mental Health Scale is a 35-item self-report measure which is rated on a 4-point Likert scale from 0, 'do not agree at all' to 3 'completely agree'. To the researcher's knowledge, it is the only existing measure which examines the construct of izzat (Gilbert et al., 2007).

The ATMHP was developed to examine the various aspects of izzat, or shame in relation to mental health difficulties (Gilbert et al., 2007) and is divided into three subscales, internal shame, external shame and reflected shame. In each subscale, the respondent is asked to imagine "how you might feel about yourself if you suffered from mental health problems". Internal shame refers to negative self-directed attention and self-evaluations. This includes items such as "I would see myself as inadequate" and "I would see myself as a failure". External shame is related to the attentional focus on what others may be evaluating about the self and may be associated with behaviours such as social withdrawal or lowered posture in response to the perception of others thinking negatively about the self (Gilbert et al., 2007). Items in this subscale include "I think my family would see me as inferior" and "I think my community would see me as weak". Finally, the reflected shame subscale, which relates directly to the concept of izzat, refers to the perceived shame which may be brought to others by the self, e.g. feeling ashamed for bringing shame to one's family. Items in this subscale include "My family would be seen as inadequate", and "I would worry that my mental health problems could damage my family's reputation".

Higher scores on the overall scale and subscales indicate higher levels of shame and izzat in relation to mental health difficulties. The overall scale scores can range between 0 and 105. For this study, the measure was chosen not only because of its focus on a construct thought to influence intention to seek psychological help in this population, but also because it has been normed using a South Asian migrant sample (Gilbert et al., 2007). The subscales were demonstrated in a study by Gilbert et al. (2007) to have good internal consistency (Cronbach's alpha between .85 and .97), with similar values reported by Pilkington et al. (2011) of between .90 and .96. In this study, Cronbach's alpha analyses revealed good to excellent internal consistencies; between .78 and .97. A Cronbach's alpha analysis of the overall scale score indicated a very strong reliability (.97)

2.3.4 Measure of current level of psychological distress

In order to measure the impact of current levels of psychological distress on intention to seek professional help, the General Health Questionnaire-12 (GHQ-12: Goldberg, 1972) was used. The GHQ-12 consists of 12 self-report items which are rated on a four-point Likert scale. The measure has been widely used as a psychometric tool for screening 'mental health disorders' and providing an indication of the severity of symptoms of 'disorders' such as anxiety and depression (e.g. Goldberg & Williams, 1988; Weich, Holt, Twigg, Lewis, & Jones, 2003; Weich & Lewis, 1998). Furthermore, its reliability and validity has been widely demonstrated and it has been translated into over 35 languages (Jackson, 2007).

A translated version of the GHQ-12 has been validated for Nepalese populations (Koirala, Regmi, Sharma, Khalid, & Nepal, 1999). The translated version was used in the copy of the questionnaire pack given to individuals in the Nepalese language. There are two scoring methods for the GHQ-12. The original method, scoring 0-0-1-1 is used to determine whether an individual meets clinical threshold. The alternative method of scoring using a Likert scale, scored 0-1-2-3 is used to assess the severity of symptoms of common mental health difficulties (Lloyd, Pouwer, & Hermanns, 2012). In this study, the original scoring method with a recommended clinical threshold score of three was used as in a Nepalese validation study by Koirala et al. (1999). A Cronbach's alpha analysis revealed good internal consistency of this measure (.80), similar to the figure identified in a study of the validity of the GHQ in another South Asian population (.87; Bhui, Bhugra, & Goldberg, 2000).

2.3.5 Measure of acculturation

The Self-administered Questionnaire of Acculturation (SAQA: Palmer et al., 2007, Appendix 4e) was used to measure acculturation. The measure was

designed for and validated with immigrant South Asian populations in the UK and considers acculturation as a multidimensional construct (Palmer et al., 2007). The SAQA consists of 17 items, which are split into three subscales: behaviours suggesting greater acculturation to the host community (e.g., use of the English language), attitudes indicative of greater or lesser acculturation (e.g., feelings of acceptance or fear of racism) and behaviours associated with society of origin (e.g., use of Asian media and clothing). Palmer et al. (2007) report good reliability coefficients (Cronbach's alpha) between the three subscales as being between .72 and .93, whilst (Pilkington et al., 2011) report more modest reliability coefficients between .60 and .66. In this study, Cronbach's alpha analyses revealed modest to quite poor internal consistencies: behaviours suggesting greater acculturation to the host community (.63), attitudes indicative of greater or lesser acculturation (.60) and behaviours associated with society of origin (.50). During the initial expert interviews and pilot of the questionnaire, interviewees were asked to list the most widely used languages in Nepal (or by Nepalese people living in the UK; NLU) and those suggested most commonly i.e. Nepalese, Hindi, Urdu, Gurung, were included in items 1 and 2. At the suggestion of the expert interviewees, the inclusion of 'Nepalese/Hindi' was included in items in which the original questionnaire used the term 'South Asian' (i.e. items 13-15). For example "In what language are the newspapers you regularly read? a) Don't read newspapers, b) South Asian languages only, etc.", "Nepalese/Hindi" was added, in recognition that much of the popular TV or music used by Nepalese individuals is in Hindi.

Unsuccessful attempts were made to contact the authors with regards to the scoring of the questionnaire as the suggested scoring did not indicate face validity. For example, for the item asking about the languages of TV programmes normally watched, an answer indicating that either 'mainly' or 'only' South Asian or Nepalese TV programmes were viewed, were included in the 'behaviours suggesting greater acculturation' subscale. In order to improve the construct validity of the three subscales the original scoring was used where appropriate. Two trainee clinical psychologists and a clinical psychologist grouped the other items according to face validity, into the three subscales recommended by the authors of the measure (1. behaviours suggesting greater acculturation, 2. attitudes indicating greater acculturation and 3. behaviours associated with country of origin). A decision was made to retain the distinct subscales rather than to amalgamate the subscales into a single score in order to measure the different facets of acculturation. Four items which over 95% of participants had positively endorsed were not included in the analysis due to their lack of discriminative power. These items

were those related to understanding, speaking, reading and writing a non-English language.

2.3.6 Measure of causal beliefs

In order to measure explanatory beliefs about the causes of 'mental distress', the Mental Distress Explanatory Model Questionnaire (MDEMQ; Eisenbruch, 1990, Appendix 4f) was used. The MDEMQ is a 45-item measure in which respondents rate on a 5-point Likert scale the likelihood of "mental distress" being caused by a variety of factors from 0, "not at all likely" to 4 "highly likely". In the explanatory paragraph included on the measure, Eisenbruch's use of the term 'mental distress' is explained as referring to experiences such as "mild or severe distress", being "sad or anxious", "strange beliefs" and being "destructive towards the self or others". This term has been used as synonymous with the concept of 'mental health difficulties' in a number of studies (e.g. Fung & Wong, 2007; Hamid & Furnham, 2013; Mathews, 2011; Rose, 2010; Sheikh & Furnham, 2000) and was therefore considered to be measuring a construct similar to that being examined in this study.

Eisenbruch (1990) designed the measure to be analysed in four 'causal categories': "Western physiological" (e.g. "Genetic or inherited defect", "Physical illness"), "non-Western physiological" (e.g. "eating food that is wrong for the person" or "Body out of balance or harmony"), "stress" (e.g. "conflict with family or friends", or "bad experiences during childhood") and "supernatural" (e.g. "Person's soul leaving the body temporarily or becoming scattered").

The MDEMQ was primarily designed for use with individuals from Western backgrounds and has not been specifically validated with the target population of this study. However, it has been used in previous research to examine causal beliefs about mental distress in British Asians (Sheikh & Furnham, 2000) and has been shown to predict attitudes towards seeking professional help in East and South East Asian women (Fung & Wong, 2007). The internal reliability according to the Cronbach's alpha analysis for the four categories was demonstrated with British Asians and Pakistani participants to be acceptable, between .71 and .95 (Sheikh & Furnham, 2000). In this study, Cronbach's alpha analyses revealed good to excellent internal consistencies: non-Western physiological causes (.78), Western physiological causes (.87); Stress-related causes (.92) and supernatural causes (.90).

Eisenbruch's (1990) original paper lists the possible causes of mental distress included in the MDEMQ, but does not present them as items in a questionnaire format. Following unsuccessful attempts to contact the author

of the measure, or other researchers who had used the original measure in published studies, a modified version developed by Rose (2010) was used. This version was a modified version of the MDEMQ used by Fung and Wong which groups the items in the four causal categories i.e. all items relating to 'Western physiological causes' followed by all items relating to 'non-Western physiological causes'. This was modified to ensure random distribution of the questionnaire items to reduce the likelihood of a response set caused by answering similarly to all items in a particular category (Rose, 2010).

2.3.7 Measure of experiences of accessing support for mental health difficulties

The Experiences of Help-Seeking Questionnaire (EHSQ, Appendix 4g) was designed to collect information about participants' personal experiences of mental health difficulties and help-seeking was optional. This questionnaire was based on the Intentions to Seek Help scale (ISH: Rose 2010) and modified in light of data collected from expert interviews. It was anticipated that the number of respondents who will self-identify as having mental health difficulties was likely to be low. Therefore, the completion of the section of the questionnaire asking respondents to give an account of their personal experiences of mental health difficulties and help-seeking was optional. The questionnaire consists of 12 questions which the respondents could answer in relation to either their own experiences or the experiences of a person known to them.

The questionnaire aimed to give respondents the opportunity to provide information about any experiences of actual help-seeking, whether professional or otherwise and reasons for this. To the researcher's knowledge, no existing studies have examined the attitudes or experiences of NLU towards help-seeking or the reasons for not accessing services. This questionnaire was therefore aimed to provide additional data of the possible reasons for the low help-accessing rates amongst this population.

2.4 Intended data analysis

This study aimed to examine factors which predict intention to seek help for mental health difficulties in NLU and if participants reported details of actual help-seeking, to examine which factors predicted this behaviour. The TPB was used as a guiding framework to conduct the data analysis. Seventeen of the questionnaires completed by paper had missing items and data replacement was performed as described in Appendix 6. The online survey included a forced-response function which meant that no data was missing for the online questionnaires.

Analysis of potential method-effects was conducted to examine whether significant differences occurred in the responses of those who had completed questionnaires online as opposed to completing a paper copy of the questionnaire. This allowed for examination of any differences in the main study variables, dependent on the recruitment method used.

Analyses of distribution and collinearity were then conducted to ensure that the assumptions for the use of a linear regression model were met. Bivariate analyses of the variables hypothesised to be associated with intention to access mental health services were then carried out. Next an analysis to identify reliable predictors of intention to access mental health services was conducted. This method of analysis often used to examine relationships between components of the TPB model and additional variables is a multiple regression analysis (MRA; Langdrige, Sheeran, & Connolly, 2007). And in this analysis, variables which were significantly correlated with intention were entered into the MRA.

In existing research involving similar predictors (see Pilkington et al., 2011; Rose, 2010) multiple-prediction models accounted for around 20% of the variance. Based on these studies, the eight predictors were expected to account for 20% of the variance in intention.

An a-priori sample size calculation was made in order to assess the minimum sample size required to perform these intended statistical analyses (see Appendix 9 for full calculation). This calculation was based on a multiple linear regression with the anticipated effect size for predicting health seeking behaviour, and assuming adjustment. The number of predictors (eight), an acceptable alpha level (.05), desired statistical power (.80) and an anticipated effect size (.25) were used. The anticipated effect size was taken from a similar TPB study of the predictors of intention to seek help for mental health difficulties in an ethnic minority population (Rose, 2010). The calculated minimum sample size required was 69.

2.5 Ethical considerations

A number of potential ethical issues were considered in the design of this study. Firstly, the impact of answering potentially upsetting questions through the process of completing the questionnaire was considered. In order to ensure participants' welfare, an information sheet detailing the nature of the study and what involvement would entail was given to each potential participant. Participation was entirely voluntary, with the option of withdrawing from the study during completion of the questionnaire, or withdrawing their data at any time. This was designed to ensure that participants were not pressured to complete the questionnaire. Participants

were required to sign a consent form acknowledging these issues and agreeing to participate.

Upon completion of the questionnaire, participants were given a debrief sheet which provided more information about the study. Furthermore, potential sources of support were provided, should participants feel that they had been emotionally impacted through the completion of the study.

No specific identifiable data was collected which ensured participant confidentiality and anonymity. In order to identify individual participant data should an individual wish to withdraw their data, a unique code was created by each participant using the first three letters of their first name and the first three letters of the town in which they were born. For example, an individual named Prakash, born in Kathmandu would enter the code PRAKAT. Acknowledging the possibility that individual codes could conceivably be decipherable, all the data collected was securely stored on a password-protected computer and accessed only by the researchers.

With consideration to data collected via the online questionnaire, right to withdraw, not provide identifiable information and to give informed consent were all carried out in line with what was expected of participants who completed paper copies of the survey. In acknowledgement that often online participants may give consent without actually reading the relevant information (British Psychological Society, 2007), participants were able to leave the questionnaire website at any point, should they discover that they wished to cease participation. They were also provided with the researchers' contact details should they wish to remove their data or be provided with additional information.

The sample recruited were a non-clinical population and therefore ethical approval was sought and obtained from the University of Hertfordshire, Health and Human Sciences EDCA. Copies of the ethics application and approval certificate can be found in Appendices 7 and 8.

3. Results

This section begins with a descriptive analysis of the demographics characteristics of the study participants. Following this, score distributions for the main study variables: intention to seek help, acculturation, izzat, and causal beliefs are described.

Results are then reported in relation to the research hypotheses. Firstly the hypothesised associations between the main study variables with intention to seek help are reported. An analysis of predictors of intention to seek help using the Theory of Planned Behaviour (TPB) as a framework is then reported. Next analysis of the relationship between experience of mental health difficulties and actual help seeking is reported. Finally, other results of interest relating to the help-seeking experiences are described. Data collected using the survey questionnaire was collected and scored according to the procedures described in Appendix 6.

3.1 A description of the sample.

The demographic characteristics of the study participants are detailed in Table 1.

Table 1. Demographic features of the sample

		Online sample	Community Sample	Total
Total number of participants (n, %)		25(38)	40 (62)	65 (100)
Gender	Male	14 (56)	32 (80)	46 (71)
	Female	11 (44)	8 (20)	19 (29)
Language of completion (n %)	Nepalese	0	27 (68)	27 (42)
	English	25 (100)	13 (33)	38 (58)
Age (years)	Mean (SD)	38.04 (11.39)	52.67 (18.38)	46.36(17.25)
Age category (years)	n (%)	25 (100)	33 (100)	58 (100)
	18-30	9 (36)	6 (18)	15 (26)
	31-50	12 (48)	7 (21)	19 (33)
	51-70	4 (16)	13 (39)	17 (29)
	71+	0 (0)	7 (18)	7 (12)
SE ^a classification	n (%)	25 (100)	36 (100)	61 (100)
	Managerial and Professional	8 (32)	1 (3)	9 (14)
	Intermediate	6 (24)	10 (28)	16 (25)
	Small and own account workers	0 (0)	5 (14)	5 (8)
	Lower supervisory and technical	1 (4)	2 (6)	3 (5)
	Semi-routine and routine	5 (20)	3 (8)	8 (12)
	Not classified ^b	5 (20)	15 (42)	20 (31)
Highest educational qualification	n (%)	25 (100)	39 (100)	64 (100)
	PHD ^c	2 (8)	1 (3)	3 (5)
	Masters ^c	8 (32)	3 (8)	11 (17)
	Undergraduate ^c	5 (20)	10 (26)	15 (23)
	A Level ^c	6 (24)	4 (10)	10 (15)
	GCSE ^c	3 (12)	8 (21)	11 (17)
	None	0 (0)	13 (33)	13 (20)
	Other	1 (4)	0 (0)	1 (2)
Location in the UK	n (%)	25 (100)	40 (100)	65 (100)
	Berkshire	6 (24)	25 (63)	31 (48)
	London/Greater London	7 (28)	7 (18)	14 (22)
	Kent	2 (8)	2 (5)	4 (4)
	Other (UK)	7 (28)	2 (5)	9 (14)
	Nepalese town specified	3 (12)	4 (10)	7 (11)
County of origin	n (%)	25 (100)	40 (100)	65 (100)
	Nepal	25 (100)	38 (95)	63 (97)
	UK	0 (0)	2 (5)	2 (3)
Number of years in UK	n (%)	25 (100)	40 (100)	65 (100)
	Less than 1 year	1 (4)	2 (5)	3 (5)
	1-4 years	9 (36)	21(53)	30 (46)
	5-10 years	10 (40)	9 (23)	19 (29)
	Over 10 years	5 (20)	8 (20)	13 (20)
Religious affiliation	n (%)	25 (100)	40 (100)	64 (100)
	Hindu	12 (48)	11 (28)	23 (36)
	Buddhist	6 (24)	12 (30)	18 (28)
	Christian	1 (4)	6 (15)	7 (11)
	Kirat	1 (4)	6 (15)	7 (11)
	No Religion	2 (8)	4 (10)	6 (9)
	Buddhist/Hindu	3 (12)	0 (0)	3 (5)
	Muslim	0 (0)	1 (0)	1 (2)

^a Socio-economic classification

^b Not classified includes student, unemployed, or inadequately described occupation. ^c Or equivalent qualification

Participants in this study were over 18 and identified themselves as Nepalese. In total a non-clinical population of 65 Nepalese people living in the UK (NLU) was recruited. Participants ranged from age 20 to 74 (although seven people did not specify their age). The mean age was 46.36 ($SD = 17.25$).

Of the final sample, 25 (38%) individuals completed the questionnaire online and 40 (61%) completed a paper questionnaire (either in person, or by post; henceforth referred to as the community sample). All online questionnaires (i.e. 100%) were completed in English (due to methodological restrictions) and of the community sample, 27 (67%) questionnaires were completed in the Nepalese language version (41% of the total). According to an independent samples t-test, online participants were significantly younger than participants from the community sample ($t(56) = -3.50, p = .001; d = .96$). The mean age of online participants was 38.04 ($SD = 11.39$) and the average age of community sample was 52.67 ($SD = 18.38$).

The majority of the sample had obtained a qualification equivalent to A-Level or above (61%, $n = 39$), with a significant proportion reporting postgraduate level qualification (22%, $n = 14$). A chi-square test of independence examined the relationship between method of completion (online or community sample) and level of education (educated to undergraduate level or below undergraduate level). The percentage of individuals educated at undergraduate level or above in the online participants was considerably higher (by 32%). The relationship between these variables was statistically significant (see Table 2).

Table 2. Cross tabulation of method of completion and level of education

Education	Method of completion		Total N (%)	χ^2 (df)	p
	Online n (%)	Community n, (%)			
Below Undergraduate level	10 (40)	25 (64)	35 (100)	3.57 (1)	0.06
Undergraduate level or above	15 (6)	14 (36)	29 (100)		
Total	25 (100%)	39 (100%)	64 (100)		

Socio-economic status classifications were made using reported occupation. These classifications were derived according to the National Statistics Socio-Economic Classification system (Office for National Statistics, 2010). This classification system uses occupation and employment status (i.e. self-employed or employee in a small or large organisation). Given that only

information about occupation was collected (and not employment status), this should be viewed as a fairly crude classification which may not accurately estimate SES.

Based on the data collected, participants had a range of occupations, with army or ex-army being the largest number (18%, $n = 11$). Of the socio-economic status categories (excluding 'not classified'), 'intermediate occupations' (which includes army/Gurkhas) was the largest group (25%, $n = 16$). A chi-square test of independence was used to examine the relationship between method of completion and SES (higher three occupational categories or lower three occupational categories). No significant relationship was identified (see Appendix 10 for cross table).

The majority of the participants (97%, $n = 63$) identified their country of origin as Nepal, with a small number reporting that they were born in the UK (3%, $n = 2$). Participants reported living across the UK in Berkshire (48%, $n = 31$), London/Greater London (22%, $n = 14$) and other locations. Participants were asked to specify how long they had lived in the UK (<1 year, 1-4 years, 5-10 years or 10+ years). Over half of the participants (51%, $n = 33$) had lived in the UK for 4 years or under and 20% had lived in the UK for over 10. Independent samples t-tests indicated that according to the acculturation measure used, those who had lived in the UK for more than 4 years ($n = 31$) had higher attitudes indicating greater acculturation than those who had lived in the UK for 4 or less years ($n = 33$), ($t(62) = -2.52, p = .014, d = .63$), reported engaging in more behaviours suggesting greater acculturation ($t(62) = -2.28, p = .03, d = .57$) and engaging in fewer behaviours associated with the country of origin ($t(62) = 3.37, p = .001, d = .85$). Means (SD) for groups compared are presented in Table 3.

Table 3. Mean (SD) acculturation scores for participants living in the UK for over 4 years or 4 years and under.

	Over 4 years ($n = 31$)	4 years or under ($n = 33$)
Attitudes indicating with greater acculturation	5.35 (2.03)	3.97 (2.35)
Behaviours suggesting greater acculturation	11.97 (2.80)	9.67 (4.92)
Behaviours associated with the country of origin	5.71 (2.37)	8.00 (3.01)

The majority of participants stated that they had some religious affiliation (91%, $n = 58$) with only 9% ($n = 6$) reporting they were 'not religious'. The highest percentage of participants stated their religion as

'Hindu' (36%, $n = 23$). One participant gave no information on this item. Given the low number of participants in each group, a non-parametric Mann-Whitney U Test was used to examine the difference in intention to seek help based on whether participants were religious or not. No significant difference was identified ($U = 140.50$, $p = .45$). The mean level of intention to seek professional help for religious participants was 61.48 ($SD = 11.25$) and for non-religious participants was 65.17 ($SD = 15.74$).

3.2 Descriptive statistics, distributional and graphical analysis of the main study variables

Means, standard deviations, interquartile ranges (IQR), medians and skewness of the main study variables were examined and the distributions checked for unusual observations and normality (see Table 4). The skewness of two of the main study variables, level of distress (GHQ-12) and behaviours associated with country of origin (from the acculturation measure) were larger than 1, indicating that these variables were noticeably skewed and deviated from normality. The degree of skewness in the other variables was modest.

Table 4. Descriptive and distributional analyses of the main study variables.

Variable	<i>n</i>	<i>Mean</i>	<i>SD</i>	<i>Median</i>	<i>IQR</i>	<i>sk</i>
Intention	64	81.83	11.34	62	14	.68
Izzat	62	41.97	25.86	45	44	.06
Level of distress (GHQ-12)	65	1.65	2.57	0	2	2.1
Acculturation - behaviours suggesting greater acculturation	64	10.78	4.17	11.5	4	.33
Acculturation - attitudes indicating greater acculturation	64	4.64	2.29	4.5	4	.37
Acculturation - Behaviours associated with country of origin	64	6.89	2.93	7	5	-1.16
Western Physiological causal beliefs	54	26.09	7.49	26	11	-.24
Non-Western Physiological causal beliefs	54	8.96	3.68	9	6	.24
Stress related causal beliefs	54	41.74	10.14	43	12	-.83
Supernatural causal beliefs	54	48.91	14.73	50	23	-.37
Age	58	46.36	17.25	44.5	36	.25

Box plots and QQ plots were used to explore the distribution of the main study variables (see Figure 3 and Figure 4). The boxplots indicated that level of distress (GHQ-12) clearly deviated from normality whilst the QQ plots indicated that there were issues with the level of distress (GHQ-12), but there was a slight discrepancy for normality of age.

Figure 3. Box plots for main study variables

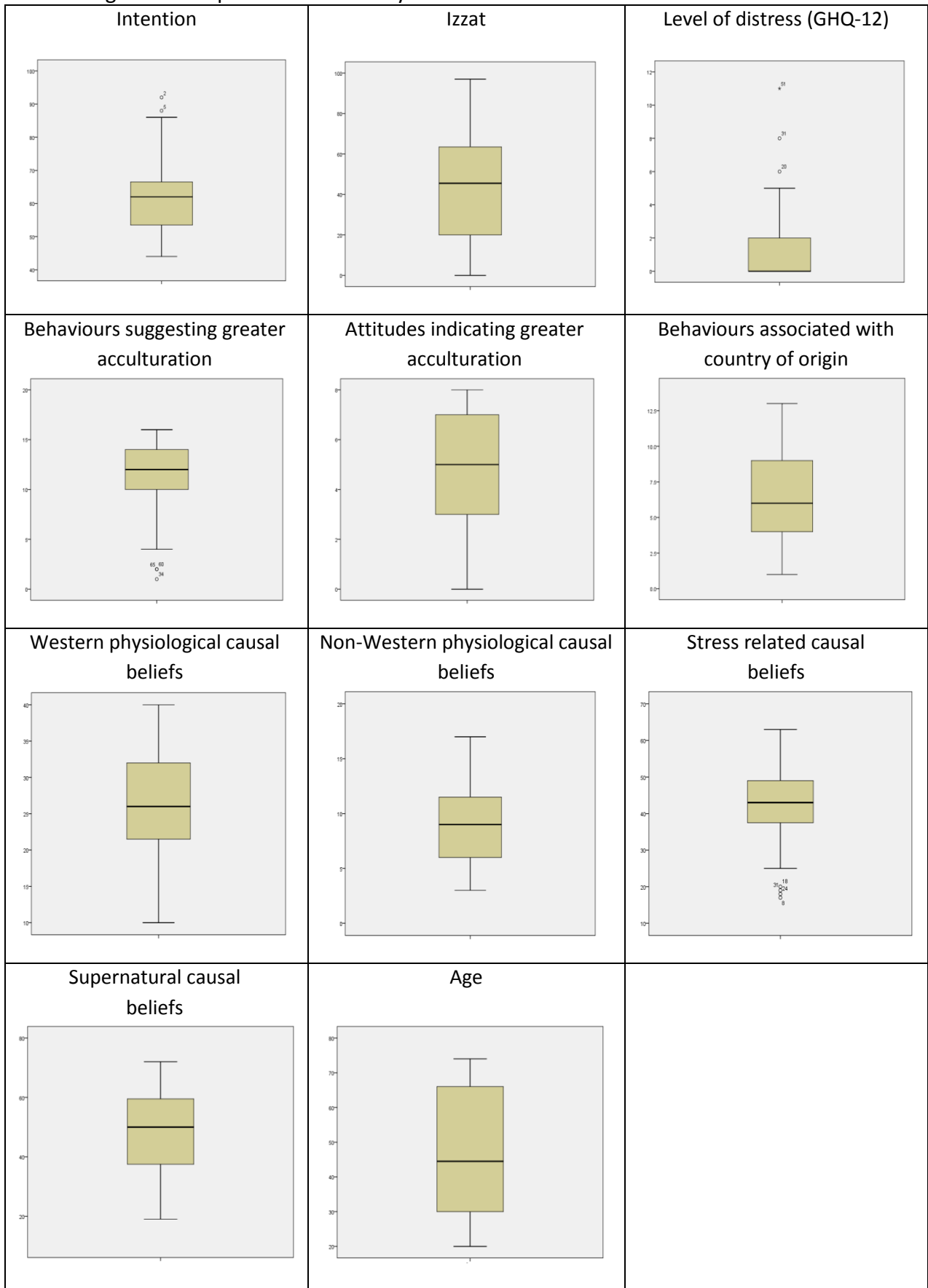
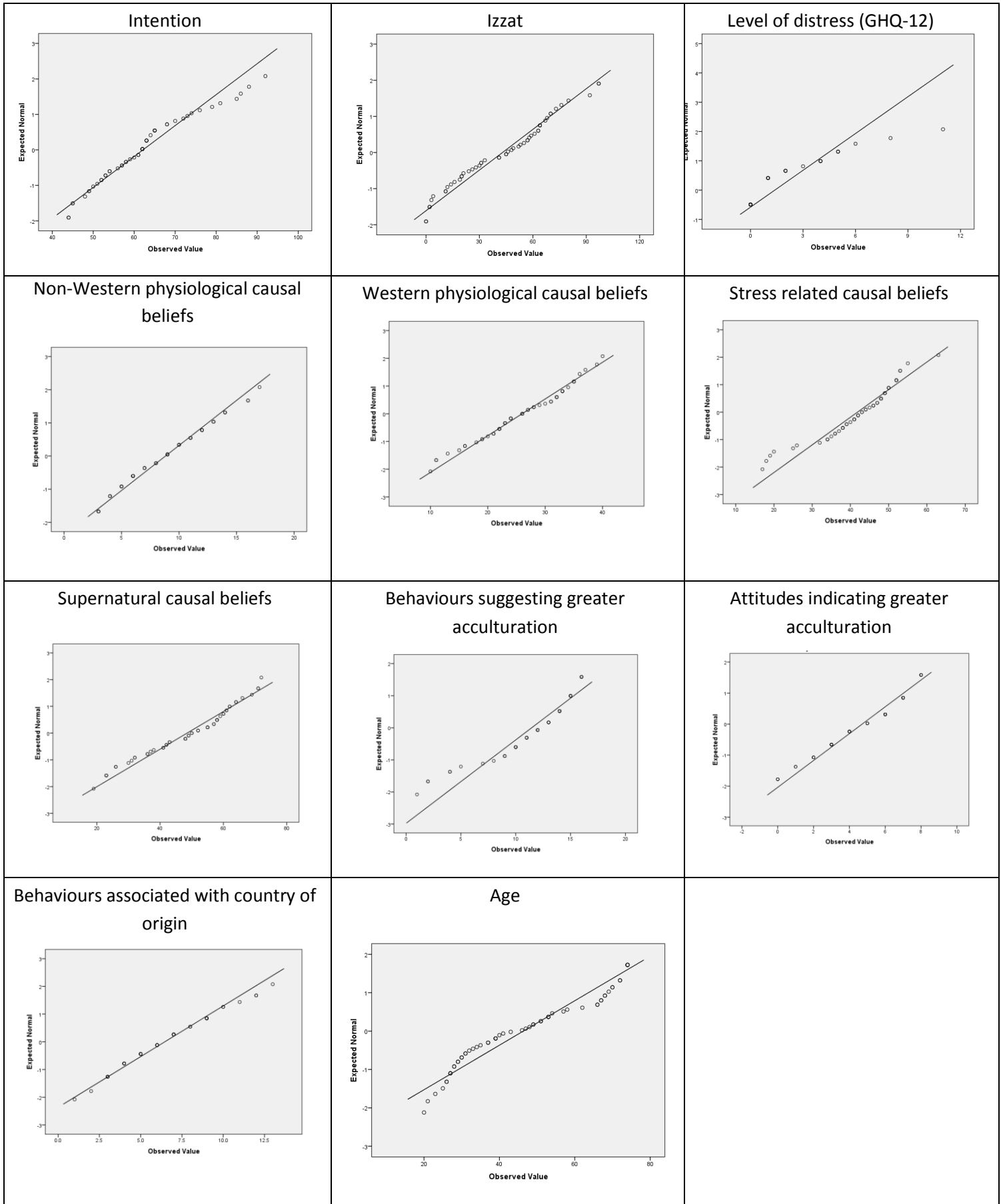


Figure 4. Normal QQ plots for main study variables.



The analysis of distribution of the study variables (see Figure 3) indicated that level of distress score (as measured using the GHQ-12) had a number of outliers and was significantly skewed. In order to address this, an ordinal classification system was devised, splitting the scores as described in a study by Russ et al., (2012) in which GHQ-12 scores were split into four categories: asymptomatic (score 0), subclinically symptomatic (score 1-3), symptomatic (score 4-6) and highly symptomatic (score 7-12). The frequency (percentage) of each GHQ-12 category is presented in Table 5.

Table 5. Percentages of frequency of the GHQ-12 categories (N = 65).

	Frequency (Percentage of total)
Asymptomatic	34 (52)
Subclinically symptomatic	18 (28)
Symptomatic	10 (15)
Highly Symptomatic	3 (5)

Because of the low numbers of ‘highly symptomatic’ participants, this group was amalgamated into the group of ‘symptomatic’ participants, $n = 13$ (20% of total). A chi-square test of independence indicated no significant gender differences based on level of distress (GHQ-12; see Appendix 10).

3.2.1 Beliefs about the cause of mental health difficulties

As described in the Methods section, the data collected relating to beliefs about the causes of mental health difficulties were divided into four causal categories: western physiological, non-western physiological, supernatural and stress. Correlational analyses between the four causal categories indicated strong intercorrelation between Western physiological explanations and stress ($r(54) = .84, p < .001$) and weak-moderate intercorrelation between all other causal variables (see Table 6).

Table 6. Bivariate correlations between causal belief categories (n = 54)

	Stress related causal beliefs	Western-physiological causal beliefs	Supernatural causal beliefs
Western-physiological causal beliefs	$r = .84, p < .001$		
Non-Western physiological causal beliefs	$r = .41, p = .002$	$r = .55, p < .001$	
Supernatural causal beliefs	$r = .52, p < .001$	$r = .45, p = .001$	$r = .38, p = .005$

Table 7 details the mean (*SD*) endorsements of the NLU towards the four categories of causal belief. These are compared with data from a study of the causal beliefs of South Asian and Pakistani individuals (Sheikh & Furnham, 2000).

Table 7. Mean and standard deviations (SD) of the endorsement of causal belief categories amongst this sample and data from other South Asian cultural groups.

Causal belief category	This study Mean (<i>SD</i>) <i>n</i> = 54	Sheikh and Furnham, 2000	
		British Asians Mean (<i>SD</i>) <i>n</i> = 115	Pakistani Mean (<i>SD</i>) <i>n</i> = 77
Stress	41.75 (10.1)	45.80 (12.9)	56.53 (8.2)
Western-physiological	26.09 (7.5)	31.38 (8.8)	35.90 (6.9)
Non-western physiological	8.96 (3.7)	15.16 (5.6)	18.47 (5.0)
Supernatural	48.91 (14.7)	47.35 (19.8)	57.80 (18.6)

3.2.2 Izzat

Subjective norms or level of *izzat* was measured and compared with a sample of British South Asians. Mean scores of 41.97 (*SD* = 25.86) were similar in this sample were similar to those in a study of British South Asians by Pilkington et al (2011), (*M* = 45.0, *SD* = 22.5).

An independent samples t-test suggested that there were no significant differences in subjective norm/izzat between men and women ($t(60) = -61$, $p = .50$, $d = .17$). Mean izzat scores for men were 40.63 (*SD* = 26.50) and for women were 45.00 (*SD* = 24.78).

3.2.3 Acculturation

Participants completed an acculturation measure which aimed to examine three different aspects of acculturation: behaviours suggesting greater acculturation, attitudes indicative of greater or lesser acculturation, and behaviours associated with the country of origin. The maximum ranges of these three subscales were 18, 8 and 19 respectively. The mean of these three subscales were, in the same order: 10.78 (*SD* = 4.17), 4.64 (*SD* = 2.29), and 6.89 (*SD* = 2.93). Bivariate correlations revealed that there were significant differences in all acculturation subscales based on time spent in the UK (see Table 8).

Table 8. Analysis of difference in acculturation subscales based on time spent in the UK

	Years spent in the UK	<i>M (SD)</i>	<i>N</i>	<i>T</i>	<i>p</i>	<i>D</i>
Behaviours suggesting greater acculturation	Under 4 years	9.67 (4.92)	33	-2.28	.01	.57
	4 years or above	11.97 (2.80)	31			
Attitudes indicative of greater or lesser acculturation	Under 4 years	3.97 (2.35)	33	-2.52	-.03	.63
	4 years or above	5.35 (2.03)	31			
Behaviours associated with the country of origin	Under 4 years	8.00 (3.01)	33	3.37	.001	.85
	4 years or above	5.71 (2.37)	31			

As detailed in Table 9, independent samples t-tests revealed significant gender differences in the behaviour suggesting greater acculturation subscale, but not in the other two subscales.

Table 9. Analyses of gender differences in acculturation subscales.

	Gender	<i>M (SD)</i>	<i>N</i>	<i>t</i>	<i>p</i>	<i>D</i>
Behaviours suggesting greater acculturation	Males	10.02 (4.29)	45	-2.32	.02	.67
	Females	12.58 (3.29)	19			
Attitudes indicative of greater or lesser acculturation	Males	4.69 (2.12)	45	.26	.80	.07
	Females	4.53 (2.72)	19			
Behaviours associated with the country of origin	Males	7.27 (3.01)	45	1.65	.17	.45
	Females	6.00 (2.60)	19			

Inter-correlational analyses between these subscales indicated a strong negative correlation as would be expected between behaviours suggesting greater acculturation and behaviours associated with the country of origin ($r(64) = -.79, p < .001$). Attitudes indicative of greater or lesser acculturation did not significantly correlate with either of the behavioural subscales of the acculturation measure.

Given the strong correlation between the two behavioural subscales of acculturation, the two subscales were amalgamated to form a single score as they would not have unique contributions in a final prediction model. The 'behaviours associated with country of origin' scores were reversed to create a single score indicative of 'behaviours indicative of greater or lesser acculturation' (which will be shortened in the subsequent analysis to 'level of behavioural acculturation'. The mean score of the level of behavioural acculturation scale was 3.82 ($SD = 6.69$). Level of behavioural acculturation significantly correlated with education ($r(65) = .60, p < .001$), and Non-Western physiological causal beliefs ($r(54) = -.44, p = .001$),

and age ($r(61) = -.61, p < .001$). The remaining attitudinal subscale of the acculturation measure will henceforth be referred to as 'level of attitudinal acculturation'.

3.3 Analysis of the hypothesised associations between intention to seek professional help and the main study variables.

In order to test the research hypotheses, potential predictor variables of intention to seek professional help were analysed. Initially, correlational analyses between the potential predictor variables and outcome variable, intention to seek help, were conducted to examine the direction and degree of the relationships (see Table 10). Each of the correlations with the outcome variable intention to seek professional help were checked for linearity using scatter plots which are presented in Appendix 11.

Table 10. Correlation matrix involving predictor variables and the criterion variable intention to seek professional help.

	1.	2.	3.	4.	5.	6.	7.	8.	9.
1. Intention to seek professional help									
2. Stress related causal beliefs	.09								
3. Western-physiological causal beliefs	.01	.84**							
4. Non-Western physiological causal beliefs	-.30*	.41**	.55**						
5. Supernatural causal beliefs	.01	.52**	.45**	.38**					
6. Level of behavioural acculturation	.32**	.02	-.17	-.44**	-.23				
7. Level of attitudinal acculturation	.19	-.26	-.19	-.26	-.18	.20			
8. Izzat	-.44**	.10	.10	.32*	.13	-.22*	.17		
9. Education	.20	-.28*	.05	-.29	-.07	.60**	-.03	.20	
10. Age	-.24	.19	-.02	.17	.01	-.61**	.01	.19	-.67**

** $p < .01$ * $p < .05$

NB. Pearson's correlations for all variables except ranking variable 'Education' for which a Spearman's analysis is used.
 Sample sizes variable from minimum 54 to maximum 65.

3.3.1 Association between acculturation and intention to seek help.

As detailed in research hypothesis 1a (section 1.8.2.), greater acculturation was hypothesised to be positively associated with intention to seek help. Following the amalgamation of the two behavioural subscales, the association between the two acculturation subscales (level of behavioural and attitudinal acculturation) and intention were analysed. Level of behavioural acculturation was significantly correlated with the outcome variable, intention to seek professional help ($r(64) = .32, p = .01$). This indicated that as predicted, those engaging in more behaviours suggesting greater acculturation and fewer behaviours associated with country of origin (i.e. were more behaviourally acculturation) were more likely to have stronger intention to seek professional help. However, in contrast to the predicted association, no significant correlation was found between intention to seek professional help and level of attitudinal acculturation ($r(63) = .19, p = .15$).

3.3.2 Associations between Western-physiological or stress-related causal explanations of mental health difficulties and intention to seek help.

As detailed in research hypothesis 1b (section 1.8.2.), Western-physiological and stress-related causal explanations were hypothesised to be positively associated with intention to seek help.

A very strong positive relationship was identified between stress-related and Western-physiological causal beliefs ($r(54) = .84, p < .001$), indicating that those who had strongly held stress-related causal beliefs were also likely to strongly hold Western-physiological causal beliefs. Contrary to the hypothesised association, no significant correlation was found between either causal belief variables or intention to seek professional help (Western physiological causal beliefs $r(54) = .01, p = .94$; stress-related causal beliefs $r(54) = .09, p = .51$). Because no association was found, no further attempts were made to examine whether an amalgamated variable including both causal belief categories was associated with intention to seek professional help.

3.3.3 Association between level of education and intention to seek help.

As detailed in research hypothesis 1c (section 1.8.2.), level of education was hypothesised to be positively associated with intention to seek help. In this sample, education was not found to be significant correlated with intention ($r(64) = .20, p = .12$). However this moderate correlation approached significance indicating that is possible that with a larger sample, this association would have reached significance.

3.3.4 Association between non-Western physiological and supernatural causal explanations of mental health difficulties and intention to seek help.

As detailed in research hypothesis 2a (section 1.8.2.), Non-Western-physiological and supernatural causal explanations were hypothesised to be inversely associated with intention to seek help.

A moderate positive relationship between supernatural and non-Western physiological causal beliefs ($r(54) = .38, p < .005$) indicating that participants who strongly endorsed non-Western physiological causal beliefs were also significantly more likely to endorse supernatural causal beliefs. As hypothesised, non-Western physiological causal beliefs significantly negatively correlated with intention to seek professional help ($r(54) = -.30, p = .03$), indicating that those who held more strong beliefs about the non-Western physiological causes of mental health difficulties had lower intention to seek professional help. Contrary to the hypothesised association, no significant correlation was found between supernatural causal beliefs and intention to seek professional help ($r(54) = .01, p = .95$).

3.3.5 Association between izzat and intention to seek help.

As detailed in research hypothesis 2b (section 1.8.2.), levels of izzat were hypothesised to be inversely associated with intention to seek help. As hypothesised, levels of izzat were found to moderately negatively correlate with intention to seek professional help ($r(61) = -.44, p < .001$), indicating that individuals who experienced higher levels of shame or izzat around mental health difficulties had lower levels of intention to access professional help.

3.3.6 Association between age and intention to seek help.

As detailed in research hypothesis 2c (section 1.8.2.), age was hypothesised to be inversely associated with intention to seek help. In this study, contrary to the research hypothesis no significant association was found between age and intention to seek professional help ($r(58) = -.24, p = .07$). However, this moderate correlation approached significance indicating that is possible that with a larger sample, this association would have reached significance.

3.4 Developing a model of predictors of intention to seek professional help.

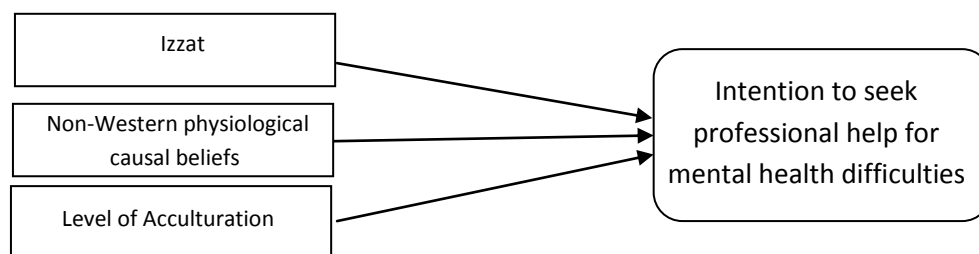
Using the theoretical framework of the TPB, hypotheses were made in this study about the association between a number of key variables and intention to seek professional help (see hypothesis 3, section 1.8.2). Tests to examine whether multicollinearity was a concern amongst the predictor variables to be entered into the multiple regression analysis were carried out using the tolerance value and a variance inflation factor cut-off value of 5 (See Table 11). These tests indicated that multicollinearity was not a concern for izzat and level of acculturation and a modest concern problem for non-Western physiological causal beliefs.

Table 11. Descriptive and distributional analyses of the predictor variables entered into the multiple regression analysis.

	Tolerance	VIF
Izzat	.78	1.28
Level of Acculturation	.96	1.06
Non-Western Physiological causal beliefs	.42	2.41

The multiple regression was run to identify reliable predictors of intention to seek professional help from Non-Western physiological causal beliefs, level of acculturation and izzat (as can be seen in figure 5) and to remove those variables which had no significant predictive power as identified by preliminary correlational analyses.

Figure 5: A Theory of Planned Behaviour (TPB) based initial model of the potential predictors of intention to seek professional help for mental health difficulties.



The overall model was significant and accounted for 22.9% of the variance in intention to seek professional help for mental health difficulties ($F(3,49) = 4.85, p < .01, R^2 = .23$) but the adjusted R^2 was smaller ($R^2 = .18$); this suggested that non-significant predictor variables were included in the model. Only izzat statistically significantly added to the prediction ($p < .01$) with an inverse relationship with intention to seek professional help as can be seen in Table 12.

Table 12. Beta values and levels of significance for the three predictor variables entered into the multiple regression analysis ($N = 65$).

Predictor Variable	Beta	T	Significance
Izzat	-.38	-2.87	<.01
Non-Western physiological causal beliefs	.12	.89	.38
Level of Acculturation	-.11	-.78	.45

A backward selection procedure was then used to remove non-significant predictors from the model. The final model removed Non-Western physiological causal beliefs and level of acculturation, leaving izzat as the only significant predictor of intention. This confirmed that neither of the other two predictor variables merited further consideration within the multiple-regression analysis.

3.5 An exploratory sub-group analysis of the factors related to actual professional help-seeking

In this study, the TPB was used as a theoretical framework. Using this theoretical framework, it was hypothesised (see hypothesis 3, section 1.8.2) that actual help-seeking behaviour would be predicted by intention to seek help for mental health and that in turn, intention would be predicted by the variables mentioned in research hypotheses 1 and 2, i.e. causal beliefs, acculturation, izzat, age and education. As detailed below (section 3.6) a significant number of participants indicated that they had experienced mental health difficulties, ($n = 19$, 29%). However, as hypothesised (see hypothesis 4, section 1.8.2) the number of individuals who reported seeking help from a mental health professional was very low ($n = 5$, 8% of the total and 26% of those who reported having experienced mental health difficulties).

This meant that entering the data into a formal path analysis for the second half of this research hypotheses, namely the association between intention to seek professional help and actual help-seeking, was not possible. An examination of the differences in demographic features of those who sought help for mental health difficulties and those who did not is presented in Table 13.

Table 13. Demographic features of those who sought help for mental health difficulties and those who did not.

	Help sought	Help not sought
Gender (n, %)		
Male	4 (75)	7 (50)
Female	1 (25)	7 (50)
Age (M, SD)	52.20 (14.45)	39.64 (12.18)
Language of completion (n %)		
English	4 (80)	13 (93)
Nepalese	1 (20)	1 (7)
Method of completion (n %)		
Online	4 (80)	11 (79)
Community	1 (20)	3 (21)
Religious affiliation (n %)		
Yes	5 (100)	14 (100)
No	0 (0)	0 (0)
Education (n %)		
Below undergraduate	3 (60)	7 (50)
Undergraduate or above	2 (40)	7 (50)

An examination of the means (SD) on the main study variables of those who had sought help and those who had not is presented in Table 14.

Table 14. Means (SD) for the main study variables for those who experienced mental health difficulties by whether help was sought or not.

	Help sought (<i>n</i> = 5) <i>M</i> (<i>SD</i>)	Help not sought (<i>n</i> = 14) <i>M</i> (<i>SD</i>)
Intention to seek professional help	59.80 (11.17)	65.71 (14.22)
Izzat	44.60 (25.03)	46.64 (27.62)
Level of distress (GHQ-12)	2.40 (2.51)	2.07 (2.02)
Level of behavioural acculturation	4.20 (6.14)	6.21 (5.01)
Level of attitudinal acculturation	4.00 (2.45)	4.43 (1.99)
Western physiological causal beliefs	26.75 (5.25)	25.08 (8.96)
Non-Western physiological causal beliefs	9.75 (1.50)	7.23 (3.63)
Stress related causal beliefs	47.00 (4.08)	40.62 (13.28)
Supernatural causal beliefs	66.75 (9.64)	48.54 (14.76)

Mann-Whitney U-tests were conducted for the variables which appeared to have large mean differences. There was a significant difference in level of supernatural causal beliefs dependent for those who had sought help, compared with those who had not ($U = 7.00, p = .03$). However, this analysis must be interpreted with caution due to the low numbers of participants in both groups.

3.6 Prevalence of mental health difficulties amongst the sample

Level of distress, or prevalence of current mental health difficulties was measured firstly through a measure which relates to current symptoms related to common mental health difficulties, the GHQ-12. Participants were also asked about whether they had experienced current or past mental health difficulties. Table 15 details the number of individuals who gave clinically significant scores for current mental health symptomology and the number of individuals who endorsed the statement indicating that they had or were currently experiencing mental health difficulties. 30% ($n = 19$) of the participants stated that they had experienced emotional and psychological problems, with a smaller figure, 25%, ($n = 16$) reporting current mental health symptomology above clinical cut-off on the GHQ-12. This figure is significantly lower than prevalence figures for a rural population in Nepal (38%; Khattri et al., 2013) but similar to estimates of psychological distress in British South Asians (25%; Williams, Eley, Hunt, & Bhatt, 1997).

Table 15. Current and past experience of mental health difficulties of the sample.

General Health Questionnaire - 12 score	Above clinical cut-off <i>n</i> (%)	Below clinical cut-off <i>n</i> (%)
		16 (25)
Have you ever experienced emotional/psychological problems? (<i>n</i> = 64)	Yes <i>n</i> (%)	No <i>n</i> (%)
	19 (30)	45 (70)

3.6.1 Intention and level of distress

Using the ordinal scoring method, which grouped individual reports of level of distress, according to the GHQ-12, into asymptomatic, sub-clinically symptomatic and symptomatic, an examination of the association between intention and level of mental stress was conducted. In this sample, level of intention to seek professional help was not associated with level of distress ($r_s(64) = -.22, p = .09$). This indicates that individuals experiencing higher levels of distress or mental health symptomology were not significantly more likely to have increased intention to seek professional help.

3.7 Experiences of mental health difficulties and help-seeking amongst the sample

Of the 19 individuals who reported that they had experienced emotional or psychological problems, only 5 participants reported seeking professional help (8% of the total sample and 42% of those who had experienced mental health difficulties). Participants were asked, if they were willing, to provide further information about the types of difficulties they (or a person well known to them) had experienced, whether they had wanted to seek professional help and their experience of seeking help had they done so.

3.7.1 Types of emotional or psychological problems experienced.

Six participants (9.2%) gave a description of their own experiences of psychological or emotional difficulties and a further 22 (34%) gave the same relation to someone 'well known' to them. Some of the descriptions given detailed several types of difficulties.

Table 16 details the responses grouped by type of difficulty, of which anxiety related difficulties were the most often cited (43%, $n = 12$). A number of participants specified comorbid psychological difficulties. 14% ($n = 9$) of participants who said that they were willing to share their (or a close others') experiences did not specify the nature of the difficulties.

Table 16. Frequency counts and percentages of participants' own or a close others' reported emotional/psychological difficulties.

Reported difficulties	Frequency	Percentage of all participants (N = 65)	Percentage of participants who reported their own/a close others' psychological difficulties (n = 28)
Anxiety related difficulties (e.g. panic, stress etc.).	12	19	43
Depression	4	6	14
Sleeping difficulties	7	11	25
Eating problems	3	5	11
Alcohol problems	2	3	7
Other (including psychosis, self-harm, 'loss of focus', relationship difficulties)	9	14	32
Reported difficulties	Frequency	Percentage of all participants (N = 65)	Percentage of participants who provided a description of their own psychological difficulties (n = 6)
Anxiety related difficulties	3	5	50.
Sleeping difficulties	4	6	67
Depression	1	2	17
Eating	1	2	17
Other (e.g. relationship difficulties)	2	3	22

3.7.2 Desire to seek help for mental health difficulties.

Participants' who had experienced mental health difficulties and were willing to answer further questions were asked to state whether they wanted help for mental health difficulties. Only 17% ($n = 11$) of participants endorsed the item, which suggested that they were happy to answer questions about their own help-seeking preferences and experiences. Of these, 27% ($n = 3$) said that they did want to get help for the psychological or emotional difficulties they had experienced. Of those who answered in relation to a person 'well known' to them (54%, $n = 7$) said that this person had wanted to get help for psychological/emotional difficulties. 42% ($n = 27$) of the participants said that they did not wish to answer any further questions and left the remaining questions blank.

3.7.3 Forms of help wanted by participants.

Despite only 14 participants stating that they or someone known to them wanted help, 38 participants then went on to answer questions about the type of help that they (or a person well known to them) wanted. The majority of these participants (82%, $n = 31$) stated that they or someone known to them wanted some form of professional help (e.g. psychotherapy, GP, psychiatrist). Only one person said that they had wanted support from an Asian mental health organisation. A large proportion had wanted non-professional help such as support from friends/family or prayer e.g. 58% ($n = 22$) reported wanting support from family. Table 17 shows the number of individuals who indicated that they or a person well known to them wanted help and the type of support they wanted. Some participants indicated that they wanted several types of support.

Table 17. Frequency counts and percentages of the different forms of help wanted by participants or individuals well known to them.

Type of help wanted	Frequency	Percentage of all participants ($N = 65$)	Percentage of those who reported what type of help that they/a close other wanted ($n = 38$)
Support from friends	20	31	53
Support from family	22	34	58
Support from GP	10	15	26
Psychiatrist	7	11	18
Prayer	11	17	29
Psychologist/Therapist	11	17	29
Social worker	2	3	5
Asian mental health organisation/service	1	2	3

3.7.4 Forms of help actually used by participants who experienced mental health difficulties.

Table 18 details the types of help which were reportedly actually used by participants who had reported experiencing mental health difficulties. When calculated as a percentage of the total number of participants, 8% ($n = 5$) reported using support from friends, 8% ($n = 5$) from family, and 6% ($n = 4$) reporting seeking help from a GP.

Very few of the total number of participants who reported that they had experienced mental health difficulties said that they had sought professional psychological or mental health support ($n = 5$, 8%.) Some of these participants detailed more than one type of professional mental health services they had accessed. None of

the participants reported seeing a psychiatrist or receiving counselling or psychotherapy.

Table 18. Frequency counts and percentages of the different forms of help actually used by participants with experience of mental health difficulties.

Type of help sought	Frequency	Percentage of all individuals who reported experiencing psychological/emotional difficulties (<i>n</i> = 19)	Percentage of all participants (<i>N</i> = 65)
Support from friends	5	26	8
Support from family	5	26	8
Support from GP	4	21	6
Saw a psychiatrist	0	0	0
Counselling/Psychotherapy	0	0	0
Prayer	3	16	5
Asian mental health organisation/service	0	0	0
Attend NHS mental health services (e.g. Community Mental Health Team)	1	5	2
Medication	3	16	5
Hospital inpatient admission	1	5	2
Advice/involvement of social worker	2	11	3

3.7.5 What stopped participants or individuals well known to them from seeking help?

A number of statements were endorsed by those who said they did not seek help for the emotional/psychological difficulties they were experiencing (or the difficulties of an individual well-known to them). Many participants said that they “hoped the problems would go away on their own” (39%, *n* = 11). Table 19 details the frequencies and percentages of the reasons which participants (or close others) chose not to see help. Some participants detailed more than one reason for not seeking help.

Table 19. Frequency counts and percentages of the reasons participants (or person known well to them) did not seek help.

Reason for not seeking help	Frequency	Percentage of all participants (N = 65)	Percentage of individuals who had experienced mental health difficulties or close others (n = 28)
Didn't want to burden others with difficulties.	9	14	32
I/they felt ashamed.	3	5	11
I/they hoped the problems would go away on their own.	11	17	39
I/they felt embarrassed.	5	8	18
I/they worried what friends and family would think.	4	6	14
I/they did not want to bring shame on the family/community.	2	3	7
I/they did not know where to find help	7	11	25
I/they thought that the problem was not bad enough	6	9	21
I/they thought that the help or advice would not be useful	5	8	18

3.7.6 Why did participants or individuals well known to them not take up services which were offered?

A number of participants (or individuals well known to them; $n = 13$) who reported that they did not take up services, gave the following reasons for doing so. Of these 13 individuals, 31% ($n = 4$) said that the services they wanted was not available, 46% ($n = 6$) said that they did not wish to use the service offered, 15% ($n = 2$) said that the service offered did not suit their lifestyle, 8% ($n = 1$) said that the service was not religiously or culturally appropriate.

4. Discussion

The overall aim of this study was to explore which factors influence the strength of intention to seek professional help for mental health difficulties in Nepalese people living in the UK (NLU). This was undertaken using a theoretical framework which has been widely used in health related research: the Theory of Planned Behaviour (TPB; Ajzen, 1985). This theory provides a basis upon which to test which factors are the best predictors of intention. This research is important in increasing the understanding of the mental health needs of a significant group in the UK for whom there is almost non-existent research in the field of mental health. Evidence from South Asian groups more generally has demonstrated that low mental health service access rates are determined by a number of culturally specific factors such as shame, level of acculturation and beliefs about the causes of mental health difficulties.

The results of this study will be considered in light of the original hypotheses. Accordingly the clinical relevance in terms of implications for this population, other Black and Minority Ethnic (BME) populations and mental health care services will be discussed. The strengths and limitations of this study and opportunities for further research will then be discussed before final conclusions are drawn.

4.1 *An exploration of the hypotheses*

4.1.1 *Variables associated with intention to access mental health services*

An adapted version of the Theory of Planned Behaviour (TPB; Ajzen, 1985) was used as a guiding theoretical framework for this study, with the primary focus being on the first half of the causal chain, i.e. which factors predict intention to access professional help for mental health difficulties. Based on the existing literature for South Asian and Nepalese individuals, hypotheses were made about the likely predictors of intention to seek professional help for mental health difficulties. It was hypothesised that izzat, acculturation, causal explanations for mental distress, age and education would explain the variance in intention to access professional help for mental health difficulties. In the absence of research evidence for NLU in this area, initial correlational analyses were conducted to examine any emergent relationships between intention and potential predictor variables.

As hypothesised, this study found evidence of significant inverse relationships between intention and non-Western physiological causal beliefs (e.g. body out of balance, being hot), engagement in behaviours associated with country of origin,

engagement in behaviours suggesting greater acculturation (part of the acculturation measure) and izzat. In other words, individuals who held non-Western physiological causal beliefs about mental health difficulties viewed mental health difficulties as more shameful and stigmatised and indicated lower intention to seek help. Those who adhered to behavioural customs associated with Nepalese culture, were less likely to intend to seek help for mental health difficulties. Similarly, as hypothesised, this study found that those who engaged in more behaviours suggestive of greater acculturation had higher intention to seek professional help.

As detailed in the results section, the correlation between the two behavioural subscales of the acculturation measure was so strong that they were amalgamated into one unitary score, which also correlated significantly with intention. This indicated that individuals with greater acculturation (according to the two behavioural subscales of the acculturation measure) had increased intention to seek help for mental health difficulties. Whilst the correlation between age and intention did not reach significance, the weak negative correlation identified suggests that taking into account the limitations of this study (discussed below), it is possible that age may be a pertinent factor in help-seeking intention in this population.

There was no evidence in this study of a relationship between intention and stress-related, Western physiological or supernatural causal beliefs. Similarly no support was found for the hypothesised relationship between intention and educational attainment and between intention and attitudes reflective of greater acculturation. Possible explanations for the findings of non-significant relationships between these variables and intention will be discussed below.

When considered through the theoretical lens of the TPB, the variables measured in this study can be viewed as relating to the three aspects of the first part of the TPB causal chain: perceived behavioural control, subjective norms and attitudes towards the behaviour. In this study two demographic variables were examined in relation to intention to seek professional help for mental health difficulties: age and education. Three broad categories of psychologically derived variables were also examined: beliefs about the causes of mental health difficulties, acculturation, and izzat.

In this study, the main variables are argued to be related to all three of the elements of the first part of the TPB. Causal beliefs relate to the explanations which the NLU in this study gave as to the underlying causes of mental health difficulties. These are argued to have a direct association with the attitudes towards seeking help from psychological services in that they are likely to influence the type of help which is thought to be necessary. An individual viewing their mental distress as supernaturally caused is likely to view help-seeking from a mental health service less favourably and therefore have lower intention to access such a service, because they do not feel this service will address the cause of their difficulties. This study provides preliminary

evidence for a negative association between non-Western physiological causal beliefs and intention to seek professional help. It is not possible to ascertain from this data the psychological mechanism by which this association functions. However, it could be hypothesised that an individual strongly holding non-Western physiological causal beliefs about mental distress may also be more inclined to seek non-Western sources of support and thereby have lower intention to seek Western mental health services.

A significant negative correlation was also found for a relationship between izzat and intention to seek professional help. The concept of izzat links to the TPB concept of subjective norms, in that it refers to the individual's perception of the views of others in the community about seeking help. This study found preliminary evidence for an association between izzat, the perceived views of family and community members about family honour and intention to seek professional help, with a strong inverse relationship identified.

Finally, a significant positive association between greater behavioural acculturation and intention to seek professional help was identified. Acculturation has been argued to link both to the attitudinal and perceived behavioural control variables of the TPB in that it relates to the attitudes of a host or society of origin towards help-seeking. It can also be argued to relate to perceived behavioural control because of its relation to language and understanding of the host country and its professional systems which will influence the individual's perceived ability to access services.

In terms of the emergent relationships identified through the correlational analyses, this study found support for the association of aspects of all three of variables in the first part of the TPB causal chain with intention to seek help for mental health difficulties. This provides initial support for the utility of the TPB model for this behaviour in this sample.

4.1.2 The multiple regression analysis

Following the initial exploratory analysis, a multiple regression analysis was carried out to examine the hypotheses that intention to seek professional help would be predicted by the variables measured. All the variables found to significantly correlate with intention (i.e. izzat, non-Western physiological beliefs and acculturation) were entered into the multiple regression analysis. Only izzat was found to be significantly associated with intention, with levels of izzat being inversely related to intention and accounting for 23% of the variance in intention. Although there were significant associations between the other variables entered into the multiple-regression analysis and intention, there was no evidence that non-Western physiological causal beliefs or acculturation significantly accounted for any variance in intention in the final model.

In this sample, it appears that the relationship between izzat and intention to access mental health services was highly significant. The backwards selection procedure used to remove non-significant predictors from the multiple-regression analysis confirmed that neither non-Western physiological beliefs nor acculturation merited further consideration. It is likely that both non-Western physiological beliefs and acculturation are related to izzat. For example, greater acculturation (in this study measured as being related to engaging in more behaviours indicative of greater acculturation and less behaviours associated with the country of origin) is likely to be accompanied by a decreased sense of duty to adhere to culturally determined rules which form the basis of the concept of izzat used in this study. Similarly, lower belief in non-Western physiological causes of mental distress could be seen as being linked to lower levels of izzat, because favouring stress-related or Western physiological causal beliefs may lead to a less stigmatising view of mental health difficulties.

The relationships between the variables entered into the final multiple regression model provide a clear indication that in this community, high levels of shame, izzat and the feeling that mental health difficulties bring dishonour and reputational damage to family and communities mean that NLU are less likely to access mental health services. From this study it is not fully clear how variables such as acculturation and causal beliefs are linked and there are likely to be methodological shortcomings of the measures used in this study (discussed below) which may account for the non-significant findings. Further research would be required to fully understand the complex relationships between these variables, izzat and intention to seek help for mental health difficulties.

4.1.3 Prevalence of mental health difficulties in this sample, intention and actual help-seeking

A non-clinical sample was recruited for this study which allowed for an estimate of the prevalence of current symptomology indicative of common mental health difficulties to be made. The prevalence of mental health difficulties as measured using the GHQ-12 was 25% within this sample. This figure is similar to estimates within non clinical British South Asian populations (e.g. Williams, Eley, Hunt, & Bhatt, 1997) and in line with global estimates of the prevalence of mental health difficulties (WHO, 2001). The data from this study would therefore support the suggestion by some researchers that it is not low prevalence of mental health difficulties which predicts low access to mental health services in NLU (discussed below).

Following a review of the literature, it was hypothesised that of the NLU who participated in this study and reported having experienced mental health difficulties, a low number would have actually sought professional help from mental health services. Participants of this study were asked to share, if they were willing, their experiences of actually seeking help (professional or otherwise) for mental health difficulties. The

analysis of the data collected in this study confirmed, as hypothesized, that although many NLU reported experiencing or having experienced mental health difficulties, very few reported accessing mental health services (42% of those who had experienced mental health difficulties and 8% of the whole sample). In line with the TPB, it was hypothesised that accessing mental health services would be predicted by intention to do so and mediated by the significant predictors of intention (e.g. izzat).

Only 8% ($n = 5$) of all the participants reported both having experienced mental health difficulties and actually having accessed professional support for these difficulties. Because of the low numbers of individuals who reported accessing services for their own mental health needs, the subsample did not have enough statistical power to examine the second part of the TPB causal chain. In other words it was not possible to establish whether intention to seek help was significantly associated with actual help-seeking behaviour. A significant difference was found in the level of 'supernatural causal beliefs' dependent on whether an individual had sought professional help or not and interestingly, individuals who had not sought help reported slightly higher intention to seek help than those who had sought help. However, because only 5 individuals reported both experiencing mental health difficulties and seeking help, these findings should be interpreted with caution and further research is required to specifically examine factors which relate to actual help-seeking in this population.

Information was obtained from the participants in this study about the reasons those who experienced mental health difficulties had not accessed services and the potential barriers to service access. These are considered below. The majority of those who answered questions about their own (or a close other's) mental health difficulties said that they had wanted to seek professional help. The most commonly given reasons for not seeking help was that participants hoped that the problems would go away by themselves, feeling that they didn't want to burden others with the difficulties and not knowing where to find help. These could be seen as being related to some of the variables measured in this study e.g. 'not knowing where to find help' could be related to an individual's level of acculturation and 'hoping that the problems would go away by themselves' could be related to an individual's explanation as to how these problems arose.

4.2 Linking the findings to existing research

This study has identified a number of findings which have not previously been examined. However, it is possible to compare the findings of this study with that of previous research literature and to use this literature to begin to understand the findings identified.

The reasons for the low mental health service access rates in NLU are not currently understood in the literature. A number of research studies have suggested

that there is lower prevalence of mental health difficulties in immigrant South Asian populations. For example, Cochrane & Stopes-Roe (1977) found that amongst Indian immigrants there were significantly lower rates of 'psychological disturbance' than in a native British sample. Similarly, Nazroo (1997) reported significantly lower rates of anxiety in community samples of immigrant South Asians. A possible explanation for this could be that NLU are simply not experiencing mental health difficulties which warrant professional support. However both of these studies have significant limitations, e.g. Cochrane and Stopes-Roe's study focused only on inpatient admissions which means the results are not generalisable to wider South Asian populations. Furthermore, the findings of this study suggest that the prevalence of mental health symptomology in this NLU sample is comparable with estimates of prevalence in other South Asian populations. Therefore, the findings of this study would reject the assertion that lower prevalence of mental distress in NLU predicts lower access rates.

This finding is particularly important in recognition of the common stereotype relating to South Asians not being 'psychologically minded' (Webb-Johnson & Nadirshaw, 2002). The finding that the reported psychological distress in this sample is comparable to the rates which would be expected in the general population would suggest that it is not a lack of ability to recognise or conceptualise psychological distress in this population that leads to low mental health service access rates. Rather, there are likely to be other important factors which serve as barriers to getting help.

Izzat, has been identified in the literature as being a major barrier to accessing mental health services in South Asian populations (Anand & Cochrane, 2005; Chew-Graham et al., 2002; Pilkington et al., 2011) and the results of this study would suggest that izzat is an important negative predictor of intention in NLU. It is important to consider which cultural aspects of NLU populations may influence the role of izzat in relation to intention. Ideas of collectivism and allocentricity (i.e. community mindedness over individual interest) are likely to be important in helping to understand the role of izzat in predicting intention in this cultural group. Segal (1998) describes allocentrism as being linked to expectation of sacrifices to be made for the good of the family, such as between family arranged marriages or financial investment in a family member's education. In terms of mental health issues, the role of family honour, or izzat would seem to fit with these types of decision-making processes when it comes to making a decision about whether to access mental health services. There is limited quantitative research to support this finding. However, Pilkington et al. (2011) similarly found that for South Asian individuals who had migrated to the UK, izzat was an important predictor of intention. Interestingly, their study found that for individuals born in the UK, levels of izzat were lower. In this study, only a small number of participants were born in the UK and it was therefore not possible to examine whether similar distinctions may be made in the NLU population.

Given the finding in this study that izzat plays a significant role in predicting intention, it would appear likely that in this population mental health issues are rarely discussed or considered within communities and families. With this in mind, it could be hypothesised that the experience of psychological distress, necessitates thinking about whether help-seeking is appropriate. Alternatively, it could be hypothesised that the anticipated experience of stigma, in the event of experiencing psychological distress, might mean that NLU are even less likely to intend to seek help. Interestingly in this study, no significant association was found between intention to seek help and level of psychological distress (as measured using the GHQ-12). However, the weak relationship which approached significance (Pearson's $r = -.20$, $p = .11$) sort this out suggested that those with higher levels of reported mental health symptomology were slightly less likely to intend to seek help. Research into the role of psychological distress in mental health care service access has been inconclusive. For example, some studies have found inverse relationships between help-seeking intention and level of psychological distress (e.g. Wilson, 2010). Conversely, other studies have found that individuals with higher levels of distress are more likely to intend to seek help (e.g. Rosenthal & Wilson, 2008; Yorgason, Linville, & Zitzman, 2008). Further research is required to explore whether the relationship between distress and intention would reach significance in a larger NLU sample and if so what the reasons for this may be.

In considering the findings of this study, it is important to consider what it is about Nepalese culture, social norms or values which may influence the interaction between izzat and the likelihood that NLU will intend to seek help from mental health services. One potential factor which may play a part is the influence of caste. Nepal has a complex caste system which hugely influences social norms, rules and values within Nepalese culture (Jones & Boyd, 2011). Caste has been considered in the research in terms of 'opportunity structure', a term referred to by Bennet (2004) as the interaction between various social processes which determine, for example, an individuals' benefit from and participation in social, political and economic capital. In 2001, the national census in Nepal identified 100 ethnic and caste groups (Aasland & Haug, 2011). In the past, these would have determined an individual's occupation, access to education, marital prospects etc. Although the influence of caste today is not as widespread, particularly with the introduction of a law affirming the equality of the different caste groups (Aasland & Haug, 2011), it still widely contributes to the beliefs, values and rituals of large parts of Nepalese society and discrimination on the basis of caste still persists (Aasland & Haug, 2011; Jones & Boyd, 2011). It was not within the scope of this study to examine whether factors related to caste and the behavioural norms associated are relevant to mental health service access. However it is possible that being in a culture which is influenced by a caste system goes hand in hand with the concept of izzat and family honour, in terms of the perceived shame and one's position in society.

The finding that factors such as acculturation, education, age and causal beliefs about mental distress were not significantly associated with intention is in contrast to much of the previous research of South Asian populations. For example, level of education has been consistently found to be an important factor in mental health service use for South Asian populations. However, the high levels of education in this sample (with 61% reporting being educated to A-Level or above compared with an estimated 44% in the general population, OECD Indicators, 2012), may begin to explain the finding that there was no significant relationship between education and intention to seek professional help. It is possible that a less homogenous sample (in terms of education) may have identified a non-linear relationship e.g. a sudden increase in intention to seek help in those who have completed school education and are literate. The exclusion of illiterate individuals from this study (by merit of not being able to complete a questionnaire) does not allow for further exploration of the relationship between education and intention.

It is also possible that explanatory models of causation of mental distress differ between this population and the native British population. However, this cannot be drawn out from the data collected in this study. In this sample, although none of the causal belief categories measured were related directly to intention, *izzat* and non-Western physiological beliefs were significantly correlated, indicating that higher levels of shame may be linked to holding beliefs about e.g. movements of wind, drafts, gas, milk or air flowing through a person's body being linked to mental distress.

4.3 Clinical relevance and implications of this study.

This study sought to understand the intentions of NLU towards seeking professional help for mental health problems in the context of NHS mental health services which are currently being underutilised by BME communities and specifically underutilised by NLU communities (Amani, 2012). Whilst this study did not have the scope to fully identify the barriers which may prevent NLU from accessing mental health services, it provides invaluable information about the factors which are likely to impact upon intention to access these services. The findings of this study have clinical implications at all levels of clinical practice and service delivery and for mental health research with NLU and other BME populations.

4.3.1 Implications for professional mental health services

The most pertinent clinical implication of this study pertains to the finding that there are significant barriers which are likely to prevent NLU from intending to seek help for mental health difficulties. The results of this study suggest that societal shame and the cultural requirement to maintain family honour have a significant role in determining the likelihood that NLU will seek professional help.

A number of organisations have provided policies and recommendations for improving access to mental health services and engaging with BME communities on mental health issues (e.g. Department of Health, 2009; Mental Health Network, 2012). These suggestions include building relationships with community organisations, establishing focus groups with service users from BME groups, and improving outcome monitoring for BME groups. The results of this study point to the need for these types of initiatives to be implemented whilst holding in mind and working with the importance of the culturally specific barriers. Working with communities to address barriers to services such as stigma has been shown to improve attitudes towards service access and treatment outcomes for the general public (e.g. Howard & Goelitz, 2004; Shin & Lukens, 2002). Gater et al. (2009) report the results of a social group intervention with a psycho-educational element which was run for depressed Pakistani women within a community centre. This study reported improved social functioning in participants and that participants felt that the intervention was culturally acceptable.

Public psycho-education has been described as being an intervention which “may circumvent the stigma associated with receiving help” (Howard & Goelitz, 2004, p.2). Wolff, Pathare, Craig and Leff (1996) provide a useful framework upon which to base these types of psycho-educational interventions, which include the importance of listening to a community’s attitudes and ensuring continuing contact with the community. In this population a key first step to engagement may be to use psycho-educational approaches to reduce the levels of izzat associated with accessing mental health services.

The findings of this study are indicative of the unmet need in this population i.e. the comparable prevalence of mental health difficulties to the general population but the significantly lower rates of access. Many governmental and healthcare policies have stressed the need for the involvement of underserved communities in order to improve access to professional support for mental health difficulties (Department of Health, 2005, 2007; WHO, 2007). There is already evidence available suggesting that community outreach projects, such as that headed by Amani (2012), can serve to improve mental health awareness within the NLU population. Amani (2002) demonstrated that lay-mental health workers from within the NLU community could be trained and work effectively to promote awareness of mental health issues and improve mental health in this population. The results of this study would support the assertion that in order for individuals from NLU communities to feel able to access support for mental health difficulties, culturally acceptable outreach projects, which specifically address the cultural issues of this community are needed.

4.3.2 Implications for mental health policy and awareness.

Despite the large numbers of Nepalese individuals currently living in the UK, they are a relatively invisible group in terms of the data and research available for this

specific group. For example, healthcare services often collect data about Nepalese individuals as 'Asian other' which limits the amount of information available about service access and treatment pathways for NLU. This lack of data provides a significant barrier to improving access to healthcare in this population. This needs to be addressed at policy level, to collect information specifically about NLU communities in order that service provision can be planned.

Psycho-educational interventions targeted specifically at NLU communities are likely to begin to address the barriers to accessing services, particularly with regards to the stigma of mental health difficulties. However, these types of interventions will only reach those who are willing to participate and engage with this type of education. Centuries of cultural norms and strongly held views are unlikely to be changed overnight. At a broader level, it is possible that challenging stereotypes and misrepresentations in the media and other influential culturally specific sources will begin to tackle the stigma which appears to be so prevalent in this community. For example, there has been research reporting the success of the use of mental health awareness campaigns within BME communities (e.g. Knifton et al., 2010). The authors suggest that these types of top-down public education forums are invaluable in terms of addressing stigma, shame and attitudes towards mental health.

This study provides information which could lead to an understanding of which groups of NLU are the least likely to access mental health services. In this sample, although the relationship between age and intention to access mental health services and between education and intention did not reach significance, there was an association which approached significance. In other words, the results of this study would suggest that older, less educated participants were slightly less likely to positively state intention to access mental health services. Furthermore, individuals with lower levels of acculturation had lower intention. As discussed, it is possible that methodological and sampling issues may account for the lack of a significant correlation between intention and age and between intention and education. However, the emerging relationships between these variables and intention should be considered in policy making and legislation so that particular groups who are the least likely to access psychological support (i.e. older, less educated and less acculturated individuals within an NLU community) can be specially targeted.

4.3.4 Implications for clinical psychology

All clinical psychologists have a duty to provide culturally aware care to the people they see. The British Psychological Society's Division of Clinical Psychology (BPS, DCP) provides specific good practice guidelines for Clinical Psychologists working with individuals from BME backgrounds (British Psychological Society, 1998). The guidelines, which the BPS recommend should be adhered to by clinical psychologists in all aspects of clinical and research practice, incorporate 'competencies' including acknowledging

different cultural perspectives, and evaluating availability and accessibility of psychological services for BME communities (British Psychological Society, 2005). These guidelines are aimed at improving the ability of psychologists to consider and work with cultural differences, the specific needs of BME groups and the impact of racism on mental health.

In accordance with the BPS guidelines, accounting for the culturally specific issues which may arise for NLU could help to increase the number of NLUs accessing mental health services and improve outcomes for those who engage in psychological therapy. This study suggests that NLU who do access psychological therapies may have experienced shame and stigma from family members or their community in doing so. Providing space for an individual from this community to address issues of stigma and validate anxieties about it is likely to be valuable in reducing dropout and facilitating a therapeutic alliance.

Clinical psychologists are trained across a number of therapeutic modalities and as such should be able to select the most appropriate intervention for each individual. The concept of *izzat*, which is prominent in Nepalese society and has been demonstrated in this study to be strongly linked to NLU intention to access professional support for mental health difficulties, relates to a culture based on collectivist ideas of community, groups and shared meaning. This could be argued to be in contrast to the Beckian ideas of a cognitive model of emotional dysfunction, relating to the self, the world and the future, which are more individualistically focused and dominate much of the psychological thinking in professional mental health services (Beck, Rush, Shaw, & Emery, 1979). In recognition of the emphasis on collectivism in Nepalese culture, it may be pertinent to select therapeutic interventions which are consistent with these ideas, such as systemic therapy, mindfulness based therapies or acceptance and commitment therapy.

4.3.5 Implications for future research with NLU populations.

As the first quantitative study examining attitudes towards help-seeking in the NLU population, the findings of this study provides valuable information which has implications for future research with NLU populations and potentially other South Asian populations.

In recruiting for this study, the researcher experienced difficulties in approaching the topic of mental health difficulties with this population. For example, on a number of occasions when introducing the research to potential participants, the researcher was met with apparent hostility or defensiveness e.g. one participant was keen to strongly deny that he had mental health difficulties and declined to participate despite an explanation that a non-clinical sample was being recruited. It appeared that for some individuals the perception that they were being approached because they had mental health difficulties caused shame. The occasions when recruitment worked

best were when potential participants were approached through trusted members of the community, or community organisations who endorsed the research. Similarly, when the researcher approached participants in their first language, Nepalese, individuals often appeared to be more willing to engage in a discussion about participation.

These findings have implications for future research with this population, particularly mental health research which is likely to evoke shame or provoke hostility. In order to effectively and culturally acceptably recruit NLU to research, the findings of this study would point to the need for a cultural bridge between researchers and the community population i.e. to recruit through community organisations or through obtaining the backing of trusted community figures in order to circumnavigate the stigma which may be attached to mental health difficulties.

4.4 Strengths and limitations of this study

This study was the first UK study to directly examine the help-seeking intentions and beliefs of NLU. As such, it has a number of strengths which mean that this research makes a significant contribution to the evidence base. However, a number of methodological limitations must also be considered in discussing the findings of this study. These strengths and limitations will be considered in turn.

4.4.1 Sampling methods

This study has several significant strengths in terms of the recruitment of participants. Firstly, a strength of this study was that questionnaires were distributed in both Nepalese and English languages, allowing for individuals who did not speak English to participate in the study, resulting in the collection of a more representative sample than studies recruiting only English speakers (e.g. Pilkington et al., 2011). Research which focuses only on English speaking participants is likely to gather a significantly skewed sample in terms of education levels and acculturation. Conclusions drawn from such research are therefore likely to further bias the research against the parts of the BME communities which are least likely to access services.

A further strength of this study is the sample size which was able to be collected despite the significant stigma within this community of the topic being researched. Furthermore, recruitment from non-clinical or NHS settings allowed the researcher to reach participants who may lack trust in, or be fearful of services. To the researcher's knowledge this is the only study of its kind to ask NLU directly about mental health issues and service access. This may be partly reflective of the difficulties faced when raising these issues amongst the Nepalese community and in finding individuals willing to participate. The researcher approached non-English speaking participants in Nepalese which may have meant that individuals felt more able to participate. However, sampling bias may have been introduced in the recruitment of

only those individuals who felt comfortable enough to participate in a study relating to a highly stigmatising topic. It is possible that as a result, a more highly educated and acculturated sample has been recruited. Alternatively, willingness to talk about the topic being addressed may have influenced the responses given by participants who were ashamed or afraid of a lack of confidentiality.

A further selection bias may have been introduced through the use of a self-report written questionnaire. When recruiting for this study, the researcher observed on a number of occasions, individuals who had agreed to participate struggling to complete, or failing to indicate responses on any of the items. On these occasions individuals were asked if they needed assistance or were given the option of discontinuing. This observation is in keeping with that of Bhui (2001), who details examples of research participants who pretended to read self-report measures rather than admit illiteracy. In this study on occasions where significant sections of questionnaires were left blank, or an individual was asked to discontinue, data from these participants was excluded from the study.

A further limitation of this study was that 71% of the participants recruited were male. The convenience sampling technique used meant that many of the organisations which were recruited from were frequented mostly by males; this may skew the sample. There has been research to suggest that South Asian women experience particularly high levels of depression (Gater et al., 2009; Husain et al., 2011). Similarly, research has shown that healthcare access rates may differ significantly based on gender (see Raine, 2002 for a review). In this sample no significant gender differences were found in terms of the current prevalence of mental health difficulties or access rates. However it is possible that a sample including more females would have had a higher prevalence leading to different conclusions.

In this study, a large proportion of the participants had lived in the UK for 4 years or under (51%). As previously stated, a large number of NLU are Gurkhas, Gurkha veterans or family members of Gurkhas (Casey, 2010). In 2009, the 'Gurkha Justice Campaign' was successful in its attempts to campaign for the right to remain in the UK for all Gurkha veterans who served in the British Army before 1997 (Kochhar-George, 2010). Whilst only 18% of participants stated that their occupation was army, or ex-army, it is likely that many of the participants are affiliated with Gurkhas and thus moved to the UK following the passing of this law.

4.4.2 Statistical power

The original a-priori sample size calculation suggested that a sample size of 69 was required for an anticipated effect size of .25. When data collection was closed, a sample of 65 participants had been reached. A conservative anticipated effect size of .25 was chosen for this study in the absence of previous research which could be

used to base this decision on. Some of the hypothesised relationships between intention and potential predictor variables were weaker than expected in this sample. It is possible that the modest sample collected in this study lacked the statistical power required to measure the expected effect sizes.

4.4.3 The measures and study design

The use of a questionnaire design itself has both strengths and inherent limitations. Recruitment through the study used complementary online and paper questionnaire methods which maximised recruitment by reaching a wider geographical area online whilst allowing those without computer access to participate on paper. However, the response rates for postal and online surveys have often been demonstrated to be low and have been criticised for the potential non-response bias introduced by merit of the individuals choosing to respond doing so because they have a particular motivation or interest in the topic of research (Johansen, Rognerud, Sundet, & Aarø, 2012; Sica, 2006). It is likely that bias was introduced in this sample in this way. However, the introduction of bias in this way may also be true of face-to-face interview participants and given the limited budget and time frame for this study, the scope to recruit interpreters and collect a representative sample through interviewing would have been very limited.

A further methodological limitation of this study was the use of a cross-sectional as opposed to a longitudinal design. The use of a cross-sectional design in this study has benefits in terms of ease of administration, which, as discussed, allowed for data collection from a large number of participants in an under-researched population. However, the stability of the main study variables over time and the ability of this study to examine causal connections between the main study variables rather than to examine only associations was limited (Robinson, Schmidt, & Teti, 2005). This means that although hypotheses can be made about the causal nature of the relationships between significant predictors e.g. izzat and intention to seek professional help, it is not possible to ascertain from this cross-sectional study whether, for example, high levels of izzat lead to lower intention to seek professional help, or whether this relationship is mediated by another, or several other variables.

An advantage of the selection of measures which have been widely used across cultural groups such as the GHQ-12 and MDEMQ allows for inter-cultural comparisons to be made. However, the limitations of using measures which are not specifically designed for a Nepalese or NLU population may impact upon the findings of this study. Dinges and Cherry (1995) describe (using a five-point analysis from Good and Good, 1986) the cultural variations in the expression of mental health symptomology. They suggest that a number of variables impact upon how mental health difficulties are perceived. These include 'normative uncertainty' (i.e. assumptions within a particular culture about abnormal behaviour or symptomology which may inform cultural

interpretations of an individuals' mental health), 'centricultural bias' (i.e. the use of criteria defined by one culture to define mental health difficulties in another) and 'category validity' (i.e. the different cultural expression of symptomology assumed to be reflective of the same mental health 'disorder'). It is acknowledged that the use of non-culturally specific measures may mean that the validity of this study's findings can be questioned, in terms of the epistemology and cultural specificity of the measures.

Pilot interviews were conducted before the questionnaire was circulated in which a number of items contained within the standardised questionnaires were identified as being difficult to understand. The decision to retain the standardisation of the questionnaires by not removing or amending these items may have subsequently impacted on the ability of respondents to understand and answer these particular items. However, because most of the standardised measures used have not been validated with Nepalese individuals or NLU specifically, it is difficult to know the extent to which this may have impacted upon responses. There is a general dearth of research in the area of mental health for Nepalese and NLU and in particular, very few measures which have been validated for Nepalese populations, an exception, in this study, is the GHQ-12. In order to better understand the mental health needs of the Nepalese population and barriers to accessing services in the UK, there is a need for further validation studies of the relevant measures with NLU and Nepalese populations.

The internal reliability of all of the measures used was examined. The majority of the scales were found to have good reliability, with the exception of the acculturation measure, the Self-Administered Questionnaire of Acculturation, whose subscales had only moderate reliability (between .50 and .63). Additionally, the validity of this measure was brought into question (as discussed below) and therefore, any examination of the relationship between acculturation and intention to seek professional help should be interpreted with caution.

The acculturation measure used in this study, developed by Palmer et al. (2007) was the only existing measure of acculturation to have been validated with a South Asian population. The authors were not contactable regarding the use of this measure and the factor analysis information available in the published data indicated that some of the items within the measure did not have face validity when considered in the three subscales. Consequently, for the purposes of this study, items were entered into three subscales on the basis of content validity. However, correlational analyses of the three subscales indicated that there was no significant correlation between attitudes indicative of greater or lesser acculturation and either of the 'behavioural' subscales (behaviours suggesting greater acculturation and behaviours associated with the country of origin). The 'attitude' subscale of the acculturation measure included items which could be argued not to be particularly associated with acculturation. For example, the items "Do you fear racist attacks?" and "Do you fear being discriminated

against for a job because of your ethnic origin?” could be argued to be reflective of the geographical location of the respondent. It may be that there is a genuinely higher likelihood of experiencing racist attacks in some parts of the UK than others and as such, fearing racist attacks may be aptly justified, rather than reflective of an individual’s level of acculturation.

Another potential limitation of the measures used in this study may provide an explanation for the finding that there were no significant relationships between three of the ‘causal-belief’ categories (supernatural, Western-physiological, stress-related causal beliefs) and intention to seek professional help. The Mental Distress Explanatory Model Questionnaire (MDEM-Q; Eisenbruch, 1990) was used to examine the different explanatory beliefs which NLU held about the causes of mental illness in this study. This measure has been widely used in research relating to help-seeking attitudes in various cultural populations. However, in a number of studies (e.g. Gomez, 2007; Rose, 2010) including this study, strong correlations have been found between causal belief categories themselves. For example, in this study, ‘Western physiological’ and ‘Stress related’ causal beliefs were very strongly correlated, indicating that often participants held both views. It is possible that participants in this study held different causal beliefs about differing types of mental health difficulties e.g. seeing stress-related cause as being linked to depression but Western-physiological causes being linked to psychosis. Alternatively, participants may have held several causal explanations as playing a role in mental health difficulties. In this study the high correlations between the subscales suggest that an exploratory factor analysis of the items in the measure may not equate to the four subscales suggested by Eisenbruch (1990). This is likely to limit the validity of the measure in this study and further examination of the explanatory beliefs held amongst NLU communities is required to fully ascertain the impact that these have on help-seeking intentions.

4.4.4 Theoretical and epistemological considerations

This study examined the beliefs about causes of mental distress and the explanatory models which NLU hold about mental health difficulties. However, it was not within the scope of the study to examine the potential differences between Western and NLU cultures in terms of the definitions of what constitutes ‘mental illness’. The term ‘mental health difficulties’ has been used throughout this thesis in recognition of the potential flaws in diagnostic categorisation of ‘mental illness’ and ‘disorders’ (see Cooksey & Brown, 1998; Neimeyer & Raskin, 2000 for more indepth discussion). However, it is recognised that the majority of the measures used in this study are designed within a Western medical-model framework of ‘mental disorder’. This conceptual framework is inherently focused on Western cultural ideas about mental health difficulties and may therefore not fit with the conceptualisations held by many of the immigrant NLU population.

Many of the variables examined in this study as potential predictors of intention to seek professional help were not found to be significantly related to this variable. However, it is possible that the non-significant findings are related to the ability of participants to answer questions in relation to their attitudes towards seeking professional help, based on their knowledge of the existence of these professional health-care systems, or what seeking help would entail. For example, individuals who have access to within-culture resources for managing mental health difficulties (e.g. traditional healers such as tantrics, herbalists or palm-readers) may have lower motivation to seek professional help because they have culturally appropriate resources available, but also because they lack knowledge of the types of services potentially available. It may be that a sample with more second-generation NLU (i.e. individuals born in the UK and identifying themselves as Nepalese) may have been more able to answer questions relating to specific knowledge of the mental health services available; although this in itself would have limited the study in terms of level of acculturation of participants.

The TPB was used as a guiding framework for this study. However, the very limited research relating to the mental health of Nepalese and NLU individuals and complete dearth of research in relation to the TPB framework means that it is not possible to fully ascertain whether the use of this model is valid with this population. Furthermore, the limited number of individuals who reported actually accessing mental health services meant that only part of the TPB, namely the factors influencing intention, was examined. The second part of the TPB chain, i.e. the link between intention and actual service access was not examined in this study. This significantly limits the scope of this study to test the utility of the TPB model for this population.

4.5 Recommendations for future research

The findings of this research provide a good basis from which to understand the reasons why NLU might choose to access services and which factors might influence the decision to do so. However, as with any research, particularly a study in an area where there is limited existing research evidence, many questions are left unanswered. Further to a detailed understanding of the barriers and issues around service access in the NLU communities specifically, it may also be pertinent to conduct further intercultural research. This study forms part of a research base which aims to develop an understanding about the perceptions of different ethnic minority groups in the UK towards mental health and psychological services. Future research would benefit from joining the efforts of researchers studying individual cultural groups, to understanding these issues cross-culturally.

Due to the quantitative design of this study there are many questions which arise from the data collected which cannot be answered through the analyses conducted. What are the experiences of NLU who do access mental health services?

Do they experience shame and stigma in relation to their service access? What would need to change in order for those who experienced mental health difficulties but do not access services, to do so? Further research using a focus group or more qualitative research design would be better placed to explore these types of questions, to compliment and further the understanding developed through this study.

As discussed above, the ability to draw conclusions from this study regarding the general NLU population is limited by the demographics and characteristics of the sample collected. Some attempt to increase the heterogeneity of the population recruited may have been useful in helping to understand the factors which may impact on intention to seek professional help. For example, with a larger research budget and a Nepalese speaking research assistant, it would be possible for illiterate participants to be recruited. This would increase the likelihood of recruiting a more representative sample in terms of factors such as educational attainment, gender, and acculturation. Alternatively, future research which selects a sample based on a particular religious group (e.g. Hindus), caste or socio-economic category may serve to reduce the impact of intra-group diversity of the population recruited.

Bearing in mind the theoretical framework used to guide this research, a useful future line of research would involve the recruitment of a larger sample of individuals who have actually accessed mental health services. This would allow for a formal analysis of the second half of the causal chain i.e. the link between intention to carry out a behaviour and actually carrying out the behaviour. Recruiting participants from a population of NLU who reached clinical cut-offs for mental health difficulties may also be of merit, as the current data requires some speculation on the part of participants who were not currently experiencing mental health difficulties.

A number of the identified limitations of this study relate to the measures used. As discussed above, both the Self Administered Questionnaire of Acculturation (Palmer et al., 2007) and the Mental Distress Explanatory Model Questionnaire (Eisenbruch, 1990) have significant shortcomings, which are likely to influence the validity of the research conducted using them. Future research would benefit from conducting exploratory factor analyses for both of these measures, in order to ascertain the extent to which they are measuring the factors specified by the authors. Alternatively, it may be pertinent to design and validate more suitable measures in these areas, for South Asian populations.

There is a lack of statistical data for NLU generally which means that this study is also not able to compare figures for mental health services in the NLU population with access figures for other services in the UK. As such, it is not clear whether low access figures to mental health services are specific or whether they form part of a wider picture of underutilisation of this population in general. Further research would benefit from developing an understanding of whether NLU are less likely to access

services e.g. educational, physical health, social care, in general, or whether this is an issue mainly for mental health services.

The low numbers of NLU who reported accessing mental health services or having high intention to do so, mean that it is likely that most of the evidence-based treatments (EBTs) and guidelines used to inform UK mental healthcare services are not based on research using this cultural group. Miranda et al. (2005) suggest that ethnic minority groups are “largely missing from the efficacy studies that make up the evidence base for treatments...well-controlled efficacy studies examining outcomes of mental health care for minorities are rarely available”. Whilst there have been some studies examining the cultural appropriateness and efficacy of the UK’s most commonly used therapeutic modality, Cognitive Behavioural Therapy, for mental health difficulties in Nepalese populations (e.g. Halder and Mahato, 2012), there is not sufficient evidence involving NLU populations to suggest that those who access services would receive effective and culturally appropriate intervention. Future research is required to examine the effectiveness of psychological therapies and mental health service intervention in this community.

4.6 Summary and conclusions

This study aimed to understand the views of Nepalese people living in the UK (NLU) about the factors which would influence their intention to seek help for mental health difficulties. The research was conducted in the context of numerous calls for improved access to services for people from BME communities and specifically a dearth in research regarding NLU.

The key findings of this research related to an understanding that the prevalence of distress within the NLU population are comparable to the general population, but that mental health service access is considerably lower. This study explored factors which may be related to these low access figures, using the Theory of Planned Behaviour (TPB; Ajzen, 1985) to examine the predictors of intention to access mental health services. Izzat (a concept related to honour in terms of position within a community or family honour) was found to be the most significant predictor of intention, with those reporting higher levels of izzat significantly less likely to intend to seek help. Preliminary evidence for the association between factors such as acculturation, beliefs about the causes of mental distress and intention were found. However, further research would be required to fully understand these associations.

As the first study of the factors relating to intention to access services in this population, many questions are left unanswered and there is plentiful opportunity for further research. Firstly, a qualitative study to complement the knowledge gained in this study would be useful in understanding the complex relationships between the variables measured and the real life experiences of those NLU who have accessed, or felt unable to access mental health services. Secondly, a number of the measures used

in this study (namely the MDEMQ: Eisenbruch, 1990; and the SAQA: Palmer et al., 2007) have a variety of shortcomings and further research would benefit from exploring the utility of these measures, or devising new measures for South Asian populations. Without budget restrictions, a larger sample size, including more individuals who had experience of mental health difficulties would allow for detailed examination of the predictors of actual help seeking.

A number of important clinical implications were raised from the findings of this study. Firstly, at policy and legislative levels, more emphasis on ensuring that the Nepalese nationality is recognised as a separate group within healthcare documentation would ensure that this population can begin to be specifically served. At a service and healthcare professional level, the finding that izzat is particularly significant in determining whether a NLU will intend to access services should be considered in order to provide culturally sensitive care for individuals who access services. Furthermore, involving community members and providing outreach for the NLU is likely to be particularly important in reaching out to a community within which stigma against mental health difficulties is pervasive.

5. References

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6. Appendices

Appendix 1: Description of literature searches

1.2 Access of immigrants originating from South Asia to Mental Health Services in the UK.

Database Searched	Date Searched	Search terms and settings used	Number of results
Web of Knowledge	17.07.13 07.05.14	Topic=(help-seeking OR "Service-use") AND Topic=("mental health" OR psycholog* OR Depression OR Anxiety OR Psychosis) AND Topic=(BME OR Culture OR Asia* OR migrant OR immigrant OR Nepal* OR India*)	1,368 Excluded Under 18, studies of non ethnic minority populations.
Key paper reference searching from above search		Papers relating to mental service access in ethnic minority populations from Asia or models of help-seeking in these populations.	
Google scholar	14.11.13 17.11.13 04.12.13 07.15.14	Mental health + access + Asian,	>100,000 – scanned for particularly relevant articles

1.3 Mental Health access for individuals of Nepalese origin

Database Searched	Date Searched	Search terms and settings used	Number of results
Web of Knowledge	05.12.12	Title=(Nepal*) AND Title=(Mental Health)	17
Google scholar	09.10.13	Nepal + mental health	45,200 – scanned for relevant articles.
Key paper reference searching from above searches		Papers relating to mental health services and views about mental health difficulties in Nepal or papers relating to Nepalese individuals in the UK.	
Grey literature searching – literature from Nepali organisations in the UK (through Google)	28.01.13	Papers relating to mental health provision or help seeking for Nepalese individuals the UK.	

1.4 Models of help seeking for mental health difficulties and 1.5 Theoretical framework for this study.

Database Searched	Date Searched	Search terms and settings used	Number of results
Google Scholar	24.11.13 07.15.14	health + help-seeking + models + systematic review	20,900 – scanned for particularly relevant articles.
University of Hertfordshire Library	12.12.13 07.15.14	In library catalogue – “Ajzen” “predicting health behaviour”	15 + 14
Cochrane Library	31.13.13 07.15.14	“Theory of Planned Behaviour”	103
Key paper and reference searching from above searches		Papers relating to the key help-seeking models and the Theory of Planned Behaviour.	

1.6 Factors influencing access to mental health services.

1.6.1 Beliefs about the causes of mental health difficulties

Database Searched	Date Searched	Search terms and settings used	Number of results
Web of Knowledge	06.01.14 07.15.14	Title=(“explanatory model”) AND Title = (mental)	29
PubMed	06.01.14 07.15.14	(Explanatory model[Title]) AND mental[Title]	8
PubMed	06.01.14 07.15.14	(somatisation[Title]) AND Asia*[Title]	1
Key paper and reference searching from above searches		Papers relating to the key explanatory models of mental health difficulties, somatisation etc.	

1.6.2 Shame/Izzat

Database Searched	Date Searched	Search terms and settings used	Number of results
Google Scholar	07.01.14 07.15.14	Izzat + Nepal	455 –scanned for relevant articles.
Google Scholar	07.01.14 07.15.14	Izzat + Mental Health + Nepal	156 – scanned for relevant results
Web of Knowledge	07.01.14 07.15.14	Title=(asian) AND Title=(stigma)	13
Key paper and reference searching from above searches		Papers relating to stigma and mental health, izzat and south Asians or Nepalese individuals	

1.6.3 Acculturation

Database Searched	Date Searched	Search terms and settings used	Number of results
Web of Knowledge	11.01.13 08.05.14	Topic=(acculturation) AND Topic=(south asian) AND Topic=(mental health services research)	5
Google scholar	11.01.13 08.05.14	acculturation + south asian + mental UK	29,000 – scanned for relevant results
Key paper and reference searching from above searches		Papers relating to the impact of acculturation on help-seeking	

Appendix 2: Information Sheet for Participants.



INFORMATION SHEET FOR PARTICIPANTS

Introduction

People from Nepal who now live in the United Kingdom are being invited to take part in this research study. The study is looking at what Nepalis think about mental illness and looking for help for mental health problems. Before you decide to take part in the study please take time to read this information which is written to help you understand why the research is being carried out and what it will involve.

What is the purpose of the study?

This study is looking at what Nepali people living in England believe causes mental health problems and what types of help they would be likely to seek if they had a mental health problem. We do not know from why Nepali people are less likely to seek help from mental health service. This is important to help us to understand what type of support Nepali people in the UK would like or not like to use when mental health problems arise.

What is involved?

If you decide to take part you will be asked to complete a set of questionnaires which should take you about 20 minutes to complete. Please complete the questionnaire by yourself. The questionnaires will ask you about your beliefs about the causes of mental health problems. It will also ask what you think about seeking different forms of help in the event of experiencing a mental health problem.

If you are happy to, you can also answer questions about your own (or family members/friends') experiences of mental health problems and seeking help.

You will also be asked for some information about yourself such as your age, where you are from, your level of education and occupation. You will not have to give any information which would allow us to recognise who you are.

Who is taking part?

This study will include Nepalis living in the UK. They must be over 18 years of age.

The researchers

The research is being carried out by Anna Thake, Trainee Clinical Psychologist. She has spent 6 years living in Nepal, speaks some Nepali and has a particular interest in studying mental health in the Nepali community.

The study is supervised by Dr Nick Wood and Dr Barbara Mason, Senior Clinical Tutors & Chartered Clinical Psychologists, University of Hertfordshire.

Do I have to take part?

No. If you do not want to take part, or you change your mind *at any time* you do not need to give a reason. You can tell me at any time if you want to stop taking part, or for me to remove your answers to the questionnaire.

What do I have to do?

If after reading this information sheet you would like to take part in the research, you will be you will need to sign the consent form. Once you have completed the questionnaires you can send them back to the researcher in the stamped addressed envelope provided with the questionnaires (or if you are completing online, simply complete the online survey). You will also be given a de-briefing sheet, describing the study again in case you have any questions after you have completed the questionnaires.

Will taking part be confidential (private)?

Yes. If you do decide to take part, you will not be asked to put your name or any other information on the questionnaires which means we would be able to recognise you. Instead each questionnaire is given a unique number before it is given out to participants. Completed questionnaires will be kept securely and will only be accessible to the researcher. The overall findings of the project may be published in a research paper, but no individual and their details will be identifiable.

What will happen to the results of the study?

The overall results of the study will be written up as a thesis for the requirements of the Doctorate of Clinical Psychology at the University of Hertfordshire. It is expected that the study will be written up and submitted for publication in a relevant psychology research journal. As stated previously, no individual and their details will be identifiable in written or published material.

What are the benefits of taking part?

Taking part in this study may not benefit you personally. However, it is hoped that this research will help develop a greater understanding of how Nepali people living in the UK think about mental health problems. This is relevant to everyone in the Nepali community, as everyone, at some point in their lives, may be affected by, or know someone close to them, who experiences emotional/psychological problems.

What if I have questions or concerns?

If you have any further questions about the research, please feel free to contact the Researcher, Anna Thake via email, telephone or post, details of which are below. In the unlikely event that participating in this research causes you distress in some way, please do not hesitate to contact the researcher who will be able to advise you on where you may be able to access further help.

Who has reviewed this study?

The study has been reviewed and approved by University of Hertfordshire, Health and Human Sciences ECDA.

Thank you for taking the time to read this information sheet.

Contact details of the researcher:

Name: Anna Thake

Email address: a.m.thake@herts.ac.uk

Telephone number: 01707 286322

Postal address: Doctorate of Clinical Psychology Training Course
University of Hertfordshire
College Lane Campus
Hatfield
Hertfordshire
AL10 9AB



CONSENT FORM

Name of researcher: Anna Thake, Trainee Clinical Psychologist

1) I have read information sheet for this research and understand it. I have been able to ask questions about taking part in this research and they have been answered.

(Please tick box)

2) I understand that I do not have to take part in this research study and that I can stop taking part at any time. This will not affect my healthcare or legal rights.

(Please tick box)

3) I agree to take part in the research.

(Please tick box)

Please remember that all of your responses are private and confidential. We will not know which person has given which answers.

However, if you wanted your answers to be withdrawn from the study at a later time we need to be able to identify your answers. Please create a code below that will allow us to identify and remove your answers. Your code should be unique to you, created by using the first three letters of your first name, and the first three letters of the town you were born in.

For example, if your name is 'Prakash' and the town name was 'Kathmandu', your unique code would be 'parka'

My unique code is:

Appendix 4a: Personal Background Questionnaire

University of
Hertfordshire



PERSONAL BACKGROUND QUESTIONNAIRE

a) Gender: Male Female Other (tick the box which applies to you)

b) Age (in years): _____

c) Which city/town do you live in?:(please write)_____

e) What is your first language? (please write)_____

f) If you were not born in the UK, what is your country of origin? (please write)_____

g) How long have you lived in the UK for?

Less than 1 year

1-4 years

5-10 years

Over 10 years

h) How would you describe your marital status? (Tick all the boxes which apply to you)

Single

In a relationship

Married

Divorced/Separated

Widowed

Other (please write)_____

i) Do you have children? (Please tick the appropriate box) Yes No

j) Level of education

How many years of school did you complete?:

None

Less than 1 year

1-5 years

5-10 years

10-12 years

More than 12 years

What is your highest educational qualification:

None

GCSE or equivalent

A Level or equivalent

Undergraduate degree (BSc, BA or equivalent)

Masters degree (MSc, MA or equivalent)

PhD, (Doctorate or equivalent)

Other (please specify)

k) What is your occupation? (please write)

Appendix 4b: The Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)

The Inventory of Attitudes Toward Seeking Mental Health Services

Mackenzie, Knox, Gekoksi, & Macaulay (2004)

The term “*professional*” refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term “*psychological problems*” refers to reasons one might visit a professional. Similar terms include *mental health concerns, emotional problems, mental troubles, and personal difficulties*.

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

- | | Disagree | Agree |
|---|----------|----------|
| 1. There are certain problems which should not be discussed outside of one’s immediate family..... | [0 | 1 2 3 4] |
| 2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.. | [0 | 1 2 3 4] |
| 3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems.. . . | [0 | 1 2 3 4] |
| 4. Keeping one’s mind on a job is a good solution for avoiding personal worries and concerns. | [0 | 1 2 3 4] |
| 5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.. | [0 | 1 2 3 4] |
| 6. Having been mentally ill carries with it a burden of shame. . . | [0 | 1 2 3 4] |
| 7. It is probably best not to know <i>everything</i> about oneself.. | [0 | 1 2 3 4] |
| 8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy. | [0 | 1 2 3 4] |
| 9. People should work out their own problems; getting professional help should be a last resort. | [0 | 1 2 3 4] |
| 10. If I were to experience psychological problems, I could get professional help if I wanted to.. | [0 | 1 2 3 4] |
| 11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems.. | [0 | 1 2 3 4] |
| 12. Psychological problems, like many other things, tend to work out by themselves..... | [0 | 1 2 3 4] |

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

- | | Disagree | Agree |
|--|----------|-------|
| 13. It would be relatively easy for me to find the time to see a professional for psychological problems..... | [0 | 4] |
| 14. There are experiences in my life I would not discuss with anyone..... | [0 | 4] |
| 15. I would want to get professional help if I were worried or upset for a long period of time..... | [0 | 4] |
| 16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it. . . . | [0 | 4] |
| 17. Having been diagnosed with a mental disorder is a blot on a person's life. | [0 | 4] |
| 18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting to professional help.. | [0 | 4] |
| 19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention.. | [0 | 4] |
| 20. I would feel uneasy going to a professional because of what some people would think. | [0 | 4] |
| 21. People with strong characters can get over psychological problems by themselves and would have little need for professional help. | [0 | 4] |
| 22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family. | [0 | 4] |
| 23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up." . . . | [0 | 4] |
| 24. I would be embarrassed if my neighbour saw me going into the office of a professional who deals with psychological problems.. | [0 | 4] |

Appendix 4c: Attitudes Toward Mental Health Problems (ATMHP)

Attitudes Towards Mental Health Problems

(Gilbert et al. 2007)

We are interested in people's thoughts and feelings about mental health problems. As you may know, some people suffer from mental health problems such as depression and anxiety. These can make it difficult to cope with everyday life. Depressed people can feel tired, not enjoy life, want to hide away and may withdraw from family life. Below are a series of statements about how you, your community and your family may think about such problems. Read each statement carefully and circle the number that best describes how much you agree with each statement.

Please use the following scale:

0 = Do not agree at all; 1 = Agree a little; 2 = Mostly agree; 3 = Completely Agree

Attitudes towards Mental Health Problems

For this first set of questions please think about how your community and family view mental health problems such as depression and anxiety with a difficulty to cope in everyday life.

- | | | | | | |
|----|---|---|---|---|---|
| 1. | My community sees mental health problems as something to keep secret | 0 | 1 | 2 | 3 |
| 2. | My community sees mental health problems as a personal weakness | 0 | 1 | 2 | 3 |
| 3. | My community would tend to look down on somebody with mental health problems | 0 | 1 | 2 | 3 |
| 4. | My community would want to keep their distance from someone with mental health problems | 0 | 1 | 2 | 3 |
| 5. | My family see mental health problems as something to keep secret | 0 | 1 | 2 | 3 |
| 6. | My family see mental health problems as personal weakness | 0 | 1 | 2 | 3 |
| 7. | My family would tend to look down on somebody with mental health problems | 0 | 1 | 2 | 3 |
| 8. | My family would want to keep their distance from someone with mental health problems | 0 | 1 | 2 | 3 |

External Shame/Stigma Awareness

For the next set of question please think about how *you* might feel if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life.

- | | | | | | |
|-----|---|---|---|---|---|
| 9. | I think my community would look down on me | 0 | 1 | 2 | 3 |
| 10. | I think my community would see me as inferior | 0 | 1 | 2 | 3 |

- | | | | | | |
|-----|--|---|---|---|---|
| 11. | I think my community would see me as inadequate | 0 | 1 | 2 | 3 |
| 12. | I think my community would see me as weak | 0 | 1 | 2 | 3 |
| 13. | I think my community would see me as not measuring up to their standards | 0 | 1 | 2 | 3 |
| 14. | I think my family would look down on me | 0 | 1 | 2 | 3 |
| 15. | I think my family would see me as inferior | 0 | 1 | 2 | 3 |
| 16. | I think my family would see me as inadequate | 0 | 1 | 2 | 3 |
| 17. | I think my family would see me as weak | 0 | 1 | 2 | 3 |
| 18. | I think my family would see me as not measuring up to their standards | 0 | 1 | 2 | 3 |

Internal Shame

For the next set of questions please think about how *you* might feel about yourself if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life.

- | | | | | | |
|-----|--------------------------------------|---|---|---|---|
| 19. | I would see myself as inferior | 0 | 1 | 2 | 3 |
| 20. | I would see myself as inadequate | 0 | 1 | 2 | 3 |
| 21. | I would blame myself for my problems | 0 | 1 | 2 | 3 |
| 22. | I would see myself as a weak person | 0 | 1 | 2 | 3 |
| 23. | I would see myself as a failure | 0 | 1 | 2 | 3 |

Reflected Shame 1

For the next set of questions we would like you to think about how you might feel if *you* suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life. This time consider how worried or concerned you would be on the impact on your family.

- | | | | | | |
|-----|--|---|---|---|---|
| 24. | My family would be seen as inferior | 0 | 1 | 2 | 3 |
| 25. | My family would be seen as inadequate | 0 | 1 | 2 | 3 |
| 26. | My family would be blamed for my problems | 0 | 1 | 2 | 3 |
| 27. | My family would lose status in the community | 0 | 1 | 2 | 3 |
| 28. | I would worry about the effect on my family | 0 | 1 | 2 | 3 |
| 29. | I would worry that I would be letting my family's honour down | 0 | 1 | 2 | 3 |
| 30. | I would worry that my mental health problems could damage my family's reputation | 0 | 1 | 2 | 3 |

Reflected Shame 2

For the next set of questions we would like you to think about how you might feel *if one of your close relatives* suffers from mental health problems such as depression and anxiety with a difficulty to cope in everyday life. This time consider how worried or concerned you would be on the impact on you.

- | | | | | | |
|-----|---|---|---|---|---|
| 31. | I would worry that others will look down on me | 0 | 1 | 2 | 3 |
| 32. | I would worry that others would not wish to associated with me | 0 | 1 | 2 | 3 |
| 33. | I would worry that my own reputation and honour might be harmed | 0 | 1 | 2 | 3 |
| 34. | I would worry that if this were known I would lose status the community | 0 | 1 | 2 | 3 |
| 35. | I would worry that others might think I might also have a mental health problem | 0 | 1 | 2 | 3 |

Appendix 4d: General Health Questionnaire – 12 (GHQ-12)

General Health Questionnaire

(Goldberg, 1970)

We want to know how your health has been in general over the last few weeks. Please read the questions below and each of the four possible answers. Circle the response that best applies to you. Thank you for answering all the questions.

Have you recently:

1. Been able to concentrate on whatever you are doing

- 0. better than usual
- 1. same as usual
- 2. less than usual
- 3. much less than usual

2. Lost much sleep over worry

- 0. not at all
- 1. no more than usual
- 2. rather more than usual
- 3. much more than usual

3. Felt that you are playing a useful part in things

- 0. more so than usual
- 1. same as usual
- 2. less so than usual
- 3. much less than usual

4. Felt capable of making decisions about things

- 0. more so than usual
- 1. same as usual
- 2. less so than usual
- 3. much less than usual

5. Felt constantly under strain

- 0. not at all
- 1. no more than usual
- 2. rather more than usual
- 3. much more than usual

6. Felt you couldn't overcome your difficulties

- 0. not at all
- 1. no more than usual
- 2. rather more than usual
- 3. much more than usual

7. Been able to enjoy your normal day to day activities

- 0. more so than usual
- 1. same as usual
- 2. less so than usual
- 3. much less than usual

8. Been able to face up to your problems

- 0. more so than usual
- 1. same as usual
- 2. less so than usual
- 3. much less than usual

9. Been feeling unhappy and depressed

- 0. not at all
- 1. no more than usual
- 2. rather more than usual
- 3. much more than usual

10. Been losing confidence in yourself

- 0. not at all
- 1. no more than usual
- 2. rather more than usual
- 3. much more than usual

11. Been thinking of yourself as a worthless person

- 0. not at all
- 1. no more than usual
- 2. rather more than usual
- 3. much more than usual

12. Been feeling reasonably happy, all things considered

- 0. not at all
- 1. no more than usual
- 2. rather more than usual
- 3. much more than usual

Appendix 4e: Self-Administered Questionnaire of Acculturation (SAQA)

Self-Administered Questionnaire of Acculturation

Palmer et al. (2007)

1. Below are a list of languages which you may speak. For each please indicate with a tick if you are able to understand, speak, read or write the language. (please tick all that apply).

	Understand	Speak	Read	Write
English
Nepali
Hindi
Urdu
Gurung
Other (please specify)			

2. What is that main language you use (please tick all that apply).

	At home	with friends	with neighbours	work
English
Nepali
Hindi
Urdu
Gurung
Other (please specify)			

3. Which of the following best describes your religious affiliation?
(Please tick all that apply)

Not religious	<input type="checkbox"/>	Christian	<input type="checkbox"/>
Muslim	<input type="checkbox"/>	Hindu	<input type="checkbox"/>
Sikh	<input type="checkbox"/>	Buddhist	<input type="checkbox"/>
Other (please specify)		

4. Do you see Britain as your "home"? Yes No

If no which country would you describe as your "home" (please specify)

- | | | | |
|-----|--|-----|----|
| 5. | Do you feel part of British society? | Yes | No |
| 6. | Do you see your future as secure? | Yes | No |
| 7. | Do you fear racist attacks? | Yes | No |
| 8. | Do you fear being discriminated against for a job because of your ethnic origin? | Yes | No |
| 9. | Do you fear being denied opportunities at work because of your ethnic origin? | Yes | No |
| 10. | Do you fear loss of cultural identity for yourself? | Yes | No |
| 11. | Do you fear loss of cultural identity for your children/future children? | Yes | No |
| 12. | In the past year have you celebrated any Nepali festivals? | Yes | No |

13. In what languages are the television programmes/videos/films you usually watch and the radio stations you regularly listen to? (please tick one box only)

- | | |
|---|--------------------------|
| Don't watch television/videos/films or listen to the radio. | <input type="checkbox"/> |
| Nepali/Hindi or South Asian languages only | <input type="checkbox"/> |
| Mostly Nepali/Hindi or South Asian languages | <input type="checkbox"/> |
| Nepali/Hindi or South Asian and English languages equally | <input type="checkbox"/> |
| Mostly English language | <input type="checkbox"/> |
| Only English language | <input type="checkbox"/> |

14. In what languages are the newspapers you regularly read?
(please tick one box only)

- | | |
|---|--------------------------|
| Don't read newspapers. | <input type="checkbox"/> |
| Nepali/Hindi or South Asian languages only | <input type="checkbox"/> |
| Mostly Nepali/Hindi or South Asian languages | <input type="checkbox"/> |
| Nepali/Hindi or South Asian and English languages equally | <input type="checkbox"/> |

Mostly English language

Only English language

15. What type of clothing do you wear at home? (please tick only one box)

Traditional Nepali/ Asian clothing Western style Clothing Western and Nepali/Asian clothing Equally

16. What type of clothing do you usually wear outside the home? (please tick only one box)

Traditional Nepali/ Asian clothing Clothing

Western style Clothing

Western and Nepali/Asian Clothing Equally

17. Thinking about where you are living at the moment, please indicate below who you live with. (Please tick as many boxes as apply)

I live alone I live with my parents

I live with friends I live with my partner/spouse

I live with my children I live with my in laws

I live with my grandparents

I live with other members of my family (not listed above)

Appendix 4g: Mental Distress Explanatory Model Questionnaire (MDEMQ)

Mental Distress Explanatory Model Questionnaire

(Eisenbruch, 1990)

Many people suffer mental distress at some time in their lives. Such distress can be mild or severe.

People can experience and manifest mental distress in many ways. Sometimes they feel sad or anxious. Sometimes they are unable to cope. Or sometimes they are out of touch with what is going on around them. They may have experiences of strange beliefs. Sometimes their behaviour becomes disorganised. They may become destructive towards themselves or others. Please think about how, any person, including yourself, might suffer mental distress and imagine what you might regard as the causes. There are no right or wrong answers; for each item, please tick how likely it is that each of the listed causes could contribute to mental distress:

	<i>Not at all likely</i>	<i>Unlikely</i>	<i>Neither likely or unlikely</i>	<i>Likely</i>	<i>Highly likely</i>
1. Bad experiences during childhood					
2. Exposure to a fright or shock					
3. Doing the wrong thing during pregnancy					
4. Contact with something or someone taboo					
5. Movement wind/drafts/gas/milk/air flowing through the person's body					
6. Bad luck or chance					
7. Conflict with family or friends					
8. Physical illness					
9. Someone unwittingly casting a spell e.g. the evil eye					
10. Genetic or inherited defect					
11. Bad or ominous dream					
12. Doing the wrong thing when menstruating					
13. Dangerous unprovoked spirit					
14. Effects of old age					
15. Eating food that is wrong for the person (not socially forbidden food)					
16. Person's karma (what happened to him/her in previous lives)					
17. Vital organ disrupted e.g. liver/blood/bone					
18. Pace of "modern life"					
19. Contact with something or someone unclean, contagious or polluted					
20. Body out of balance or harmony (e.g. yin/yang, hot/cold)					
21. Seeing, hearing or feeling something ominous					

	Not at all likely	Unlikely	Neither likely or unlikely	Likely	Highly likely
22. Person's soul leaving the body temporarily or becoming scattered					
23. Brain damage or head injury					
24. Unemployment					
25. Astrological destiny					
26. Break up of family or a failed relationship					
27. Someone wanting to hurt a person, engaging a witch/shaman to cast a spell					
28. Failure to properly observe rituals after giving birth					
29. Not having enough money					
30. Chemical imbalance in the brain					
31. Someone wanting to hurt a person by casting a spell					
32. Doing something forbidden by social or cultural rules					
33. Bad nerves in the body					
34. Spirit who was angry because someone did wrong					
35. Being harmed intentionally by another person					
36. Birth control against the religion or culture					
37. General life stress or trauma (e.g. grief)					
38. Too much work or study					
39. Having had an accident					
40. Migration to a new country					
41. Being born this way, e.g. inheriting bad/weak/low/cold blood					
42. Death of a relation or close friend					
43. Infection					
44. Bad or ominous sensations					
45. Being hot (but not from fever or weather)					

Appendix 4f: Experiences of Help-Seeking Questionnaire (EHSQ)

Experiences of Help-Seeking Questionnaire

1. Many people have either experienced their own emotional and psychological problems and/or know somebody else who has had these difficulties. Have you ever experienced emotional/psychological problems? (please tick the appropriate box)

Yes No

2. During the next set of questions you will be asked to think about either your own experiences of emotional/psychological problems or someone well known to you who has had these difficulties. Your answers will not be shared with anyone. Please indicate what you feel comfortable with by ticking the appropriate box:

I will answer the following questions in relation to my own experiences

I will answer the following questions in relation to a person well known to me

I do not wish to answer any further questions (go straight to the bottom of Page 14)

3. What kind of problems did you/person you know experience (e.g. reliance on alcohol, difficulties sleeping, unable or unwilling to eat, excessive worrying, etc.)? Write down a brief description of the problem and/or its formal name if you know it (e.g. anxiety, panic attacks, phobia, post-natal depression, anorexia, etc.)

4. Did you/they want to get help for these issues? (please tick the appropriate box)

Yes No Do not know

5. What help or advice did you/they seek?

Tick all boxes which apply:

- a) Support from friends
- b) Support from family
- c) Support from GP
- d) Psychiatrist
- e) Prayer
- f) Psychologist
- g) Counsellor/Therapist
- h) Social worker
- i) Asian mental health organisation/service
- j) Other (please write): _____

6. If you/they did not seek help or advice, why do you think this was?

Tick all boxes which apply:

- a) Didn't want to burden others with difficulties.
- b) I/they felt ashamed.
- c) I/they hoped the problems would go away on their own.
- d) I/they felt embarrassed.
- e) I/they worried what friends and family would think.
- f) I/they did not want to bring shame on the family/community.
- g) I/they did not know where to find help
- h) I/they thought that the problem was not bad enough
- i) I/they thought that the help or advice would not be useful
- j) Other reason/s (please write): _____

7. If you/they sought help, what was recommended? (please tick all the boxes which apply)

Tick all boxes which apply

- a) Counselling or psychotherapy in NHS
- b) Private psychotherapy
- c) Support group within Asian mental health organisation
- d) Support group in NHS /non-Asian organisation/service
- e) Medication
- f) Regular outpatient attendance (e.g. at psychiatric clinic)
- g) Admission to hospital
- h) Social worker
- i) Other (please write): _____

8. What services or help did you/they eventually use?

Tick all boxes which apply

- a) Support from friends
- b) Support from family
- c) Support from GP
- d) Saw a psychiatrist
- e) Prayer
- f) Asian mental health organisation/service
- g) Attend NHS mental health services (e.g. Community Mental Health Team)
- h) Counselling or psychotherapy in NHS
- i) Counselling or psychotherapy within Asian mental health organisation
- j) Support group within Asian mental health organisation
- k) Private psychotherapy

- l) Support group in NHS /non-Asian organisation/service
- m) Medication
- n) Admission to hospital
- o) Advice/involvement of social worker
- p) Other (please write): _____

9. Were there any services/sources of help that you/they would have used but were not available?

10. Were there any services offered that were recommended to you or the person that you/they decided not to take up? (please tick the appropriate box)

Yes No Do not know

11. If yes, what were the reasons given for not taking up the services offered?
(please tick all boxes which apply)

- a) Service not available
- b) Did not wish to use the service offered
- c) It did not suit your/the person's life style
- d) It was not culturally or religiously appropriate

e) Other (please write): _____

12. If you did use services, overall, how did you/they feel about the services received? (please tick the appropriate box)

- a) Very positive
- b) Positive
- c) Neither positive or negative
- d) Negative
- e) Very negative

If you wish, please write any further comments you have about how you/they felt about the services/help that was accessed:

**You have now reached the end of the questionnaire.
Thank you helping with the research.**



**Factors Influencing Beliefs about Mental Illness and Attitudes
Towards Seeking Help Among Nepalis Who
Live in the United Kingdom.**

DEBRIEF SHEET

**** PLEASE READ ONLY WHEN YOU HAVE COMPLETED THE QUESTIONNAIRES ****

Thank you very much for making this study possible!

The purpose of the study is to understand how Nepali people living in the UK think about mental illness and seeking different forms of help (e.g. friends, family, doctor, religious leaders, etc) in the event of experiencing a mental health problem.

We know that there are many things that may affect someone's decision to access mental health services. These include differences in people's beliefs about the causes of mental illness, stigma and the influence of social networks, i.e. friends and family. The researcher has not found any studies in the UK which look at which of these things predict whether a Nepali living the UK is likely to seek help if they had a mental health problem

It is hoped that this research will lead to a greater understanding of the way in which people think about mental health problems which may provide useful information for services who work with the Nepali community in the UK to develop more culturally appropriate help and support.

If you would like to access the overall findings of the study once it is completed and written up, please feel free to contact me (Anna Thake), either via email, post or telephone:

Name: Anna Thake

Email: a.m.thake@herts.ac.uk

Telephone number: 01707 286322

Postal address: Doctorate of Clinical Psychology Training Course

University of Hertfordshire, College Lane Campus

Hatfield, Hertfordshire, AL10 9AB

It is possible that by participating in this study has made you aware of your own mental health concerns. If you feel that you need to discuss these issues further you can access the following sources of support:

- **Your local GP**

- **City Hindu Network.**

78 Pall Mall

London

SW1Y 5ES

Telephone: 07775 823348

- **Rethink - Asian Mental Health Helpline**

5th floor

Royal London House

22-25 Finsbury Square

London

EC2A 1DS

Telephone: 020 8800 7494

Fax: 0808 800 2073

Website: www.rethink.org.

- **MIND - The national mental health charity**

Telephone: 0845 7660163

Website: www.mind.org.uk

- **The Samaritans**

Telephone: 08457 90 90 90.

Appendix 6. Scoring procedures for missing items on measures.

Demographic questionnaire and Experiences of different forms of help and support questionnaire.

For any items unclear or missing, this data was simply not recorded.

Missing item on the Inventory of Attitudes Towards Seeking Mental Health Services, Attitudes Towards Mental Health Problems Scale and the Mental Distress Explanatory Model Questionnaire.

If less than 4 items were missing, a mean of all other scores was taken and this mean score was entered into any missing item. If more than 4 items were missing, the measure was not scored and counted as missing data.

Missing items on the SAQA

If less than 4 items were missing, the item was scored as a 0 and total scores were recorded accordingly. If more than 4 items were missing, the measure was not scored and counted as missing data.

Appendix 7: Ethical Approval Certificate

UNIVERSITY OF HERTFORDSHIRE
HEALTH AND HUMAN SCIENCES

MEMORANDUM

TO Anna Thake

CC Nick Wood

FROM Dr Richard Southern, Health and Human Sciences ECDA Chairman

DATE 18 July 2013

Protocol number: LMS/PG/UH/00102

Title of study: Factors Influencing Beliefs about Mental Illness and Attitudes Toward Seeking Help Among Nepalis Who Live in the United Kingdom

Your application for ethical approval has been accepted and approved by the ECDA for your school.

This approval is valid:

From: 18 July 2013

To: 31 December 2013

Please note:

Approval applies specifically to the research study/methodology and timings as detailed in your Form EC1. Should you amend any aspect of your research, or wish to apply for an extension to your study, you will need your supervisor's approval and must complete and submit form EC2. In cases where the amendments to the original study are deemed to be substantial, a new Form EC1 may need to be completed prior to the study being undertaken.

Appendix 8: Application for Ethical Approval

UNIVERSITY OF HERTFORDSHIRE

FORM EC1: APPLICATION FOR ETHICAL APPROVAL OF A STUDY INVOLVING HUMAN PARTICIPANTS

(See Guidance Notes)

Relevant ECDA:	
	<input type="checkbox"/>
Science & Technology	<input type="checkbox"/>
Health & Human Sciences	<input type="checkbox"/>

OFFICE USE ONLY
Protocol :

Office Use only		Date Received by Clerk:	
Expedited Review			
Approved by Reviewer 1 (<i>sign & date</i>)		Approved by Reviewer 2 (<i>sign & date</i>)	
Further Action: (tick appropriate box and provide details)			
Request Further Information	<input type="checkbox"/>	<u>Details:</u>	
Refer for Substantive Review	<input type="checkbox"/>		
Refer for Full review	<input type="checkbox"/>		
Reject	<input type="checkbox"/>		
Substantive Review			
Approved by Reviewer 1 (<i>sign & date</i>)		Approved by Reviewer 2 (<i>sign & date</i>)	
Approved by Reviewer 3 (<i>sign & date</i>)		Approved by Reviewer 4 (<i>sign & date</i>)	
Further Action: (tick appropriate box and provide details)			
Request Further Information	<input type="checkbox"/>	<u>Details:</u>	

Refer for Full review		
Reject		
Full Review		
Request Further Information		<u>Details:</u>
Reject		
CONFIRMATION OF APPROVAL		
<p>[To be completed by the Chairman or Vice-Chairman of the relevant ECDA, or by the Chairman of the University Ethics Committee –(see GN 2.1.4)]</p> <p>I confirm that this application has been approved by or on behalf of the committee named below.</p> <p>Name/Sign.....Date.....</p> <p>Name of committee</p>		

DECLARATIONS

DECLARATION BY APPLICANT (See GN 2.1.3)

- (i) I undertake, to the best of my ability, to abide by accepted ethical principles in carrying out the study.
- (ii) I undertake to explain the nature of the study and all possible risks to potential participants, to the extent required to comply with both the letter and the spirit of my replies to the foregoing questions (including information contained in Appendices 1 & 2).
- (iii) Data relating to participants will be handled with great care. No data relating to named or identifiable participants will be passed on to others without the written consent of the participants concerned, unless they have already consented to such sharing of data when they agreed to take part in the study.
- (iv) All participants will be informed (a) that they are not obliged to take part in the study, and (b) that they may withdraw at any time without disadvantage or having to give a reason.

Where the participant is a minor or is otherwise unable, for any reason, to give full consent on their own, references here to participants being given an explanation or information, or being asked to give their consent, are to be understood as referring to the person giving consent on their behalf. (See Q 19 above; also GN Pt. 3, and especially 3.6 & 3.7)

Enter your name here.....Anna Thake.....Date.....10.07.13.....

If you are a member of staff, please obtain the signature of your line manager to indicate their agreement to this application:

.....
(Signature) (Name in BLOCK CAPITALS and position within the School)

DECLARATION BY SUPERVISOR (see GN 2.1.3)

I confirm that the proposed study has been appropriately vetted within the School in respect of its aims and methods as a piece of research; that I have discussed this application for Ethics Committee approval with the applicant and approve its submission; and that I accept responsibility for guiding the applicant so as to ensure compliance with the terms of the protocol and with any applicable ethical code(s).

Enter your name here.....Dr Nick WoodDate...10.07.13...

Instructions for Applicants

Applicants are advised to read the Guidance Notes before completing this form. Use of this form is mandatory [see UPR RE01, SS 7.1 to 7.3]. Your School may choose to add additional School specific questions in a separate appendix to the Form EC1. Please clarify with your Supervisor whether your School has chosen to append any extra questions.

Approval must be sought **and granted** before any investigation involving human participants begins [UPR RE01, S 4.4(iii)].

Abbreviations

GN=Guidance Notes

UPR=University Policies & Regulations

Q=Question

S=Section

SS=Sections

Pt=Part

PLEASE NOTE: Where alternative answers are offered, put a cross in the appropriate box.



For example: YES

Where a "write in" answer is requested, begin in the space provided below the question and continue as necessary. **All questions must be answered. Please answer in BLACK.**

1. THE STUDY

Q1. Please give the title (or provisional title) of the proposed study. (NB – you will be asked for further details later)

Factors Influencing Beliefs about Mental Illness and Attitudes Toward Seeking Help Among Nepalis Who Live in the United Kingdom.

2. THE APPLICANT

Q2. Please answer **either Q2.1 or Q2.2** by providing the information requested. **Q2.1** should be answered by individual applicants, both staff and students, who require protocol approval for work which they themselves intend to carry out. **Q2.2** should be answered by academic staff requiring approval for standard protocols governing classroom practical work (or equivalent work) to be carried out by a specified group of students. (See GN 2.2.1& 2.2.19)

Q2.1. Name of applicant/(principal) investigator

Miss Anna Thake

Status:

(a) undergraduate

(b) postgraduate (taught/research)

(c) academic staff

(d) other - please give details here

School/Department

Psychology

Programme of study or award (e.g. BA/MSc/PhD/Staff research)

Doctorate of Clinical Psychology

E-mail address

a.m.thake@herts.ac.uk

Name of supervisor

Dr Nick Wood

Supervisor's contact details (email, extension number)

n.1.wood@herts.ac.uk

01707-284767

Q2.2. Class Protocol Applications Only.

Name of applicant/(principal) investigator (member of staff)

School/Department

Programme of study or award (e.g. BSc/MA)

Module Title

Year/group to be governed by the protocol

Number of students conducting the study

Programme Tutor (if different from the applicant)

E-mail address

Please note: Risk Assessment Form EC5 is mandatory for all Class Protocol Applications and must accompany this application.

3. DETAILS OF THE PROPOSED STUDY

Q3. (a) Is it likely that your application will require NHS approval? (See GN 2.2.2)

YES

NO

YES, please answer **(b)&(c)** (If NO, please continue on to **Q4**)

(b) Please confirm whether your research involves any of the following:

NHS Patients

Clinical trial of an investigational product

Clinical trial of a medical device

Exposure to any ionising radiation

Adults who lack the capacity to consent

Human Tissue

(c) Please confirm whether this study is considered to be a Clinical Trial of Investigational Medical Products (CTIMP) or Clinical Trial of Investigational Medical Devices. (See GN 2.2.2)

Y

NO

If YES, please indicate if the study involves any of the following categories:

Children under 5

Pregnant women

A group of more than 5,000 people

Study would be undertaken overseas

If your study is likely to require NHS approval or is a Clinical Trial of Investigational Medical Products or Devices, DO NOT complete this form any further and submit it to your relevant ECDA at this stage. All NHS applications must be made on an IRAS form. If your study is a Clinical Trial of Investigational Medical Products or Devices involving one of the above specified categories, you will be contacted by the relevant ECDA with information on the next steps. Please note, you will be issues with a UH Protocol Number but this will not be valid until you have sent your relevant ECDA a copy of your NHS approval.

Q4. Please give a short synopsis of your proposed study; stating its aims and highlighting, if appropriate, where these aims relate to the use of human participants. (See GN 2.2.3)
Please enter details here.

The purpose of the study is to investigate the beliefs of individuals of Nepali origin currently living in the UK (NLU) towards seeking help for mental health problems. Access to mental health services by individuals of Black and Ethnic Minority (BME) origin is known to be low and those who do access services have poorer outcomes and experience lower service satisfaction than individuals from a white British background (Sashidharan 2003). However, limited research or data exists examining NLU's understanding of and attitudes towards mental health difficulties and accessing services. Casey (2010) suggests that this lack of data is a significant barrier to research or policy making for NLU.

Although research in the area of mental health difficulties or service access with Nepali populations is very limited, a number of studies using ethnically diverse populations have investigated the factors influencing help seeking behaviours and attitudes towards professional help seeking for mental illness. For example, Sheikh and Furnham (2000) found that causal beliefs of mental illness significantly predicted attitudes towards professional help seeking in British Asian and Pakistani populations. Studies of South Asian populations have also suggested that factors such as shame or stigma, acculturation to

the current country of residence, sex, level of religious belief and level of education impact on intentions and attitudes towards accessing mental health services (Pilkington et al., 2011, Sheikh and Furnham 2000). Furthermore, Fung and Wong (2007) found that perceived accessibility of services (e.g. the likelihood of being allocated a mental health worker from a similar cultural background) was the most significant predictor of attitudes towards professional help-seeking in South Asian women.

There are currently no existing studies to the researcher's knowledge, which have examined the attitudes of NLU towards mental illness and seeking professional help or which have investigated the role of stigma, acculturation, or demographic factors in predicting help-seeking attitudes and behaviours. The present study will therefore aim:

- To explore NLU intentions to seek professional help for mental health problems, including psychological therapy.
- To establish (if NLU are willing to divulge such information) whether attempts to access mental health services have been made.
- To examine whether demographic factors relate to intentions to access mental health services.
- To examine how factors such as beliefs about the causes of mental illness, influence of community and close others, preferences for accessing alternative sources of support and attitudes towards seeking professional help, relate to intentions to access mental health services.
- To establish, using a modified version of the Theory of Planned Behaviour (TPB: Ajzen, 1985), which of the above factors are the strongest predictors of intention to seek professional help.

It is hoped that this research will lead to a greater understanding of the way in which NLU think about mental health problems which may provide useful information for services who are working to provide more culturally appropriate support for individuals from this community with mental health difficulties. A full proposal of rationale behind the study, aims, design and methodology can be found in Appendix 7.

Q5. Please give a brief explanation of the design of the study and the methods and procedures used, highlighting in particular where these involve the use of human participants. You should clearly state the nature of the involvement the human participants will have in your proposed study and the extent of their commitment. Thus you must complete and attach the Form EC6 (Participant Information Sheet) (see Appendix 2). Be sure to provide sufficient detail for the Committee to be clear what is involved in the proposed study, particularly in relation to the human participants. (See GN2.2.4)

The study will use a non-experimental research design, which will involve a survey of NLU using questionnaires. A copy of the survey can be found in Appendix 5. Consultation with an NLU working in the mental health field has been conducted and changes made accordingly. The survey will be piloted with up to 5 Nepalis known to the researcher following the receipt of ethical approval, particularly in relation to the length and understandability of the language used. The process of translation of the survey into Nepali is currently underway. The following questionnaires will be used:

1) Demographic variables – Personal Background questionnaire

A questionnaire will be designed to gather information about demographic variables including age, sex, current location, marital status, level of education, occupation etc. Participants will be self-selected and the researcher will have little control over the demographics of respondents. Therefore, this information will be used to describe the characteristics of the population being studied.

2) Attitudes towards help-seeking

The Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) devised by Mackenzie, Knox, Gekoksi, & Macaulay (2004) will be used to assess attitudes towards accessing professional help for psychological problems. The overall score indicates an individual's attitudes towards accessing mental health services should they develop symptoms of mental illness. There is research demonstrating the reliability and validity of this questionnaire using immigrant Asian populations samples e.g. (David, 2010; Pilkington, Msetfi, & Watson, 2011).

3) Subjective norms – a measure of shame (Izzat)

There is a significant literature documenting the links between shame or stigma and intention to access mental health services. 'Izzat' is a term which is linked to the notion of shame in South Asian culture and is used to describe a learnt, complex set of rules an Asian individual follows in order to protect the family honour and keep his/her position in the community (Gilbert, Gilbert and Sanghera 2006). Within Nepali culture, there is significant stigma towards mental health difficulties, with fear and shame that recognised mental illness may impact on status within a community, marriage prospects and bring shame upon the family, (Jha, 2012). A number of studies have examined the impact of izzat on intention to access mental health services in South Asian populations (Anand and Cochrane, 2005, Chew-Graham, Bashir, Chantler, Burman and Batsleer, 2002).

According to the TPB, subjective norm refers to the individual's perception of the expectations of close others (individuals or groups) and his or her intention to conform to these expectations (Fishbein & Ajzen, 1975). A measure of attitudes towards mental health, particularly measuring the construct of izzat, will be therefore be used to assess subjective norms in the NLU population. The Attitudes Towards Mental Health Scale (ATMHP: Gilbert et al. 2007) is a self-report measure which has been validated and normed with South Asian populations. The measure is divided into three constructs, internal shame (negative self-evaluation), external shame (belief's about other's negative views of individuals with mental health difficulties) and reflected shame (belief about the shame which can be brought to families or communities).

4) Beliefs about the causes of mental distress

In a country where there is a huge disparity in education, caste systems, religious and cultural observances it is likely that range of causal explanations for mental health difficulties by individuals from Nepal will also be large. The Mental Distress Explanatory Model Questionnaire (MDEMQ, (Eisenbruch, 1990)) is a 45 item, Likert-scale rated which identifies four clusters of explanations for mental distress: stress, Western physiological, non-Western Physiological, and Supernatural. Participants are asked to rate how likely each of the listed causes could contribute to mental distress on 5-point Likert scale from 'Not at all likely' to 'Highly likely'. The MDEMQ was designed to be applicable to individuals from any cultural background. Although it has not been specifically validated with NLU, it has been used in previous research to examine causal beliefs about mental distress in British Asians (Sheikh & Furnham, 2000) and has been shown to predict attitudes towards seeking professional help in East and South East Asian women (Fung & Wong, 2007).

5) Current level of psychological distress

In order to assess the impact of current levels of psychological distress on attitudes towards seeking professional help, the General Health Questionnaire-12 (GHQ-12) will be used. The GHQ-12 was devised by Goldberg (Goldberg, 1972) and its validity for use in a wide range of populations, including rural Nepali communities has been established (Koirala, Regmi, Sharma, Khalid, & Nepal, 1999). This measure will be used to examine whether an association exists between levels of distress and help-seeking behaviour.

6) Personal experience of accessing mental health services

It is anticipated that the number of respondents who will self-identify as having mental health difficulties is likely to be low. Therefore, this section of the survey will be optional. However, given that little is known about the reasons why low numbers of NLU access mental health services, obtaining information regarding the experiences of any respondents who have accessed services, alongside the other data collected in this survey, could begin to provide some information about the relationship between attitudes and actual attempts to access services.

The questionnaire will be devised for the purposes of this study and will aim to collect information

about whether the respondent has experienced mental health difficulties, which if any services were accessed and what the reasons behind non-access were. Expert consultation was conducted to identify some of the likely sources of support which NLU might access.

7) Acculturation

Acculturation has been described as “a process that involves one culture trying to adapt to another, usually the dominant culture”. A number of studies have documented the impact of acculturation of Asian populations on attitudes towards seeking psychological support, (Cheung & Snowden, 1990; Hamid, Simmonds, & Bowles, 2009). In South Asian samples, research has suggested that individuals with lower levels of acculturation are less likely to access services (Zhang & Dixon, 2003).

Acculturation will be measured in the present study using an adapted version of the 17 item questionnaire devised by Palmer et al. (2007). This questionnaire refers to aspects of acculturation such as clothing style, use of language and use of own-culture media. The questionnaire was specifically designed and validated for South Asian populations living in the UK (Palmer et al., 2007). Many of the items include the words “South Asian”, for example “In what language are the newspapers you regularly read? a) Don’t read newspapers, b) South Asian languages only, etc”. For these items, “South Asian” will be replaced with “Nepali” or “Hindi” (in recognition that much of the popular TV or music used in Nepal will be in Hindi).

Q6. Please give the starting date and finishing date. (For meaning of “starting date” and “finishing date”, see GN 2.2.5)

Starting date: 01/07/2013
Finishing Date: 31/12/2013

Q7. Where will the study take place? (If this is on UH Campus, who will permission be obtained from e.g. your Module Leader, Programme Tutor, Pro-Vice Chancellor (Student Experience) or the Dean of Students. If this is NOT on UH Campus, please attach a copy of the written permission, given by the proprietor, manager or other person with such authority over the premises, to use the premises for the purposes of carrying out this research(see Appendix 2) (See GN 2.2.6)

Please enter details here.

As the study is a survey design, which will be administered electronically or by post it will be run from the UH Campus. However, no formal research premises will be required.

Q8. If the location is off campus, have you considered whether a risk assessment is necessary for the proposed location?(in respect of hazards/risks affecting both the participants and researchers) Please see **Form EC5** (see Appendix 2, which is an example of a risk assessment form.)Please use this example if a risk assessment is necessary and you have not been provided with a subject specific risk assessment form by your School or Supervisor.
(See GN 2.2.7)

N/A

Q9.(a) Will anyone other than yourself and the participants be present with you when conducting this study?
(See GN 2.2.8)

YES NO

If YES, please state the relationship between anyone else who is present other than the applicant and/or participants? (e.g. health professional, parent/guardian)

(b) Will the proposed study be conducted in confidence? If NOT, what steps will be taken to ensure confidentiality of the participants' information. (See GN 2.2.8)

Confidentiality of all participants will be ensured by the anonymisation of survey responses. Only the researcher and supervisors will have access to completed survey data and all data will be stored on a password protected computer.

4. HARMS, HAZARDS & RISKS

Q10. Will this study involve invasive procedures on the human participants? (See GN 2.2.9)

No

(If YES, please fill out [Appendix 1 – Increased Hazards and Risks.& Q14](#))

(If NO, answer [Q11, Q12, Q13](#))

Once this is complete, move on to [Q15](#))

[Q1, Q12, Q13& Q14 - NON INVASIVE STUDIES ONLY](#)

Note: You are advised to read GN2.2.10, 2.2.11, 2.2.12 & 2.2.13 carefully before you answer the following questions.

1. Are there potential hazards to participant(s) and/or investigator(s) from the proposed study? (See 2.2.10)

YES NO

If YES,

(a) Indicate their nature here.

(b) Indicate here what precautions will be taken to avoid or minimise any adverse effects.

12. Will or could the study cause discomfort or distress of a mental or emotional character to participants and/or investigator(s)? (See NG2.2.11)

If YES,

(a) Indicate its nature here.

The survey is designed to collect information regarding mental health issues and attitudes towards accessing mental health services. It is possible that answering questions of this nature may highlight mental health issues or distress for respondents.

(b) Indicate here what precautions will be taken to avoid or minimise such adverse effects.

In order to ensure participants are able to seek help if any issues are raised by the completion of the survey, a debrief sheet will be provided (Appendix 6) which will include sources of support which participants could access should they feel they require some assistance with mental health issues.

Q13. Will or could medical or other aftercare and/or support be needed by participants and/or investigator(s) as a result of the study?(See GN 2.2.12)

YES NO

(a) If you have answered 'YES' to Q11, Q12 & Q13, please state here the previous experience (and/or any relevant training) of the supervisor (or academic member of staff applying for a standard protocol) of investigations involving the hazards, risks, discomfort or distress detailed in those answers. (See GN 2.2.13)

Dr Wood, Dr Mason and Miss Anna Thake have experience of working with individuals in distress in their professional capacity as Clinical Psychologist and Trainee Clinical Psychologist respectively. Miss Thake has several years' experience of working on a variety of clinical trials, which necessitated the reporting and processing of Serious Adverse Events or Reactions for which she has received training. Similarly, Dr Wood and Dr Mason have extensive experience both as a researchers and research supervisor on research studies with clinical and non-clinical populations who may experience distress as a result of participating in the research. Miss Maharaj, who will be Clinical Supervisor for this project has extensive experience working and conducting research with members of the Nepali community.

(b) Please describe in appropriate detail what you would do should the adverse effects or events which you believe could arise from your study, and which you have mentioned in your replies to the previous questions, occur.

(See UPR RE01, S 2.3 (ii) and GN 2.2.13)

As previously stated, a debrief sheet will be provided (Appendix 6) including sources of support which participants could access should they feel they require some assistance with mental health issues. Participants will also be provided with contact details for the researcher should they have any queries regarding their participation in the study.

5. ABOUT YOUR PARTICIPANTS

Q15. Please give a brief description of the kind of people you hope/intend to have as participants, for instance, a sample of the general population, University students, people affected by a particular medical condition, children aged 5 to 7, employees of a particular firm, people who support a particular political party.

Participant inclusion criteria will stipulate that respondents must be aged 18 or over, be self-defined as first generation Nepalis (i.e. a citizen of Nepal or formally a citizen of Nepal now with British citizenship. Respondents must have indefinite leave to remain in the UK (i.e. must be permanent residents).

Q16. Please state here approximately how many participants you hope will participate in your study.

It is anticipated that between 75-100 participants will be recruited.

Q17.By completing this form, you are indicating that you are reasonably sure that you will be successful in obtaining the number of participants which you hope/intend to recruit. Please outline here how you intend to recruit them. (See GN 2.2.14)

Participants will be recruited from Nepali communities using two methods. Firstly, the survey will be presented in electronic form using the Bristol Online Survey (BOS) software. This survey will be presented in Nepali and English language and will be sent to participants in the following places:

- Social media groups (e.g. Facebook groups)
- A 450 person database of potential Nepali research participants held by a Community Development Lead social worker in Reading, Berkshire.
- The primary researcher has approached a number of community organisations working with Nepali individuals in both Berkshire and Hertfordshire. These organisations have expressed an interest in distributing questionnaires to their members.
- The researcher has contacted a Gurkha organisation which may be willing to circulate surveys.

Secondly, the researcher will use a snowballing method to access Nepalis in the community. This will include approaching individuals known to the researcher, community centres, churches and professional contacts with access to Nepali individuals. These individuals will be given questionnaire packs and stamped-addressed envelopes to complete return to the researcher. Alternatively, the researcher will help participants to complete questionnaires in person if they require assistance or their level of literacy is low.

6. CONFIDENTIALITY AND CONSENT

[For guidance on issues relating to consent, see GN 2.2.15 &Pt. 3.]

Q18.Is it intended to seek informed consent from the participants?

YES NO

(See UPR RE01, S 2.3 & 2.4 and GN 3.1)

If NO, please explain why it is considered unnecessary or impossible or otherwise inappropriate to seek informed consent.

If YES, please attach a copy of the Consent Form to be used (See Form EC3 & EC4 for reference and GN 3.2), or describe here how consent is to be obtained and recorded. The information you give must be sufficient to enable the Committee to understand exactly what it is that prospective participants are being asked to agree to.

A copy of the consent form to be used is attached in Appendix 3.

Q19.If the participant is a minor (under 18 years of age), or is otherwise unable for any reason to give full consent on their own, state here whose consent will be obtained and how? (See especially GN 3.6&3.7)

Q20. Are personal data of any sort (such as name, age, gender, occupation, contact details or images) to be obtained from or in respect of any participant? (See GN 2.2.16)

YES

If YES,

(a) Give details here of personal data to be gathered, and indicate how it will be stored.

No identifying information (i.e. contact details, names etc.) will be collected. However, other personal data to be gathered will include: Age, gender, occupation, which will be helpful to contextualise the sample responses. All data will be stored on the researcher's personal password protected computer.

(b) State here what steps will be taken to prevent or regulate access to personal data beyond the immediate investigative team?

On receipt all survey responses will be entered into a purpose-designed database. Paper copies of the surveys will be held in a secure cupboard in a locked room within the Doctorate of Clinical Psychology department at the University of Hertfordshire. These will only be accessed by the researchers.

The computer database will be password protected and held on a password protected personal computer of the primary researcher. This will be accessed by the research supervisors as necessary.

(c) Indicate here what assurances will be given to participants about the security of, and access to, personal data.

The information sheet (Appendix X) will detail the anonymity and security of the personal data supplied. This informs participants that all data will be stored securely with the primary researcher and only accessed by the researchers.

(d) State here, as far as you are able to do so, how long personal data collected during the study will be retained, and what arrangements have been made for its secure storage.

Participant identifiable information will not be collected as part of this study. However, the data detailed in Q20 a) will be stored securely at the Doctorate of Clinical Psychology at the University of Hertfordshire for 5 years after the end of the study, whereupon it will be confidentially destroyed.

Q21. Is it intended (or possible) that data might be used beyond the present study? (See GN 2.2.16)

YES NO

If YES, please give here an indication of the kind of further use that is intended (or which may be possible).

It is anticipated that data from the study will be used to write a paper for publication in a peer-reviewed journal. Therefore, data will be kept in order that further analysis can be conducted as and if required.

If NO, will the data be kept for a set period and then destroyed under secure conditions?

YES

If NO, please explain here why not.

Q22. If your study involves work with children and/or vulnerable adults you will require a satisfactory Enhanced Criminal Records Bureau Disclosure. (See GN 2.2.17) Please indicate as appropriate:

(a) CRB Disclosure not required

(b) CRB Disclosure required and obtained

If a satisfactory CRB Disclosure is required, a copy of this must be attached to Appendix 2 in order for reviewers to be able to consider your application.

7. REWARDS

(a) Are you receiving any financial or other reward connected with this study? (See UPR RE01, 2.3)

YES NO

If YES, give details here.

(b) Are participants going to receive any financial or other reward connected with the study?

YES NO

If YES, give details here.

(c) Will anybody else (including any other members of the investigative team) receive any financial or other reward connected with this study?

YES NO

If YES, give details here.

8. OTHER RELEVANT MATTERS

Q24. Enter here anything else you want to say in support of your application, or which you believe may assist the Committee in reaching its decision.

APPENDIX 1 – INCREASED HAZARDS AND RISKS

This section is to be completed if your answer to Q10 affirms the **USE OF INVASIVE PROCEDURES** in your study.

Note: You are advised to read GN 2.2.10, 2.2.11, 2.2.12, 2.2.13 & 2.2.18 carefully before you answer the following questions.

Q1. Please give details of the procedures to be used (e.g. injection of a substance, insertion of a catheter, taking of a blood or saliva sample), and any harm, discomfort or distress that their use may cause to participants and/or investigator(s). (See GN 2.2.10)

(a) Indicate here what precautions will be taken to avoid or minimise any adverse effects.

Does your study involve the administration of any substance(s)? (See GN 2.2.10)

YES

NO

If YES,

(a) Give details here of the substance(s), the dose or amount to be given, likely effects (including duration) and any potential hazards to participant(s) and/or investigator(s).

(b) Indicate here what precautions will be taken to avoid or minimise any adverse effects.

QA3. Are there any potential hazards to participant(s) and/or investigator(s) arising from the use of the proposed invasive procedures? (See GN 2.2.10)

YES NO

If YES,

(a) Indicate their nature here.

(b) Indicate here what precautions will be taken to avoid or minimise any adverse effects.

QA4. Will or could the study cause discomfort or distress of a mental or emotional character to participants and/or investigator(s)? (See GN 2.2.11)

If YES,

(a) Indicate its nature here

(b) Indicate here what precautions will be taken to avoid or minimise such adverse effects.

QA5. Medical or other aftercare and/or support must be made available for participants and/or investigator(s) who require it where invasive procedures have been used in the study. Please detail what aftercare and/or support will be available and in what circumstances it is intended to be used. (See UPR RE01, S 2.3 (ii) and GN 2.2.12)

QA6. (a) Please state here previous experience (and/or any relevant training) of the supervisor (or academic member of staff applying for a standard protocol) of investigations involving hazards, risks, discomfort or distress as specified. (See GN 2.2.13)

(b) Please describe in appropriate detail what you would do should the adverse effects or events which you believe could arise from your study, and which you have mentioned in your replies to the previous questions, occur.

Q17. In the event that the study reveals that a participant has a pre-existing medical condition (of which they may or may not be aware), and which could affect their present or future health or that of others, they should be informed of this in an appropriate manner and advised of follow-up action that they should take. (See GN 2.2.18) Advice should be sought as to whether information should be passed to their GP and a decision taken whether they should be allowed to continue to take part in the study. If a potential participant is not willing to agree to such action being taken in these circumstances, they should not be allowed to take part in the study. Please indicate here what arrangements have been made for complying with these requirements.

Please revert to Q15.

APPENDIX 2 – DOCUMENTS TO BE ATTACHED

Please attach the following documents if you have affirmed possession of them in the relevant questions:

- (a) Permission from the location to be used to carry out this study (Q7)
(This includes permission to use a location on UH Campus and any location off of UH Campus which requires permission to use.)
- (b) Risk assessment for off campus location(See Form EC5)(Q8)
- (c) Copy of Consent Form (See Form EC3 & Form EC4)(Q18)
(Appendix 3)
- (d) Copy of Form EC6 (Participant Information Sheet)(Q5)
(Appendix 4)
- (e) CRB Disclosure (Q22)
- (f) A copy of the proposed questionnaire and/or interview schedule (if appropriate for this study). For unstructured methods, please provide details of the subject areas that will be covered and any boundaries that have been agreed with your Supervisor.(Appendix 5)

Additional documents attached:

Debrief sheet (Appendix 6)

Appendix 9. Power calculation

F tests – Linear multiple regression: Fixed models, R^2 deviation from zero

Analysis: A priori: Computer required sample size

Input: Effect size f^2 = 0.25
 α err prob = 0.05
Power ($1 - \beta$ err prob) = 0.80
Number of predictors = 8

Output: Noncentrality parameter λ = 17.25000000
Critical F = 2.0969683
Numerator df = 8
Denominator df = 60
Total sample size = 69
Actual power = 0.8061294

Appendix 10. Cross tables.

Cross tabulation of method of completion and Socio-Economic category.

Socio-Economic category	Method of completion		Total <i>n</i> (%)	χ^2	<i>df</i>	<i>P</i>
	Online <i>n</i> (%)	Community <i>n</i> (%)				
Lower occupational categories	11 (44)	20 (56)	31 (51)	0.79 (1)	1	.38
Higher occupational categories	14 (56)	16 (44)	30 (49)			
Total	25 (41)	36 (59)	61 (100)			

Cross tabulation of gender and level of distress (GHQ-12)

Gender	Level of distress (GHQ-12)			Total <i>n</i> (%)	χ^2	<i>df</i>	<i>P</i>
	Asymptomatic <i>n</i> (%)	Subclinically Symptomatic <i>n</i> (%)	Symptomatic <i>n</i> (%)				
Male	26 (76)	14 (78)	6 (46)	46 (71)	4.77	2	.09
Female	8 (24)	4 (22)	7 (54)	19 (29)			
Total	34	18	13	65 (100)			

Appendix 11. Scatterplots of intention to seek professional help and main study variables.

