

Mental Health and the Gujarati Communities:

A case study of Leicester

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Dedication

I dedicate this thesis to my Late Grandad, Jethabhai Patel, whose historical stories inspired me to pursue a journey in education. An admirable man, whom I miss enormously and I will always cherish the times we had together. This one's for you Dada, Love you always.

Abstract

This thesis explores the ways in which the Gujarati communities come to understand, experience and conceptualise 'mental health'. These were explored under the following categories: social, cultural, economic and institutional.

Ethnic inequalities and 'mental health' have been widely researched but explanations can provide a distorted picture for particular communities (Raleigh, 1995). Published information on measuring rates of inequalities focus use of services and wide categories such as 'South Asians' can be misleading in health research (Nazroo et al., 2002). Not only are current epidemiological studies problematic with the categories they utilise to group people together, but also using the medical model to define 'mental health' as a universally applied term indeed has its' pitfalls. The major one that is inherent to this thesis is the complex relationship culture and social factors has in contributing to understandings of 'mental health' and how they are managed. Therefore, the crux of this thesis explores practices and beliefs the Gujarati communities have that help 'mental health' management but also their limitations that constrain and restrict help-seeking from western health services. This research is informed by two key phenomena and the complex relationship between the two – 'mental health' and culture. There is an exploration of social processes such as culture and the range of identity and historical factors such as migration, family, social capital and religion to name a few. A Bourdieusian analytical framework is used, in particular his forms of capital; social, cultural and economic to illustrate how culture influences conceptualisations, experiences and management of 'mental health' and how culture contributes to the complexity that cuts across the universality/specificity binary of addressing 'mental health'.

Qualitative interviews with the Gujarati communities in Leicester were used to explore these issues. 35 interviews were conducted with first-generation Gujarati migrants and 15 were conducted with second generation Gujarati

migrants. These were all recorded, analysed using various thematic analytical techniques, analytic induction and cognitive mapping.

It is argued that, strong forms of social and cultural capital contribute to and strengthen cultural opinions of mental illness as 'mad', 'crazy' and 'slow'. Thus, these attitudes and understandings are lived realities for the Gujarati communities. However, it is also strong forms of social capital that contribute to potential 'mental health' problems due to the pressure of 'social obligations'. This entails, behaving in a certain manner that abides to and maintains acceptable norms in the Gujarati communities. Consequently, social and cultural capital are underlying factors that explain the stigmatized nature of 'mental health' and their help-seeking trajectories.

Additionally, the empirical data from my interviews has begun to demonstrate that attitudes towards 'mental health' are not as simple as being educated about it but rooted deeply in social and cultural practices, beliefs and traditions. Rightly so, Dogra et al. (2005) argues conceptualisations and expressions of 'mental health' can vary across cultures and thus these need to be considered when looking at ethnic groups. Additionally, due to the changing nature of cultures, continuous research is required to uphold suitable treatment and support for 'mental health'. Therefore, I argue that research that informs policy in this area, such as cultural components of 'mental health' needs to be inductive rather than deductive in nature.

Disclaimer

I hereby declare that this thesis is the production of my own original work. I have acknowledged all sources used directly and indirectly and have cited these in the form of references in text and a bibliography. I respect and fully abide by keeping my participants anonymised, and thus have utilised pseudonyms throughout this thesis.

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Glossary

Ah ghando varu che' - he is silly/mad.

Arti – A Hindu ritual which is part of worship and usually sang to conclude the particular worship.

Ayurveda – The traditional Hindu system of medicine which is based on the body being in a state of equilibrium and is balanced.

Bhagavad Gita – Ancient Hindu text, their holy book.

Bhagvan – God or Lord.

Dharma – Hinduism has different strands and people pray to specific Gods, and thus in its' broadest sense refers to religious affiliation.

Diwali – Hindu festival of light.

Ghando – Crazy, silly or mad.

Hanuman Chalisa – Hindu prayer.

Izzat – Honour, reputation, status or prestige.

Karma - The past determines the present which combined with the past determines the future. It is this idea that one can create good or bad

consequences in relation to their own decisions and actions. This does not only occur in this lifetime but across lifetimes and influences the process of reincarnation.

Kismet- Destiny, Fate.

Mandir – Hindu Temple.

Mansik Bimari – Mental Illness.

Mataji – This is a state when an individual becomes spiritually possessed, through religious songs, the spirit of the Goddess rises to certain individuals. The spirit results to dancing heavily, panting, screaming, chanting, singing and clapping hands. It is believed that this spirit will know what has happened in families both bad and good and people bow down to Mataji to receive blessings, as you would if you were praying.

Naat- Another word for Samaj.

Najar – This usually to refer individuals who have an 'evil eye' and put a curse on another individual and thus causes negative things to occur. It is assumed that certain people have a bad aura and the power to cause misfortune on others.

Navratri – A Hindu festival that is dedicated to the worship of Hindu Goddess Durga. The festival involves nine nights of dancing.

Pagal - Mad, crazy, insane or psycho.

Samaj – A Hindu society which traditionally was based on religion, location and occupation.

Chapter One: Introduction

I have always been rather studious, inquisitive and above all fascinated about how and why people form the opinions they have – including myself too. This interest increased the older I got. Primarily, because I was raised in a traditional, Indian family to very religious but liberal parents and home life was different to my school and work life. The disparity in opinions, practices and lifestyle in both these areas in my life is what sparked the array of questions I asked and continued to ask growing up. I still remember the time I asked a question about ‘mental health’ like it was yesterday. A few too many years ago, on a gloomy day, I was sat in my living room on my laptop doing some work – probably an assignment. The phone rang, it was a family friend wanting to speak to my mum. I could not help but overhear the conversation, not out of choice, but because it interrupted what I was doing. Whilst my mum continued to multi-task and fold some clean clothes that smelt of fresh linen, I wondered why was the phone on loudspeaker? The topics of conversation moved rather swiftly and fluidly, involving wellbeing of family members, TV shows and people. They spoke about someone, whom I did not know but the lady said, “he had become ‘ghando’ and does not go anywhere”. ‘Ghando’ refers to, and connotes words such as crazy and mad. I found it frustrating that my mum did not question her use of words and I found myself asking her: why did she say that? Why did you not say anything? He is ill, not mad there’s a big difference. But for me this was just the start of many similar instances. And, the continuation of the long list of questions: where do these opinions come from? Why is no one else surprised by these comments? What does this mean for people who have a mental illness? What does it mean for the community? Is this due to a distinctive culture? I could go on and on, but it is these questions that have resulted in the production of this research in the quest of making sense of the surrounding issues of the Gujarati communities and mental health; something very personal to me.

Thus, this thesis focuses on the ways in which the Gujarati communities in Leicester come to understand and conceptualise 'mental health'. It will also explore experiences of 'mental health' problems and how these are managed by taking help-seeking barriers (social, cultural, linguistic, economic and institutional) into consideration. The crux of this thesis explores practices and beliefs the Gujarati communities have that help 'mental health' management but also their limitations that constrain and restrict help-seeking from western health services. This research is informed by two key phenomena and the complex relationship between the two – 'mental health' and culture. It should be noted that when using the words 'mental health', these will be placed in inverted commas in recognition of the contested nature and difficulties in defining the term, which is further discussed below. Additionally, due to the cultural aspect of this thesis, there will be a consideration of what good and bad 'mental health' means in this context, which is the Gujarati communities. Therefore, no prior fixed definition has been utilised, but rather dictated by my participants, whom have been given a platform to express their own views on 'mental health' and practices surrounding its' management.

Thus, the purpose of this chapter is to provide a brief exploration of the ways in which these concepts are pivotal to this thesis and how they will be explored thoroughly, analytically and critically throughout the subsequent chapters.

Background of the study

Defining 'mental illness' is complex due to its' multi-faceted nature (Fernando, 2010). There are a variety of meanings across different professional groups, scientific disciplines and political agendas. The World Health Organisation (hereafter WHO, 2011) describes it as psychological ill health, mental disability and impairment, either developmental or by injury. However, mental illness, which can be viewed as a form of deviance or abnormality, differs on a cultural, social and political scale (Cox et al., 2004) which makes it a difficult phenomenon to define, measure and study. For instance, the WHO (2016) argues various social, psychological and biological factors contribute to an

individual's level of 'mental health' which is time dependent. Despite these difficulties, it is a vital domain of research that requires substantial attention because good 'mental health' is important for the well-being and functioning of individuals, and more broadly societies too. WHO (2016) defines 'mental health' as 'a state of well-being in which an individual realises his or own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community' (WHO, 2016).

Therefore, it is not surprising to propose that although 'mental health' is a personal experience, its presence has wider implications for societies; a prime reason why governments give significant attention to the ways in which mental illnesses can be kept to a minimal level and inequalities be eradicated (Cox et al., 2004). To provide further policy context, in 2011, the coalition government published a 'mental health' strategy setting out six key objectives for our health services (Department of Health, 2011). Despite the strategy being widely welcomed, there is an increase burden on inadequate services and worsening health provision and outcomes in recent years. Thus, 'mental health' is an area that requires further attention, and indeed the former Prime Minister acknowledged this. David Cameron sent out a press release on 11th January 2016, pledging a revolution in 'mental health' treatment, an area that is gaining increasing financial investment (Department of Health, 2016), to tackle the disappointing progression made in this area. Subsequently, 'The Five-Year Forward View for 'Mental Health' was published in February 2016 (Mental Health Taskforce, 2016) which sets out priority actions directed to the NHS for the next five years. It was formulated by the Independent Mental Health Taskforce which was formed in March 2015 and consists of healthcare leaders as well as service users. The report outlines 24 key recommendations that need to be achieved by 2020/2021 with a key focus on a 'fresh mind-set', a mind-set that places 'mental health' needs equally on par with physical health (Mental Health Taskforce, 2016).

The explicit attention given to 'mental health' is further heightened because 'mental health' problems are on the rise and it has been well documented that

at least one in four people will experience 'mental health' problems at some point in their lives (for e.g. see: WHO, 2001; McManus et al., 2009; Mental Health Foundation, 2016; Mind, 2016). Thus, 'mental health' problems emerge as a key priority for governments and health service providers due to arguably, the current epidemic nature of 'mental health' issues.

However, a major issue for the current health service is providing a service that is sensitive to various cultural and social needs. Historically, Psychiatrists have played a prominent role in setting the boundaries of 'mental health' and defining psychiatric disorders (Vega et al., 1991), due to the central function of medicine as an agency of social control to maintain order in society (Dingwall, 2001). This was done by the process of medicalization which converted the cultural view of madness into a coherent scientific entity (Skull, 1979). By the early twentieth century, psychiatry was fully accepted as a medical discipline that had the right to control 'mental health' and did so through diagnoses and treatment. However, the validity of addressing 'mental health' problems in this manner is questionable (Steadman, 1983). This is for two reasons (1) Diagnosis and treatment serve as a purpose of social control in society, rather than understanding illness on other scales such as social and cultural. (2) Hannay's (1979) 'symptom iceberg' refers to symptoms being ignored, tolerated or self-treated in communities and thus, on many occasions it is not even presented to the health systems to address or 'control'.

Although psychiatry has indeed developed since, to incorporate social factors as determinants that contribute to illness, it still views illness through a 'medical gaze' (Foucault, 1977), where social factors are not solely the causes but contribute or are an addition to genetic-biological factors that require diagnoses and treatment. As a result, medical sociology initially used the definition of 'mental health' as unproblematic because its initial premise was to explore characteristics of sick individuals rather than their position and interactions with communities, societies and institutions (Dingwall, 2001). Arguably, in doing so medical sociology has been limited albeit evolving now, in developing 'illness' as a social phenomenon, relying instead on medical

definitions as these were largely accepted in research. As Dingwall (2001) argues:

Since these bear no known relationship to the experience of sick people, they cannot advance our understanding of illness as a social conduct. Biology of illness is complementary to sociology of illness and in no way a substitute for it (p.23).

For that reason, both schools of thought need to be used collectively. Biology provides a distinctive perspective on the medical and scientific nature of illness, yet it is incomplete on its own. This is because social experiences of illnesses also contribute to its understanding. For instance, culture and social factors can contribute and shape the way in which individuals experience and deal with mental illness (Patel and Shaw, 2009) yet biological factors can also provide explanations of types of illnesses. Thus, using both schools of thought captures the dynamic and complex aspects of life that develops a more nuanced exploration and explanation of illnesses.

Thus, focusing solely on the medical model as a framework for explaining 'mental health' can be restrictive, problematic and indeed – it can offer us a limited account of an illness. Therefore, using such a framework in isolation of social explanations to provide definitions of 'mental health' raises questions in relation to its validity, especially if it disregards the contribution that disciplines such as sociology offer in understanding 'mental health'. Consequently, this thesis does not utilise a specific definition of 'mental health' but explores how the Gujarati communities come to understand and conceptualise 'mental health'.

The west prides itself on its scientific sophistication and an advanced system of medical treatment to combat ill health; but the question of 'mental health' is somewhat different, especially when considered cross-culturally (Fernando, 2010, p.2)

Thus, this thesis is located within the social and cultural exploration of 'mental health' from the Gujarati communities' perspectives. In the subsequent chapters it will become apparent that sociological explanations that take culture and social factors into consideration serve a key component in understanding 'mental health' in this context. Although there is no cross-cultural exploration in its purest form, Gujarati communities have differences in terms of migratory histories. This is because their culture has migrated to the UK and they live amongst differing cultures.

Therefore, this thesis will focus on exploration of the Gujarati communities' understandings, experiences and management of 'mental health', taking into consideration social and cultural factors. A case study approach is utilised of the Gujarati communities residing in Leicester, a city in the East Midlands. Gujarati is the second widely spoken language in Leicester with 11.5% of its population and home to the second largest Hindu community in the UK (2011 census). The Gujarati communities are being explored because they are unique amongst the South Asian category. They are twice migrants; from India to East Africa and then to Britain (Bachu, 1985; Patel and Shaw, 2009). This is interesting in relation to 'mental health' because a large body of research advocates that migration causes an increased risk of 'mental health' problems (Cochrane et al., 1977; Cochrane, 1983; Kuo et al., 1986; Beiser et al., 1993; Nevo et al., 2006). This is because migration can cause stress, isolation, change, fragmented family ties and difficulties in adapting to new surroundings and cultures.

Furthermore, the medical model in western societies' is used for measuring prevalence through definition and diagnosis. Primarily in the UK, the rates of mental illnesses rely upon the use of a statistical measure of the number of people using official health services. Psychiatric hospital admissions, GP consultations, referrals to psychiatric clinics and community surveys demonstrate a low prevalence of mental illness among Asian people compared to that of the white majority (Cochrane and Bhal, 1989; Raleigh, 1995; Berthoud and Nazroo, 1997). On the one hand, this pattern can arguably be seen as

unexpected because Asians tend to use services and consult their general practitioners more regularly for other issues than the white population (Berthoud and Nazroo, 1997). Thus, 'underreported' rates of mental illness amongst the Gujarati communities is being questioned (Patel and Shaw, 2009). Additionally, this suggests that an exploration of understandings and conceptualisations of 'mental health' is essential because influences help-seeking behaviours and management of 'mental health' in a western setting.

On the other hand, these findings are based on epidemiological studies which are concerned with the study of distribution and determinants of health-related states in defined populations. The purpose of these types of methodologies are to determine associations and causality of various social, environmental and social factors with health; and thus, prevent and control health problems (Last, 2001). This is a crucial phenomenon to study because as argued earlier, biology is limiting in exploring the relevance of social, environmental and economic factors that also contribute to disease. Consequently, the latter is not solely random or dependent on genetics, rather – biological, social and environmental factors simultaneously affect diseases among certain populations. Inequalities regarding ethnic groups and 'mental health' are well documented (Berthoud and Nazroo, 1997; Bhugra and Bhal, 1999; Rogers and Pilgrim, 2003). For instance, as mentioned above, people with origins in the South Asian sub-continent have been reported to have lower rates of mental illness than the white majority (Cochrane and Bhal, 1989), whilst Afro-Caribbean's are overrepresented. However, intervention can only be prepared when there is an understanding of how and why certain people experience mental illnesses and social epidemiology can provide this information. For example, social epidemiology can measure the relationships between certain factors such as ethnicity and 'mental health'. However, the dynamics of ethnic communities itself is diverse. There are a variety of languages, religion, types of cuisines, cultural practices, social norms and differing beliefs amongst various generations of migrants, to name a few. This

is difficult to capture using social epidemiological methodologies, which will be explored more in-depth in the next section.

What is social epidemiology and why is it used?

The methodology of social epidemiology is not a new one and its initial foundations can be traced back to the 19th century. Social epidemiology asks and seeks to capture ‘what effect do social factors, such as social structure, culture, or environment, have on individual and population health?’ (Hanjo, 2004, p.197). Its’ basic premise lays on the foundation that people’s health is affected by social conditions, including socio-structural factors. More specifically, these include social class, race/ethnicity, income distribution and social capital (Succer, 1973; Hanjo, 2004). Socio-structural factors contribute to differing levels of health and this is evident in social inequalities in health which has been widely documented. For instance, with reference to ‘mental health’ problems, people who are socially disadvantaged are more likely to suffer from mental illnesses (Fryers et al., 2003). Although Krieger (2001) has argued that social epidemiology has contributed massively to understanding the changing distributions of population health; there are limitations in the methodology contributing towards the field of ethnicity, culture and ‘mental health’. This is because of complexities in the relationships between them but also the differing understandings of ‘mental health’ as epidemiological methodologies require rigid conceptualisations. If concepts itself are in dispute with regards to definitions, then making correlations between these can be a difficult task, if not impossible. Therefore, epidemiological studies remain insufficient in conveying how dimensions of culture can impact upon both the way ‘mental health’ is understood and the way it is managed, in complex ways. Indisputably, social epidemiology has made much advancement in demonstrating critical social determinants of health but in-depth qualitative studies are required to explore the complex nature of perceptions of ‘mental health’ and how these consequently influence management.

Current problems with Epidemiological studies

The current prevalence of mental illness in the UK is measured according to reported illnesses. However, research such as epidemiological ones that use these statistics to explore correlations are problematic for many reasons. Firstly, these studies only account for the population that seek help from 'mental health' services and thus do not account for the untreated population (Nazroo, 1998). These findings can be challenged and do not illustrate valid mental illness prevalence as Anand et al. (2005) found and argue that institutional, linguistic and cultural barriers can prevent ethnic minorities from seeking help. "“Treated” prevalence, therefore, does not reflect the “true” prevalence' (Anand et al., 2005, p.201). If we work with these trends, we risk further studies being distorted and thus current epidemiological studies can be of limited use.

Secondly, these studies are also rooted in western psychiatric practice and do not account for cultural differences in experiences and somatic expression of mental illnesses (Kleinman, 1986). For example, it is commonly documented that Indian communities rely on non-allopathic Indian and traditional systems of medicine such as ayurveda (Nagai, 2008). Non-allopathic medicine is usually known as complementary or alternative medicine to the conventional system. Non-allopathic medicines rely on therapeutic approaches that include diet, herbs, minerals and generally non-drug therapies (Gogtay et al., 2002). Thus, prevalence rates could simply present differences in pathways to treatment rather than differences in rates of illnesses (Nazroo, 1998). Consequently, these problems with epidemiological studies outline that the present information on prevalence of mental illness among South Asian communities can be very inaccurate and potentially problematic.

Thirdly, epidemiological studies tend to classify South Asian groups as a homogenous community. This type of research on South Asian Diasporas is broad in terms of geographical reach, across nations and continents (Clarke et al., 1990). The South Asian grouping covers populations from Sri Lanka, India

and Pakistan to name a few (Nazroo et al., 2002). The concept of ecological fallacy draws upon the 'error of assuming that inferences about individuals can be made from findings relating to aggregate data' (Bryman, 2004, p.212). The issue here is that epidemiology as a method of studying 'mental health' approaches the field by focusing on constructed diagnostic categories for ease such as 'South Asian' rather than paying attention to the social context of people and their lived experiences (Nazroo et al., 2002). Additionally, this risks making cultural stereotypes (Burr, 2002), which has been argued by Cochrane (1983), to have a strong influence on perceptions, experiences and management of 'mental health'. Similarly, Bhugra and Bhal (1999) suggest that it is vital to differentiate ethnic minorities because:

cultures encompass a variety of different beliefs about 'mental health' and its origins, ranging from supernatural models (spirit intrusion, spirit possession, soul loss) to religious models (moral integrity, ethical conduct) and naturalistic explanations (principle of balance, yin and yang) (p.36).

There are competing cultural epistemological understandings in relation to certain practices. Epistemology refers to what constitutes knowledge and how this information is gained. In terms of culture, it is lived through our experiences, the communities we live in and the environments we are exposed to. Different ethnic communities will have differing epistemological understandings in terms of their own culture which can impact conceptualisations of 'mental health'. An example of this in the Hindu communities would be being possessed by Goddess Durga. During religious events, religious hymns can contribute to certain people being possessed by Goddess Durga, where they visibly lose control of their body and dance, devoting their whole self to the Goddess. In Hinduism, this is viewed as a gift from God which is considered as a blessing; however, other cultures may not understand this religious experience and view it as madness or insanity. Thus, confined cultural epistemological understandings contribute to

conceptualisations of 'mental health' and these are not captured in epidemiological studies.

As a result, epidemiological studies have assumed homogeneity according to demographic location but different communities have distinctive cultures because they vary in terms of several factors such as religion, language and class etc. (Anand et al., 2005). Consequently, the 'South Asian' category has been viewed as inappropriate, too wide and misleading to be useful in health research (Nazroo et al., 2002). It is also true that when categorising, simply distinguishing a country of origin such as India can also lead to ecological fallacy. For example, the Indian communities encompasses different religions (Hinduism, Sikhism, Islam and Christianity), a variety of languages (Gujarati, Hindi, Urdu and Punjabi) and different norms (alcohol is only forbidden in Gujarat). Therefore, 'mental health' studies overlooking prevalence rates among ethnic groups need to be culturally sensitive and consider its' complexity and role in shaping perceptions, behaviours and experiences (Weich and McManus, 2002). In saying this, I also acknowledge and accept that focusing Gujarati communities does not eliminate ecological fallacy but does narrow it and indeed it can affect any category, but the emphasis on this research is to illustrate how the Gujarati communities conceptualise 'mental health' and how it is addressed.

Additionally, Epidemiological studies have found that common mental disorders are significantly more frequent in socially disadvantaged populations (Fryers et al., 2003). Indicators of low levels of relative poverty that are used for measures of inequality are less education, unemployment, lower income, material assets, housing and family structures (Fryer, 1995; Pilgrim and Rogers, 2003). Middleton and Shaw (1999) suggest that the indicators of socio-economic status such as unemployment and housing present an unequal distribution in rates of admission to psychiatric hospitals and are used by the government to distribute resources of 'mental health' services (NHSE 1995 cited by Middleton and Shaw, 1999). However, these factors do not apply to the Gujarati communities who, on the whole, are middle class and show good

signs of upward social mobility (Bachu, 1985; Patel and Shaw, 2009). However, other studies have demonstrated other factors also affect rates of mental illness. These include discrimination in the forms of racism, homophobia and structures of patriarchy (Brown and Harris, 1978; Harris et al., 2006), lack of social support and social capital, migratory experiences, (Henderson et al., 1998), cultural practices (Cochrane, 1983) and life events. In essence, these factors come under broader category of 'social factors' and social capital which may be affecting the Gujarati communities in different ways. In this thesis, I utilise Bourdieu's (1985) construction of social capital which is 'the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual; acquaintance or recognition' (p.248). Therefore, current epidemiological studies risk overgeneralising a wide category and disregarding critical components that can have an impact on 'mental health'.

Additionally, epidemiology utilises predefined definitions of mental illnesses and compare these with other social determinants. However, psychological distress may not be perceived as a mental illness in ethnic groups because it could be a western ideology (Bui et al., 2002). Although there are various definitions of ideology, in this context it refers to 'if certain representation contributes to the support and maintenance of the existing institutional arrangements, power and social relations within a society, then they can be considered 'ideological' in nature' (Augoustinos, 1998, p.157). Marshall and Yazdani (2002) found that amongst South Asian women self-harm was not thought of as a problem but as a coping strategy for managing emotionally distressing situations. Therefore, if certain behaviours are not viewed as problematic then there is no need to seek help for them (Anand et al., 2005).

However, it should not be assumed that because inter-cultural meanings of mental illness are in dispute, that these meanings are unproblematic within a western environment (Fenton et al., 1996). For example, if depression means something different in Gujarati cultures, these need to be explored in a western context as they are addressed largely by a health system built upon western

principles. Consequently, the medical model ignores social influences on mental illness and does not consider differences in cultural beliefs because the medicalization of mental illness has occurred in a western setting. Therefore, culture is too complex and dynamic to be used in Epidemiology to determine patterns and causality. As it has been argued, culture encompasses a variety of beliefs (Bhugra and Bhal, 1999) which are difficult to define as one entity that could be used as comparable factors which epidemiology seeks to do. Thus, this thesis is asking questions about the universality and/or the cultural specificity of emotions and their interpretations. Additionally, albeit explored in detail in the subsequent chapters, I will illustrate that sadness; depression and isolation do exist in the Gujarati communities but may be given different labels. This will reveal the complexities that cut across the universality/specificity binary that requires closer attention.

Purpose of study

My thesis addresses the crucial problematic issues outlined above which overlooks the importance of culture in shaping an understanding of the nature of 'mental health' (Cochrane, 1983; Patel and Shaw, 2009). In that sense, culture is understood in the broadest sense that is applied to ethnicity and identity and refers to a mixture of behaviour cognition arising from 'shared patterns of belief, feeling and adaptation which people carry in their minds (Leighton and Hughes, 1991, p.447). Furthermore, inequality regarding 'mental health' and ethnicity is an area of concern and more so with the growing ethnic population in Britain requires scrutiny. According to the 2011 census data, Indians are the largest ethnic group from the 'South Asian' category after the white majority, with an increase of 1.4 million people between the 2001 and 2011 census. Bhugra and Bhal (1992) argue that explanations for the increased or under-representation of mental illnesses among ethnic groups need justification to improve services.

Consequently, this study will address two key issues: the meaning of 'mental health' and how this can impact 'mental health' management amongst the

Gujarati communities in Leicester. The focus on one ethnic group will, to some degree, not only minimise the consequences of ecological fallacy but it will also allow for a thorough exploration of the possible influence culture has on 'mental health'. With regards to the latter, the thesis will explore the following broad areas:

1) *The meaning of 'mental health'*

As argued above, mental illness has undergone the transition from culturally being viewed as madness and criminal to a medical entity, a process more commonly known as medicalization (Skull, 1979; Conrad and Schneider, 1992). Foucault (1973; 1977) advocates that medical social control permits situations to be viewed through a 'medical gaze' (Conrad, 1992, p.216), which allows psychiatrists to legitimately govern its activities (Freidson, 1970). Thus, psychiatric categories of mental illness are bound to professional psychiatric theory and practice that occurs in the West.

Psychiatry must learn from anthropology that culture does considerably more than shape illness as an experience; it shapes the very way we conceive of illness. A true comparative cross-cultural science of illness must begin with this powerful anthropological insight (Kleinman, 1977, p.4).

In that sense, there are two opposing perspectives of 'mental health': a universalist position puts forward that mental illness can be defined in a range of contexts, whereas a relativist position would argue that mental illnesses can only be understood within a social and cultural domain (Fenton et al., 1996). This thesis is arguing that it is not as simple as belonging to one position because of the complex relationships cultural and social factors have in shaping the way we 'conceive an illness'. For example, Kleinman and Good (1985) argue that 'fundamental emotions (e.g. anger, sadness) cannot be assumed to be the same things in different cultures' (p.492). Therefore, this thesis will argue that both a universalist and a relativist position of 'mental health' needs to be used together and comparatively. The dichotomy of the perspectives is problematic

and the subsequent chapters will show that there are universal constructions of illnesses but cultural specificity contributes to how they are viewed, experienced and subsequently managed. For instance, sadness, depression, isolation etc. are inherently universal and do exist universally but are given different labels in different cultures, which also contribute to how they are understood and this complexity cuts across the universality/specificity binary.

Thus, culture is a contributing factor towards feelings, and different cultures have distinctive beliefs which not only affect meanings of mental illnesses but how it is dealt with (Fenton et al., 1996). Therefore, conceptualisation and expression of 'mental health' can vary across cultures (Dogra et al., 2005; Berthoud and Nazroo, 1997) and this needs to be considered when looking at ethnic groups. Once this is established, social support and treatment can be further explored, be it a medical approach of drug treatment or other therapies (Shaw and Middleton, 2000) or, indeed, a range of these dictated by the needs of the communities. Therefore, the first research question that this thesis will address is 'in what ways do Gujarati communities understand and conceptualise 'good 'mental health''?

2) The attitudes, experiences and management of mental illnesses

It has been argued that the incidence of psychosocial distress within various health services among the Gujarati communities is at least as low as that for the White British communities, and that it is possibly even lower (Patel and Shaw, 2009). Conversely, the criticisms of epidemiological studies suggest that this may not be a true portrayal of mental illness prevalence amongst the communities and requires further exploration.

Arguably different factors influence mental well-being: forms of discrimination (Racism, Homophobia, gender) (Brown and Harris, 1978; Harris et al., 2006), genetic inheritance, childhood experiences, levels of social support, life events, housing, employment, financial security, access to health care (Henderson et al., 1998) and culture (Cochrane, 1983). It is critical to note that

Sociologists do not argue that people should not be held responsible for their behaviour because they are victims of 'society' but they do suggest that social structures impose restrictions on behaviour as surely as biological inheritance does, and that the effects of social conditions on mental illness need to be understood, to explain both individual distress and how that distress might be related to larger forces (Michello et al., 1999, p.4).

In relation to this thesis, there is an exploration of how attitudes, experiences and responses of 'mental health' are approached in social and cultural structures. Although, it is beyond the limits of this thesis to make causal claims about whether the current low reported rates of mental illness among the Gujarati community is because of help-seeking barriers; an exploratory approach will allow for an in-depth study of the ways in which social and cultural determinants can impact attitudes and thus, responses and management. Therefore, the subsequent chapters will provide accounts of experiences of 'mental health' problems in relation to cultural factors as well as how attitudes such as stigma for example can influence management and create help-seeking barriers.

Research Questions

Thus, these issues will be addressed in my study through the following three key questions. The follow-up questions are deliberately open-ended due to the intended exploratory nature of this research.

- 1) in what ways do Gujarati communities understand and conceptualise 'mental health'?
- 2) How has culture influenced perceived experiences of 'mental health' problems within Gujarati communities?
- 3) In what ways do the Gujarati communities manage 'mental health' problems?

- 4) what role do help-seeking barriers (cultural, social, institutional and linguistic) and alternative coping strategies (traditional healing) have in managing 'mental health' problems?

Although the criticism of using 'South Asian' as a homogenous grouping has been argued, previous literature and findings can be useful in laying out a foundation, tackling downfalls and contributing towards more effective research. Thus, consulting key literature will be essential in providing context to this study and an overview of the background of the Gujarati communities in relation to distinctive aspects such as migration, religion, caste and class, which can arguably have an influence on mental illness (Cochrane, 1983). These different factors that make up the Gujarati demographic profile will be examined alongside the key risks of mental illnesses that studies have found. However, previous studies have heavily focused on the South Asian community which risks producing cultural stereotypes.

Therefore, the distinctiveness of this research is to move away from preconceived stereotypes and take a bottom-up approach in understanding what is happening in the communities which previous studies have neglected. The analysis of the Gujarati communities and risk factors of mental illness from previous literature has facilitated a critical understanding of the key concerns which has informed the empirical research. This study has been flexible and open to change direction depending on the insights gained. Although the findings from this study may be applicable to other ethnic groups within the South Asian category, this is beyond the scope of this study and requires further cross-cultural research (Lindesay, 1997).

Outline of thesis structure

This thesis has eight chapters which have been sequentially ordered to illustrate the developmental progress of conducting this research. Here, I offer a brief outline of the 'developmental journey' of this research.

In chapter two, I demonstrate the various bodies of literature that are useful in laying out the foundation and contribute to the explorations of this study. The literature review will be essential to providing the context of understandings of 'mental health', ethnic inequalities and management. Thus, there will be an overview of the medical and social model as forms of social control that shape and control 'mental health', ethnic inequalities which cover socioeconomic status, migration, racism, social capital, employment and work ethic. Subsequently, there will be a focus on illness behaviours exploring help-seeking barriers and alternative management strategies; namely ayurveda and yoga.

Sequentially, chapter three discusses the methodology. There is an extensive elaboration of the process I went through to generate the data to write this thesis. It provides information on theoretical and philosophical underpinnings, research approach; methods used for data collection, sampling and access, ethical considerations and conclude with personal and wider reflections. Elaborating on the justification for methods utilised above, this chapter also has indeed elements of narration to illustrate the emotional dimensions of conducting such research and focuses on the evolvement of the research design due to adopting principles of grounded theory.

Continually, chapter four is an addition to the methods chapter, but rather focuses on introducing the participants that took part in this study; the Gujarati communities that reside in Leicester. The chapter provides an overview of the history of migration and how the communities have come to settle in Leicester. There is also an analytical component that illustrates their attitudes and feelings towards migration and settling in a new environment. As a result, this process justifies the theoretical framework utilised in this thesis. There is a detailed overview of Bourdieu (1986) and the forms of capital which will be used throughout the latter three analytical chapters.

Chapter five, which is the first analysis chapter, addresses understandings and attitudes of 'mental health'. This chapter seeks to answer the question, in what ways do Gujarati communities understand and conceptualise 'good 'mental

health''? This is a crucial starting point because if the communities do not view 'mental health' as a problem, they will not seek to manage it, whether that is in a community setting or by seeking medical help. This chapter is categorised by two broad areas. The first focuses on exploring the understanding and meaning of 'mental health' by delving into understandings, depression, language and use of words, religion and causes of 'mental health' problems. The second area explores attitudes towards 'mental health' under the following factors: not openly discussed, denial and acceptance of 'mental health', personal issue that does not need addressing and othering.

The second analysis chapter wholly deals with the research question What are the perceived experiences of 'mental health' problems within the Gujarati communities? This chapter explores variations between first and second-generation Gujarati's and indeed in some cases in a comparative manner. Drawing on acculturation theory, this chapter provides an analysis of three main areas: the expectations parents have of their children in various cultural facets (e.g. speaking Gujarati), the opinions of second-generation migrants on these elements which demonstrates an 'acculturation gap' (second-generation have different opinions) and thirdly, how this could impact their 'mental health'. More specifically, the focus will be on ways in which first-generation migrants are responding, managing and coping with these changes. This will be done by exploring various values, beliefs and practices of Gujarati culture that participants revealed. These were: language, religion, importance of organisations, taking care of elders and marriage practices. This chapter will then go on to provide an overview of acculturation and explore its relevance in generating intergenerational discrepancies, which could be a risk factor for 'mental health' problems.

The purpose of the last analysis chapter is two-fold and addresses research question 3 and 4. The first part provides an analysis of the ways in which the Gujarati communities have practices and beliefs that help maintain 'mental health' management, simultaneously highlighting the limitations of such an

approach. The areas emerged as key in that respect were religion, community organisations, going to visit religious figures and the communities' way of thinking and attitudes. Other categories were agency, ayurveda relating to yoga and community help and services. The second part explores how cultural beliefs and attitudes impact upon help-seeking behaviours. Factors that influence help-seeking patterns and thus require attention are religion in terms of karma, spirituality, GP interaction in relation to language, somatic expression, GP appointments and perceptions of western medications. Other factors include communities' reactions (gossip and stigma) and cultural norms (hidden issues and family reputation). Expanding on the previous analysis chapters, this too illustrates the complexities cultural and social attitudes have on dealing with 'mental health' problems the communities may or may not face.

Finally, the conclusion chapter will summarise the key findings by providing multiple reflections on the research questions, data found, the methodologies used and reflections on the study. There will be an implicit focus on how this thesis contributes to the context of culture and 'mental health', using the Gujarati communities as a case study. It will reiterate the main findings, emphasising the 'complexities' in this area and how the study answered all four of the research questions using Bourdieu's (1980) various concepts of capital as a theoretical framework. It illustrates the intricate relationship the forms of capital have on how 'mental health' is understood, conceptualised, caused and indeed approached and managed. Lastly, I will offer reflections on the study but crucially provide recommendations on how it can be used in service provision to impact practice and improve healthcare. This will allow to address the disadvantages of traditional biomedicine, which disregards the links between illness and social, moral or religious influences and the role of traditional healing systems (Dein et al., 2001).

Chapter Two: Literature Review

Introduction

The previous chapter provided context to this thesis and put forward the three areas it will primarily focus on (1) understandings of 'mental health' (2) experiences of 'mental health' problems and (3) management. Therefore, this chapter will sequentially address key literature in these areas. There will be a brief exploration of the history of mental health, outlining the criticisms of the medical model and the consideration of culture and the social model of health in understanding 'mental health'. There will be a consideration of explorations of inequalities in 'mental health' and ethnic communities paying attention to literature on socioeconomic status put forward by Nazroo (2003) and various other contributing factors such as migration, ethnic density and employment. Lastly, there will be an overview on illness behaviours addressing help-seeking barriers and other tradition systems of medicine to manage 'mental health'. These debates and literature will be drawn upon in the analytical chapters to provide contextualisation and reference to the way in which the Gujarati communities conceptualise, experience and manage 'mental health' problems.

Currently mental illness encompasses many conditions, like physical illness. These ranging 'from brain diseases, such as alzheimer's type dementia, through schizophrenia, the archetypal madness, to the 'common' more frequent disorders such as anxiety and depression, as well as substance-use disorders like alcohol abuse and dependence, and various personality disorders' (Busfield, 2011; p. 1). However, these illnesses were framed through a medical framework and have substantially widened from the 18th century. The next section will provide a brief historical overview of mental illness and the way in which it has come to be seen through a medical lens. This contextual information is important because, the transformation of madness into mental illness as a form of management may not be applicable to Gujarati communities

where 'madness' can be lived realities and the social realm of social control may take priority in the management of 'mental health'.

Setting the Scene – The medical model and communities as a form of social control

Medicalization of Mental Illness and care provision in a western setting

Current western ideologies and thinking about mental functioning has been highly influenced by the medical profession which originated in Greece (Busfield, 2011). The Greeks formulated a rational approach and replaced concepts of the supernatural with a view that natural phenomena can be explained through natural cause-and-effect relationships (Cockerham, 2003). Up until the middle of the 18th century people with mental illnesses reflected perceptions around insanity but there was an increasing need for madness to be controlled (Shaw, 2007). In 1744, the Vagrancy Act saw the set-up asylums. Admissions were accounted for legally and during the early 19th century the development of county asylums continued with no medical influence but an approach of 'moral treatment' (Manning and Shaw, 1999). This involved the control of madness through a calm and ordered environment with respectful procedures. However, the regulation of public asylums was done through the 1845 Lunacy Act. A common feature of these asylums was their custodial role as they provided protection through safeguarding. Although, a custodial role of the asylums was necessary with the increasing population in them, the care that was provided tended to be ineffective. Medicalization occurred in the late 18th century under the growing power and monopolization of the psychiatric profession which took control of the asylums (Freidson, 1970). The profession which presents the medical model of mental illness transformed the cultural view of madness into a coherent scientific entity (Skull, 1977).

The definition of medicalization is:

Defining behaviour as a medical problem or illness and mandating or licensing the medical profession to provide some type of treatment for it. Examples include alcoholism, drug addiction and

treating violence as a genetic or brain disorder. (Foucault, 1965; Rosen, 1972) (Conrad, 1975, p.12).

Thus, as Pilgrim (2005) argues 'madness, sadness and fear have always existed, as part of the human condition, 'mental illness' or 'mental disorder' only exist as by-products of activity by the psychiatric profession' (p. 11). The process of medicalization of mental illness has conceptualised it into various categories such as dementia, schizophrenia, and more frequent disorders such as anxiety, depression and substance use disorders (Busfield, 2011). This is critical to this thesis because psychiatry may have formulated definitions and control mental illness, but madness may still be a common understanding among the Gujarati communities.

Since asylums, 'mental health' services in Great Britain have undergone significant changes (Cockerham, 2003; Pilgrim and Rogers, 2011). Care in the community represented the biggest political change in the provision of 'mental health' care. The overall aim was to 'normalise' and remove the stigma attached to the mentally ill. A priority was to move away from the isolation of asylums and create integration into the community. The current healthcare system in Britain is provided by the publicly funded National Health Service which was formed in 1948 when the government took on the responsibility for health care delivery.

The first level of care for mental problems is the general practitioner, who treats directly about 95 percent of all patients with psychiatric complaints. Normally, a patient is not referred to a psychiatrist unless he or she does not respond to initial treatment (Cockerham, 2003 p.334).

Although common 'mental health' disorders may not need to make use of psychiatric services, it is a crucial example of how medical services act as an agency of social control of illnesses. Foucault (1973; 1977) argues that medical social control allows for conditions to be seen through a 'medical gaze' (Conrad 1992, p.216). 'Social control is usually conceptualized as the means by which

society secures adherence to social norms; specifically, how it minimizes, eliminates, or normalizes deviant behaviour' (Conrad and Schneider 1992, p.7). Examples of structures which provide social control are education and the criminal justice system.

The medical system becomes a mechanism for social control because its job is to limit the extent of this deviance by treatment to restore the capacity of individuals to fulfil their normal social roles (also intervening to ensure that capacity is maintained/improved through health promotion activity) (Conrad and Schneider, 1992 p.9).

However, this is only possible when communities adhere to structures of social control of approaching services to manage these issues. If understandings of mental illnesses are not viewed as 'illnesses' or experiences that require treatment, their management may occur in other ways than visiting GPs. Arguably, communities can also be a platform for social control and can shape the way in which 'mental health' is understood, experienced and managed. These understandings are further explored below.

Communities and social control

Communities are difficult to define because its' boundaries are not fixed but usually entail a sense of shared geographic space and acceptability of culture and norms. With the development of modern communication techniques, communities do not always share geographic space but are formulated based on common experience, culture and norms. Thus, a prime reason why this thesis uses 'Gujarati communities' rather than the 'Gujarati community' is because, although they may share a Gujarati identity, other experiences and norms may differ resulting to several communities and heterogeneity. Sociologists are interested in communities because they are a space that is key in maintaining boundaries that develops its own ethos.

The maintenance of boundaries means that individuals in communities are confined to a set of expectations and conduct

which is viewed as appropriate. Human behaviour can vary over an enormous range, but each community draws a symbolic set of parentheses around a certain segment of that range and limits its own activities within that narrower zone (Erikson, 1962, p.307).

Therefore, violating these 'expectations' and norms which are viewed as 'appropriate' can cause deviance (Erikson, 1962). Furthermore, it is because communities and societies have these norms and expectations that deviance exists. Conrad and Schneider (1992) argue that there can be no deviance without rules and there can be no communities or societies without norms. However, deviance is a relative concept because communities are pluralistic and diverse. For example, suicide is considered deviant and ungodly in most of the Christian world, whereas in imperial Japan it could be an honourable act (Conrad and Schneider, 1992). This suggests that the definition of deviance is a social one and Erikson (1962) argues that it is the process of audiences labelling deviancy that signifies it. Yet, deviancy is universal because all societies have behaviour that is unacceptable. Sociologists are interested in why people become deviant, and how social structures influence the existence of deviant behaviour.

This is of key interest in this thesis, if 'mental health' problems are viewed as deviant, mad or stigmatised, communities' norms and values will also dictate a form of social control-that is how 'mental health' problems are viewed, experienced and managed. Thus, although the medical model's purpose is to control illness through healthcare provision, the social model that is made of communities' norms and values can serve a similar parallel role. For example, if it is culturally appropriate for Gujarati individuals in their communities to go to ayurvedic clinics for depression, it will be controlled through this medium. Or alternatively, if 'mental health' problems are stigmatized or viewed as not requiring assistance within communities it may be socially appropriate to tolerate these problems relating the 'symptom iceberg' (Hannay, 1979) discussed in the latter half of this chapter. As a result, exploring the realms of

communities and their culture can provide further understandings of the social and cultural context of health; where sociological approaches are situated.

Sociological approaches and the social model of health

It was not until the 1950s, sociologists began researching and studying 'mental health' because they thought social factors were significant yet unexplored as contributing factors to 'mental health' problems (Conrad and Schneider, 1992). Goffman's work on asylums (1961) triggered the longstanding critical perspective of the medical model research within sociology. Goffman (1961) spent a year in a 'mental health' institution and argued that mental hospitals did not provide therapy but were detrimental to one's health due to its' institutional nature. Subsequently, Scheff (1966) researched the impacts of labelling individuals as mentally ill. Scheff suggested that the labelling process is more important than symptoms of mental illness because assumptions about patients are made based on their label. Although both pieces of work have been criticised, Conrad and Schneider (1992) argue:

It is clear that his (Scheff) work has sensitized us to the fact that it is profoundly social process that defines, identifies, and labels behaviour as madness. Work like Goffman's and Scheff's explicitly challenged the medical model of madness (p.64)

Both pieces of work challenged the medical model because they were interested in the influences of social processes on 'mental health' problems. Subsequently, this began the long array of research in sociology on 'mental health' (e.g. Aneshensel and Phelan, 1999; Schwartz, 2002; Cockerham, 2003). Sociological perspectives advocate that a prime problem of the medical perspective is that its' attempts to capture the full story of 'mental health' have proved to be unsuccessful because medicalization decontextualizes and individualizes social problems (Conrad, 1992; Cockerham, 2003). However, sociological perspectives suggest that elements of social life have dysfunctional consequences such as socioeconomic status, gender, age, ethnicity and race (Aneshensel and Phelan, 1999; Schwartz, 2002). Sociologists are primarily

interested in how social structures, stressful life events, social integration, roles, relationships and cultural systems of meaning influence 'mental health'. There is a view that these systems and inequalities have effects on the psychological well-being of individuals (see Fais and Dunham, 1939; Goffman, 1961; Scheff, 1966; Link and Phelan, 1996).

However, as argued in the introduction, sociologists are not suggesting that because social structures influence 'mental health' that people are not responsible for their behaviour. Additionally, both the medical and sociological domains of thought are complementary rather than contradicting or opposing when observing 'mental health' problems. Thus, as Michello et al. (1999) argue, social conditions allow for an exploration of individual distress as well as the ways in which distress is situated in relation to other social factors. This thesis has given a platform to the Gujarati communities to discuss 'mental health' from their perspective and thus sits within the social model of health. Cultural practices can influence both experiences and understandings of 'mental health'. Firstly, the ways in which culture influences understandings will be explored and secondly, how social, economic and cultural factors that make up ethnic communities' impact inequalities among 'mental health'.

Understanding 'mental health' differs culturally

Communities are a platform where culture is apparent, produced and recreated. Kleinman (1977) argues that culture does not only influence experiences of 'mental health' but contributes to the way in which 'mental health' is constructed and understood (Kleinman, 1977). A key concept that is influential in these debates is culture. Culture has become a 'buzz word' that has various definitions in contemporary society, from corporate culture to gang culture, it can be applied to several domains of life (Birukou et al., 2009). It was first formally defined in anthropology by Taylor (1871) as 'the complex whole which includes knowledge, belief, art, law, morals, customs and any other capabilities and habits acquired by man as a member of society' (cited by Eshun and Gurgung, 2009 p.3). The definition used in this thesis is one by Hall (1997)

because this thesis is inherently related to practices that have meaning to the Gujarati communities. Hall (1997) puts forward:

culture... is involved in all those practices... which carry meaning and value for us... the ways we classify and conceptualise them, the values we place on them (p.3).

Thus, culture is something that is embedded in practices and it is these practices that are learnt through experiences and interactions which are transmitted from generation to generation and changed over time. Evidently, if culture influences forms of behaviour, it has a close relationship to 'mental health'. Eshun and Gurgung (2009) argue that cultural traits and beliefs contribute to the way we think, respond to distress and express emotions. Additionally, psychiatric categories of mental illness are bound to professional psychiatric theory and practice that occurs in the west; a very specific cultural context. As mentioned in the introduction, constructions of emotions vary among different cultures (Kleinman and Good, 1985). For instance, psychiatric practice is different to lay beliefs held by Gujarati communities in Leicester. Therefore, conceptualisation and expression of mental distress can vary across cultures (Dogra et al., 2005) and requires further exploration with ethnic groups.

Anand et al. (2005) argue:

Cultural differences are likely to have a pervasive influence on recognition and reporting of psychiatric symptoms, the meaning attributed to them, help seeking and use of 'mental health' services and response to contemporary 'mental health' treatment procedures. This lack of understanding may lead to misinterpretation of symptoms creating diagnostic and treatment errors (p. 201).

Therefore, 'mental health' studies overlooking inequalities among ethnic groups need to be culturally sensitive and as suggested by Weich and McManus

(2002) there is a 'need to view ethnicity as a complex social, economic and cultural matrix' (p.26). This will contribute to a deeper and more valid understanding of mental illness and experiences among different ethnic groups in the UK.

Introducing ethnic inequalities and 'mental health'

Health inequalities within 'mental health' have been an area of concern for many years, and one large division within this discussion draws upon the relationship between 'mental health' and ethnicity. As explained by Bhugra and Bahl (1992), explanations about the increased or under representation of certain types of mental illnesses among ethnic groups, points towards the need for a justification to why such variations prevail, and a need for improving 'mental health' services.

It is generally reported that there are high rates of mental illness among African Caribbean people compared to White people. As for Asians, the evidence seems to be rather inconsistent. Raleigh (1995) found that 'most of the research on psychiatric hospital admissions, GP consultations, referrals to psychiatric clinics, and community surveys shows a low prevalence of mental illness overall among Asian people. Asian people also have a low rate of non-psychotic disorders (neuroses, personality disorders, drug abuse). However, the studies reviewed by Bhui (1999) found that depression rates are much lower in the South Asian community compare to the White British population but ethnographic studies found that their distress levels were high. Bhui et al. (2003) also found higher rates of depression amongst Punjabis than English subjects. This is consistent with earlier work showing that South Asians from East Africa carry a higher risk of suicide than other South Asian groups (Raleigh, 1995). Thus, the reasons for these inconsistencies need further exploration to explain and understand ethnic inequalities. There have been various theories put forward which will be explored below.

Socioeconomic status

It has been argued that Sociologists are interested in the social model of 'mental health' which aims to understand 'mental health' in the social context and to understand mental illness as emerging from different processes that influence illness alongside biological factors. Thus, health is not separate from but rather inclusive of lived experiences, interactions and practices in social life including communities. Nazroo (2003) suggests that this model does not focus on what individuals do that causes them to have bad health e.g. smoking but rather the focus is on what is it about society that can contribute to inequalities in 'mental health'. Thus, the emphasis is on the ways in which social processes can provide resources, opportunities and challenges that aid good or bad health.

However, the extent to which socioeconomic inequalities explain ethnic inequalities in 'mental health' is contested. Wild et al. (1997) argue socioeconomic inequalities have minimal contribution to ethnic inequalities in health whilst Smaje (1996) argues that socioeconomic inequalities do have a role but so do genetics and culture. However, Nazroo (2003) argues this is primarily due to the lack of good data on socioeconomic positions of ethnic communities. Additionally, these studies use oversimplified measures of socioeconomic position such as class or education and neglect the complexities of social and economic inequalities (Nazroo, 1998). The problem with this is it assumes homogeneity based on one factor and as argued in the introduction wide categories such as 'South Asians' can be of little use. Smaje (1996) suggests that although socioeconomic disadvantage can contribute to ethnic inequalities in health, ethnicity should not be solely viewed as class disadvantages. Thus, ethnicity needs to be conceptualised adequately and thoroughly. Nazroo (1998) argues that this involves recognising ethnicity as both a form of structure and identity. By reviewing existing evidence, Nazroo (2003) argues that social and economic inequalities which are underpinned by racism are fundamental causes of ethnic inequalities in health.

Nazroo (2003) found that experiences and awareness of racism is central to ethnic minorities and contributes to 'mental health' inequalities in two key ways. Firstly, personal experiences of racism can directly influence health. Secondly, racism influences structuring the social and economic disadvantage faced by ethnic minority groups. For example, Karlsen and Nazroo argue that 'Institutional racism promotes the identification of ethnic minority groups, their reification as biologically and culturally different, and their consequent social and economic exclusion' (pg. 630). Thus, socioeconomic status is not an autonomous factor but the result of other underpinning experiences such as racism. Additionally, the large migration trajectory into the UK was driven by demands in labour and thus is influenced by racism from colonial history. Therefore, the ways in which historical context and experiences of racism contribute to social and economic position needs to be considered.

Therefore, it has been shown that there is a need to move away from the oversimplistic assumptions made about the role of ethnicity and health. Nazroo (1998) argues that one-dimension assessments have been used such as country of family origin or region which is unable to address the complex relationship between ethnicity and health and as a result structural influences such as the relationship between socioeconomic status and racial discrimination are not considered. An assessment of ethnicity that includes additional dimensions, such as religion or language, allows the relationship to be explored further (Nazroo, 1998). Thus, it is crucial to assess both how these additional dimensions are related to cultural traditions and experiences in Britain whilst recognising the historic role they may play in structuring socioeconomic status but also contribute to experiences in the UK (Nazroo, 1998). Therefore, a range of contributing factors will now be considered that make up Gujarati identity, experiences and social and economic position. It is key to note that these experiences will not be considered as independent throughout the thesis but indeed the intricate relationship between them can provide a more meaningful understanding of ethnic inequalities in 'mental health'.

Migration

Migration involves movement of individuals across symbolic or political arenas into new areas and communities (Marshall and Scott, 2005). Migration changes and transforms lives including the lives of many Gujarati migrants in the UK. The specific migration history of Gujarati migrants will be explored in the subsequent chapter. However, to provide context for the following arguments they are generally twice migrants, moving from India to East Africa and migrating to England thereafter. Migration can impact health and health care systems which can be far-fetching for the communities and countries involved (Carballo et al., 1998). A large body of research advocates that migration causes an increased risk of 'mental health' problems (Cochrane et al., 1977; Cochrane, 1983; Beiser et al, 1993; Nevo et al., 2006). This is because migration can result in stress, isolation, change, fragmented family ties and difficulties in adapting to new surroundings.

The process of migration can be a time of crisis for people due to moving to new environments and adapting to change. In general, theories of migration would suggest that immigrants are more prone to mental illness due to pressures and difficulties faced when migrating. According to Cochrane (1983) 'there is a very strong background assumption that immigrants will have poorer 'mental health' than will the native populations they join' (Cochrane, 1983, p.87). This is because migration interferes with 'mental health' (Beiser et al., 1993; Nevo et al., 2006). However, it is crucial to note that there is no conclusive evidence to support the direct relationship between migration and mental illness (Kuo et al., 1986) but rather these studies have found it is the effects of migration that influence 'mental health'. As mentioned these are stress, isolation, change, break of family ties and difficulties in adapting to new environments. The two key theories relating to the impacts of migration will now be considered.

Migration and Ethnic Density Theory

'Mental health' and inequalities among ethnic groups have largely been researched. It is important to look at a variety of ethnic migrants in the UK as they share a common post-colonial experience with the Gujarati communities in Britain. Higher rates of illnesses have been found among Caribbean and Black African Immigrants, whilst low rates among Asian communities compared to their White counterpart (Bourque et al. 2010). Furthermore, studies have consistently reported higher rates of suicide amongst Irish migrants in Britain than in the population as a whole (Aspinall, 2002). The reasons behind the differences among these migrant group has been widely researched and the areas where migrants decide to settle down is of interest and questions have been asked whether ethnic segregation of communities' influences health (Pickett and Wilkinson, 2008). 'Ethnic Density Theory' has been used to explain such differences which relates to the notion that low status minority communities living in an area with a higher proportion of their own racial or ethnic group tend to have better health than those who live in areas with a lower proportion (Pickett and Wilkinson, 2008).

Leavey (1999) argues that Irish migrants move away from close-knit communities and find themselves in unsettled lifestyles of casual work, accommodation and relationships in the UK. There are higher proportions of single people, divorced and those living alone among the Irish in Britain compared to the general population. These fragmentations of Irish communities in the UK has been argued to contribute to the high levels of suicide among Irish migrants in Britain. Leavey (1999) argues that Durkheim's theory on lack of integration and higher rates of suicide is still applicable among Irish migrants in Britain. Aspinall (2002) also found that Irish migrants struggle to establish an identity due to minority status. This has been the case for other ethnic communities, Williams et al. (2007) have similarly found a minority status among Black Caribbean migrants in the UK which contribute to higher risks of psychiatric disorders due downward social mobility. Halpern and Nazroo (1999) also found the same effects of ethnic density from a national

community survey which is important as previous studies utilised psychiatric admission rates.

Additionally, Stopes-Roe and Cochrane (1990) also attempted to explain some of the discrepancies between mental illnesses and ethnic communities identified above through selective migration, ambivalent relationships and adjustment to new cultures. Selective migration is when active decisions are made to move from rural to urban environments in most cases for employment reasons. According to selection theory these communities should have good mental health as they have moved away from high poverty areas that also have high minority concentration (Halpern and Nazroo, 1999). However, the worse 'mental health' can be explained using social factors and the lack of support that high ethnic density areas have. The selection explanation is also undermined by the finding that, for migrant ethnic minority groups, economic hardship can strengthen relationships with other counterparts having a positive influence on health in return. Therefore, being in areas where ethnic communities have minority status difficulties in belonging and 'different' can have an impact on 'mental health' (Halpern and Nazroo, 1999).

Although, ethnic density theory has been largely discussed in relation to Afro-Caribbean and Irish communities there has been some focus on Asian communities. There have been some variations for mental illnesses among Asian migrants. Bhugra et al (1997) found rates were low among Asians whereas King et al. (1994) found no difference compared to the White population. However, Bhugra and Jones (2001) argue:

The key difference between these two studies was that, while King et al collected their data from an area where population density of Asians was thinner, Bhugra et al (1997) collected data from the London Borough of Ealing where, in the Southall catchment area, Asians form 50% of the population (pg. 217).

Thus, Bhugra and Jones (2001) argue that ethnic density plays a significant role in the maintenance of some types of psychological distress. However, Bourque

et al. (2010) agree that ethnic density influences risk of 'mental health' problems but the level of risk the minority status causes is context dependent. Bhugra and Jones (2001) argue that in ethnically dense communities, where the emphasis is on sociocentrism and collective responsibility, the positive effects of social support may not be apparent. Therefore, where this is the case among some Asian communities e.g. Gujarati, culture conflict may be more likely to be apparent and can result to higher rates of 'mental health' problems. This may be the case for Gujarati migrant communities in the UK. Indian migrants travelled in large kinship groups and have established networks in the UK (Bachu, 1985). They live in socially cohesive communities which have allowed for home culture to be maintained and has been shown to be more deep rooted amongst the group (Furnham et al., 2000) through forms of cultural capital (Parikh, 2006; Chaddha et al., 2009). For example, there are now many temples in Leicester and festivals such as Diwali are celebrated in the communities. Recurrent migration carries a greater risk of mental illness (Bhui et al., 2003) but because the group have travelled with family and live in high ethnic density areas the risks of social isolation poor social integration may have been reduced (Kuo, 1976; Kuo et al., 1986). However, the strong forms of capital which will be discussed in the following chapter and the emphasis on sociocentrism could impact other risks. Therefore, previous studies illustrate that ethnic density can be both positive and negative for mental health.

Acculturation

A related component to migration and how people deal with new cultures is acculturation. Broadly, acculturation theory is concerned with the ways in which ethnic minority communities adapt or react when in contact with another dominant culture (Phinney, 2003). Berry (1990) advocated that acculturation strategies accessed by ethnic minority groups is examined in terms of two facets: 1) retention of one's cultural traditions and 2) establishment and maintenance of relationships with the larger society. Berry (1990) put forward that when these two factors are considered simultaneously, a conceptual framework can be generated to illustrate four main routes of

acculturation strategies: assimilation, integration, separation and marginalisation.

To provide context, in terms of first-generation Gujarati migrants, they may have avoided 'mental health' problems due to resistive acculturation. Margination is the opposite form of acculturation, where immigrants embrace their culture of origin and exclude the host culture (Pumariega et al., 2005). This form of acculturation strategy may be more common with older Gujarati immigrants because they live in well integrated families (Cochrane et al., 1989) and use non-dominant forms of cultural capital to support maintaining their cultural identity (Parikh, 2006; Chaddha et al., 2009). Alongside, focusing on cultural identity, it has been well documented that the Gujarati communities focus on economic success to deter effects of migrating to a new environment, which is demonstrated by the 'golden mile'. Thus, margination strategies could avoid 'acculturative stress' (Berry and Sam, 1997, p.289) because effects of cultural change and isolation are avoided.

However, migration, acculturation and 'mental health' become further complex when there are more than one generation present. Dogra et al. (2005) conducted a study on the Gujarati communities in the UK and found that stress and anxiety were proposed as the main causes of 'mental health' problems. Furthermore, the study outlined a difference in opinion between two generations in relation to the causes of 'mental health' problems. 'Adults focused on economic, cultural and family factors while young people identified bullying, school problems and loneliness' (Dogra et al., 2005, p.94). There are differences across generations due to different cultural and social factors affecting people's lives. For example, the first-generation would have dealt with migration whereas the second would not have had to. Therefore, there are a range of factors that can contribute to 'mental health' problems and this can have implications for theory, 'mental health' interventions and services (Rahman and Rollock, 2004).

Racism

An additional reason that could cause ethnic inequalities in health is discrimination which is heightened due to migration and minority status as discussed above (Harris et al., 2006). Todorova et al (2010) summarises discrimination in terms of the ways in which the social context excludes or denies equality to people due to their ethnicity. Racism; a form of discrimination can impact health in a number of ways. Williams and Collins (1995) proposed at least three ways that racism affects health.

First, structurally, racism transforms socioeconomic status such that socioeconomic indicators are not equivalent across racial/ethnic groups. Secondly, racism restricts access to services and goods which promote health. Finally, racism and discrimination increase psychological distress which adversely affects physical and 'mental health' status, as well as health-related behaviours (Williams and Collins, 1995 cited by Todorova et al., 2010, p.843).

This is key, as argued above Nazroo (1998) argues that racism should not be viewed as an independent causal risk factor but indeed if it influences socioeconomic status this can contribute to ethnic inequalities. Migrants are likely to experience racism because they are migrating to a country where they are a minority and may be viewed as imposing other communities' space and viewed as the 'other'. The effects of racism can also have an impact on self-esteem and identity (Karlsen and Nazroo, 2002). Additionally, with regards to identity, if individuals are questioned and discriminated against cultural values that they view as normality; they may start to question their identity and their belonging. This confusion and uncertainty can have detrimental impacts on 'mental health'. Studies have found that experiences of discrimination such as racism is linked to poorer 'mental health' (David and Williams-Morris, 2000; Williams et al., 2003; Araujo and Borrell, 2006). This is because it can cause psychological distress, little life satisfaction, depressive symptoms, major

depression, anxiety and low level of happiness (Williams et al., 2003). These symptoms can to some degree, be controlled or avoided by focusing on education, or high levels of social support and religious involvement (Bierman, 2006; Cardarelli et al., 2007; Todorova et al., 2010). Thus, a reason why the migrant Gujarati communities may experience good 'mental health' is because they are well educated, have good social support and are religious. Therefore, the communities may have experienced some levels of racism after migration but this has not impacted their identity or caused stress because of their coping strategies and high levels of integration as close-knit communities.

Social capital

Social capital has been prominent in sociological theory for many years and had a number of theorists speculate the concept and thus a variety of definitions (e.g. Bourdieu, 1986; Coleman, 1988; Putnam, 1993). Although Bourdieu's (1986) definition of social capital is utilised in this thesis in the subsequent chapters, here I offer a brief overview of the importance of social capital and the interest it has gained in relation to exploring health.

Societies are not composed of atomized individuals. People are connected with one another through intermediate social structures – webs of association and shared understandings of how to behave (Halpern, 2005 p.3)

These 'webs of association' have a strong relationship with whom and how interaction and co-operation takes place. According to Halpern (2005), it is this relationship and co-operation social capital aims to capture. For the purpose of this discussion and as Portes (1998) argues a general consensus of social capital is 'the ability of actors to secure benefits by virtue of membership in social networks or other social structures' (pg. 6). Additionally, Portes (1998) argues there are three functions of social capital; a source of social control, family support and benefits through extra familial networks.

Academic interest on social capital is underpinned by exploring the relationship between the quality of people's social networks and the influence on various

domains in society, such as educational performance, health etc. (Halpern, 2005). Although, literature on social capital proposes positive benefits such as social support, it can result to negative consequences such as exclusion of outsiders and restrictions on individual freedom which can have negative effects on 'mental health' (Portes, 1998). Furthermore, the quality of one's social capital can influence their well-being. This dates to Durkheim's (1951) study on suicide, whom argued that individuals who had more social capital were less likely to commit suicide, whereas those who are disintegrated from society are more likely to do so. Thus, social capital has generated interest in this area because it can contribute to the understanding of health inequalities (Berkman et al., 2001; Almedom, 2005). Further literature will be explored in relation to three key aspects where social capital is present: family structure, caste and class and religion. This is because these are three key areas that make-up Gujarati identities and there is an interest in factors that contribute to the complexities of ethnic groupings.

Family structure

Scholars have argued that the make-up of one's family influences the risk of mental illnesses (Aseltine, 1996; Gilman et al., 2003; Barret and Turner, 2005). Additionally, family structure does not only influence individuals during childhood but also contributes towards mental well-being throughout an individual's life course (Barret and Turner, 2005). Family structures impact social support, financial security, and emotional stress at three levels: individual, social and cultural. Studies conducted in this area have found that nuclear families have the greatest protection against 'mental health' problems (see Adlaf and Ivis, 1996; Aseltine, 1996). Also, there is evidence to suggest that the nonexistence of both parents' accounts for the least protection against mental illness (Adlaf and Ivis, 1996). It is largely accepted that the risk of mental illness is larger in single-parent and stepfamilies (Barret and Turner, 2005). Furthermore, a study conducted by Moilanen et al. (1988) supports this statement and found that psychiatric disorders were more frequent in children of single parent families, especially those whose father was not present from

birth. This is because, emotional, social and financial support are not as strong as nuclear families. In light of this, Gujarati communities may be less likely to experience 'mental health' problems because the prevalence of single parent families is very low.

Furthermore, extended families are common among Gujarati communities (Mistry et al., 2000). Shah and Sonuga-Barke (1995) found that children fared better in extended families due to the extra familial support. However, Karlsen and Nazroo (2002) argue that family relationships can be a source of distress with ethnic groups. For example, extended family structures can cause tension between family members of different generations on child bearing, conflict with traditional roles and extra burden of care (Chase-Lansdale et al., 1994) causing psychological distress. This conflict usually occurs between grandmothers and mothers, but is detrimental for mothers who face the demanding tripartite role of mother, wife and daughter-in-law (Mistry et al., 2000). Therefore, as Raleigh (1995) argues, family support can reduce the risk of mental illness, but it can also be a form of social control and increase psychological distress. Both the benefits and negative effects from family-structures can possibly be translated to wider networks of the Gujarati communities in Leicester due them being close-knit. For instance, the demanding tripartite role that mothers face, other close members to the communities may face the demands of up-keeping roles which are in conflict, e.g. father and community member.

Religion

Leicester has the second largest Hindu community in the UK with 41,248 at the last census and religion plays a fundamental role in their lives (Raj, 2010). It can be argued that due to living in large cohesive communities the Gujarati population have been able to maintain religiosity because together they have formed places of worship and practice collectively enhancing their social and cultural capital (Gale et al., 2003). This has been possible through committees such as the Gujarati samaj's (see glossary) who organise religious gatherings for the communities. There is something overpowering about religion which binds

ethnic groups together and promotes social integration and support (Stansfield and Sproston, 2002) which may have restricted adverse effects of migration. This area is limited in the immigration literature but it has been widely recognised that religious institutions are increasingly becoming a source to not only sustain homeland culture but remain as communities in foreign countries. Therefore, these are 'critical sites shaping the identity-constructions processes of immigrants and their descendants' (Kurien, 2005, p.438). The Gujarati migrant population have put this into practice by coming together, building places of worship and celebrating religious festivals (Gale et al., 2003).

Alongside religion promoting social cohesion among the Gujarati communities, they tend to be highly religious. Data suggest that religious beliefs can have a protective influence by moderating the impact of negative interpersonal life events (Krause, 1989; Matthews et al., 1998) such as misfortune, migration and racism which influence 'mental health'. It can be used as a coping mechanism and result to a loss of worry. Additionally, Dervic et al. (2004) found that religious affiliation is associated with less suicidal behaviour in depressed patients. However, Kendler et al. (2003) and Pargament et al (2005) found that religious beliefs and practices are not always positive; a poor quality 'relationship' with God and religious conflicts are associated with poorer health. Another dimension is spirituality; King et al. (2006) found that a lack of religious belief is associated with common mental disorders but only in people who claimed to have a spiritual life view. Furthermore, a 'lack of religion may lead to common mental disorders in some vulnerable people who are seeking existential meaning for their live' (King et al., 2006, p.161). Therefore, the relationship between religion and mental illness is not conclusive but religion does form a large part of the Gujarati communities that reside in Leicester (Raj, 2010).

Caste/Class

Caste is like class in terms of status, divisions and superiority but caste was initially based from religion whereas class was initially derived from occupation and has since evolved. Beck (1992) argues that class membership is evident in

everyday life and is still associated with identification. It is prominent in a variety of forms such as: residential areas, education, speech, clothing and general lifestyle (Beck, 1992). The Gujarati communities tend to be middle class and show good signs of upward mobility due to their strong work ethic. Caste is a key determinant of status in Gujarati society (Ramji, 2006). 'Caste is an ascribed status derived from the Hindu belief in pre-destined birth' (cited in Ramji, 2006, p.708). The priestly class is the most superior which is known as the Brahmans and the lowest caste consists of servants. Each caste is divided into sub-castes which generally represents occupation. The Vaishna caste is the dominant caste of Gujarat which 'entails the acceptance of Vishnu and his incarnations as the focus of worship. Within residential clusters, the lines of caste and religious community mark off neighbourhoods' (Ramji, 2006, p.708).

The different Gujarati castes in the Vaishna category are Brahmin, Lohana, Patel, Sutar, Jain, Lohar, Patidar, Vaishnav, Kutchi Gurjar, Modi, Rajput, Kutchi, and Soni, and tend to have different occupations. Soni's are goldsmiths, Patel's are in agriculture and are both landowners and sharecroppers and Lohana's traditionally were occupied as merchants. Ramji (2006) argues that caste remains an important aspect of the British-born and migrated cohorts' sense of identity. 'Patidars (Patels) have set up samaj's' (see glossary) wherever they have settled to help their own community adapt without losing their traditions' (Ramji, 2006, p.708). This has also been the case with other castes, who have set up their own samaj's. In Leicester, there are two large organisations that oversee the various samaj's and these are the Gujarat Arya Association and the Hindu Association. In terms of 'mental health' within the communities in the UK, integrated individuals in these samaj's are likely to have more social interaction and support and thus at a lower risk of mental illness. Although caste membership and communities can provide vital support it can also stimulate pressures and tension (e.g. inter-caste marriages are frowned upon). If individuals find themselves assimilating to British culture, they may face extra stigma from their communities because they did not conform to their indigenous cultures.

Employment and work ethic

The relationship between work and 'mental health' has been well studied and documented (e.g. Bartley, 1994; Berthoud, 2000; Wildman, 2003). Occupational health as a discipline focuses on trying to understand the relationship between work and health. Accordingly, with this knowledge, intervention can be made to protect and promote well-being (Wildman, 2003). Wildman (2003) argues that employment increases financial gains and thus the availability of housing, education and other amenities which can minimise relative deprivation and increase mental well-being. Henderson et al. (1998) shows that unemployment may impair physical and 'mental health', especially anxiety and nonpsychotic depression, and increase suicide and deliberate self-harm due to a lack of benefits employment provides. The level of these situations does depend on personal circumstances and a variety of external contributing factors because unemployment is not an independent measure. However, this pattern is not linear because Bartley (1994) argues that employment can be unpleasant and insecure and thus increase the likelihood of psychological stress.

However, the Gujarati communities may be less likely to be affected by these risk factors because they are unlikely to be unemployed. According to the Labour Force Survey (2010), Indian communities have the lowest unemployment rate of all ethnic minority groups at 8%. They tend to be well educated and in well-paid jobs and have signs of upward social mobility (Cochrane, 1983). However, Berthoud (2000) also acknowledges that ethnic minorities can face discrimination in employment. This could be a reason why Gujarati's tend to be self-employed which may be a route of escapism from discrimination.

Additionally, Kessler and McRae (1981) found that women's 'mental health' improved as they entered the labour force but this was not due to earnings. This suggests that the meaning of employment is not simply down to financial

gains but it can mean more to individuals. In this case, it could be due to different expectations and women gaining alternative rewards which could be as a result of rooted sex differences. This could be likely in the Gujarati communities which tends to be patriarchal and thus jobs may be liberating for women (Kessler and McRae, 1981). The presence of separate conjugal roles in the Gujarati communities can result to women feeling isolated whilst simultaneously men may feel pressure to provide for their entire family and could result to psychological downfalls (Artazcoz et al., 2004). With all these additional factors combined, Rogers and Pilgrim (2005) argue, 'employment can bring with it stressors, as well as buffers, in relation to psychological well-being' (p.54). Thus, Artazcoz et al. (2004) argue in their findings that it is important to consider gender and social differences when overlooking effects of unemployment and 'mental health'. Furthermore, the social differences and factors will be imperative to this study. As noted earlier Gujarati's tend to be well educated and in well-paid jobs (Cochrane, 1983). Thus, if they face unemployment or rather are in undesired jobs it can be associated with poor 'mental health' due to the influence and impact it has on social status and self-esteem among the communities (Artazcoz et al., 2004).

Gender

Gender roles are key to constructing identity which can impact lifestyle choices and there are differences in prevalence of mental illness according to gender. Theory suggests gender is socially constructed (Lorber, 1994; Lucal, 1999) and refers to femininity and masculinity. The Indian culture traditionally supports segregated gender roles where women and men are coerced into different roles (Risman, 2004). This typically entails men as the sole breadwinners, women as nurturers and the presence of patriarchy. However, Risman (2004) argues that gendered routes are generally chosen even if they are not compelled in communities.

Although, reported rates suggest a low prevalence of mental illness in the Gujarati communities (Patel and Shaw, 2009), studies have illustrated a different case for women. For example, some have found that there is a higher

prevalence in suicide, deliberate self-harm and eating disorders among women (Bhugra and Bhui, 2003; Fazil and Cochrane, 2003; Anand and Cochrane, 2005). Some studies have suggested traditional cultures, where gender roles are segregated, place women in a position that makes them more likely to be affected by mental illness. For example, Brown and Harris (1978) found that ongoing low self-esteem and a lack of confidence were factors that caused depression among women. Other reasons have been bullying, subordination, families with over-control, domestic violence and social undermining (Gilbert et al., 2004). Hicks and Bhugra (2003) conducted focus groups and found three main causal factors for suicidal behaviour among British South Asian women: marital violence, being trapped in an unhappy family situation and depression. However, stereotyping South Asian culture as oppressed and suggesting the west is liberating can be problematic if taken as a legitimate fact (Anand et al., 2005). If these studies are applicable to Gujarati communities, it proposes the possibility that mental illness is high but women face barriers to seek help.

Illness Behaviours

Hannay (1979), a medical sociologist and epidemiologist set out to study the prevalence of physical, mental, behavioural and social symptoms in a sample population drawn from a Glasgow health centre. Over 1,300 registered patients were seen at home by lay interviewers and Hannay (1979) found that people do not always utilise health services. The 'iceberg' refers to serious symptoms that are not presented for assessment to doctors and the trivia are symptoms that do not need assistance from healthcare professionals. Thus, Hannay (1979) introduced the phenomenon known as the 'symptom iceberg' or 'clinical iceberg' which refers to the notion that many symptoms are not presented to health professions but are ignored, denied, tolerated or self-treated through other means. This can be common in communities where certain illnesses are stigmatised or viewed as not needing assistance from healthcare professionals. For instance, if 'mental health' problems are stigmatised among the Gujarati communities they may not seek help from health professionals. However, the size of the iceberg (the number of people and symptoms) is unknown as the

association of whether to visit healthcare professionals is dependent on a variety of factors including personal characteristics, cultural and social influences and how the illness has been viewed. Consequently, the way in which illnesses are addressed in social groups will rely on strategies that are deemed as appropriate which illustrates how crucial social and cultural factors are. Therefore, the disparity in referral behaviour which is used to describe the behaviour of patients suggests illness is not a simple matter of biological definition but is the product of actions taken by individuals in relation to it. Such actions are called illness behaviour (Hannay, 1980). The following section will explore both help-seeking barriers and alternative strategies that Gujarati communities utilise to manage 'mental health' problems.

Stigma

Many studies have discussed the issue of stigma being attached to 'mental health' (Corrigan et al., 2001; Gilbert et al., 2004; Lauber et al., 2007; Lee et al., 2009; Masuda et al., 2009). Sussman (1997) highlighted, all societies have struggled with the impact of mental illness, and rejection of mentally disabled people are common. Furthermore, Wolff et al. (1996) suggests it is likely that Gujarati young people and their parents reflect wider community attitudes to mental illness that are, in general, negative (Wolff et al., 1996). It is for these reasons that mental illnesses may be denied or hidden and it is managed through these means (Kumar et al., 2010).

Raleigh (1995) found that Asians are more likely to consult their GP on other matters in particular physical health but less likely for mental illnesses. A potential reason for this pattern is that there is stigma surrounding 'mental health' and families may want to keep it hidden. 'Izzat' is prominent in Indian culture and Gilbert et al. (2004) found that the respondents in their study described 'izzat as 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 et al., 2004, p.109). Furthermore, due to the collectivist nature of Indian culture there is a belief that individual behaviour reflects on families and thus people may not seek help (Han and Pong, 2015). Das and Kemp (1997)

argue that in Indian cultures integrity of the family always supersedes individual identity. Furthermore, a collectivist culture also suggests that cultural norms will be emphasised and thus if mental illnesses are viewed as 'mad' or 'crazy', people are less likely to seek help because of the fear of being attached to these stigmatized labels. Therefore, if these labels are prominent among the Gujarati communities it may result in keeping emotional distress hidden and Cohen et al. (2002) found a common attitude was to view mental illness as 'not real'. However, Furnham et al. (2000) found that culture was not a significant predictor of attitudes towards seeking professional help for mental illnesses among Asian groups. Additionally, Ramesh and Hyman (1981) have noted this could be because globalisation and the media has resulted in the psychologisation of many aspects of life and thus it has become common practice to seek help.

Language

Potential differences in language may contribute to South Asian populations in particular Gujarati communities feeling uncomfortable and consequently less likely to seek help (Chiu et al., 2005). For example, Krause (1989) puts forward that there is no Punjabi or Gujarati translation for the word depression. This makes communication difficult and thus a possible reason to not approach health services. Additionally, a lack of common language and knowledge could mean individuals feel like they have a minority status and thus face barriers to healthcare (Jewson et al., 2007). For example, Kleinman (1996) suggests that questions addressing if we feel 'down' or 'blue' makes sense in a western setting, but may not in other cultural communities. These quotes are not colloquial sayings in many cultures and thus confusion may arise. A response to this has been to have services ran by ethnic minorities for ethnic minorities (Ferguson and Candib, 2002) because the current western model is too ethnocentric. This could potentially be beneficial because language barriers are reduced. However, as established earlier mental illnesses may have negative connotations in the communities and result in no difference to help-seeking. Hence, services need to be sensitive to ethnic groups and accommodate their

needs (Jewson et al., 2007) but factors such as stigma and language make it a complex process. Therefore, further understanding is required on how to overcome barriers that can only be learnt by the communities; hence the purpose of this study.

Experience with services

Additionally, language can impact the way in which Asian communities express their symptoms. Kleinman (1986) argues somatisation is widespread among Asians.

Individuals experience serious personal and social problems but interpret them and articulate them, and indeed come to experience and respond to them, through the medium of the body (p.51).

Furthermore, Western societies view the mind and body as dichotomous entities and regard emotions and feelings as contributors toward mental distress whereas for Asian communities the mind and body are perceived as a whole and symptoms are described with a similar manner. For example, Krause (1989) found that women described emotions as 'dil ghirda hai' (sinking heart) which could be perceived as heart or chest problems and not their emotions. Due to symptoms being somatised GPs may interpret them as physical illnesses rather than 'mental health' problems (Wilson and MacCarthy, 1994) hence, a possible reason for general consultation with GP's being high regarding other matters (Raleigh, 1995). However, Fenton and Sadiq (1996) found that women were clearly able to identify their problems in psychological terms and talk about it openly in their mother tongue suggesting that language is the problem.

Language and somatisation suggest that GP's need to be culturally sensitive when dealing with patients. However, Raleigh (1995) argues that this can be detrimental because of commonly held stereotypes about the Asian culture. For example, it is known that the Asian communities tend to be collectivist (Triandis, 1989) and takes care of their own. This assumption could result in a bias in services and according to Raleigh (1995) less recognition of mental illness. For example, the control of women can be overlooked by professionals

as embedded in Asian culture but not a reason for causing distress. Therefore, women in this case may feel like they are treated with a lack of understanding and empathy in health services and thus an obstruction to seek help. 'Inside outside: improving 'mental health' services for Black and Minority ethnic communities in England' was a policy introduced in 2003, which aimed to improve treatment by implementing training procedures to ensure workforces are multicultural. However, communities need to inform these types of policies if they are to prove successful, and again categorising the 'Asian culture' as homogenous can be counterproductive.

Religion/supernatural explanations

A reason for help-seeking barriers amongst South Asians may be their cultural beliefs about causes of mental illnesses and alternative ways of managing them. Studies have found that religion plays a role in both of these aspects with Asians (McGrother et al., 2002; Furnham et al., 2000). Juthani (2001) argues that in Indian communities, supernatural factors play a fundamental role in the beliefs of causes of health and illness. Some individuals may perceive the symptoms to be spiritual or supernatural and not an illness (Livingston et al., 2003). This places the cause to be supernatural and thus no need to seek help from western services (Furnham et al., 2000). This attitude is common in more traditional and religious cultures such as Gujarati communities (Bachu, 1985). Furthermore, 'the interrelationship between the laws of karma, destiny and God's will is often held accountable for ill health by Hindu Indians' (Dalal, 2000 cited by Jobanputra et al., 2005, p.352). Additionally, karma is a strong belief among Hindus which refers to the ways in which 'the past determines the present which combined with the past determines the future' (Sharma, 1973, p.349). Thus, if mental illnesses are viewed as a consequence of previous actions, people may not seek help.

Although, supernatural explanations are common in Indian communities, Jobanputra et al. (2005) found that people were not held accountable or blamed for causing mental illness and this was surprising given the emphasis on evil-eye explanations in Hindu cultures. The evil eye is referred to when

individuals stare superstitiously to cause harm and cast a spell on another individual which is known as 'najar' in Gujarati.

Additionally, some people may view the reason of illness to be the will of God and thus not seek help but pray as a coping mechanism (Furnham, 2000). For example, Hindu women tend to believe in kismet which means destiny and suggests that an individual's mental illness is 'God's will may help explain why South Asian women, in general, do not engage formally in 'mental health' services and why services are under-utilised by this group' (Anand et al., 2005, p.204). Hussain and Cochrane (2004) examined coping strategies by women who experienced depression and found religion and praying to be present. A key thread of supernatural, religious explanations and culture is the use of traditional and alternative medicine.

According to the United Nations World Health Organization, over 70% of the world's population relies on non-allopathic systems of medicine, and these traditional remedies are believed to have therapeutic efficacy treating clients as having spiritual etiologies (Nagai, 2008, p.307).

It has been argued that South Asian communities use alternative medicines but little is known regarding this area and 'mental health' in western societies (Dein et al., 2001; Bhui et al., 2002) because they do not tend to discuss it with doctors (Niv et al, 2010). Jobanputra et al. (2005) describe Indian health beliefs as holistic which include physical, psychological, social and supernatural factors. The next part of the review will explore attitudes towards alternative treatments and views that are specific to Gujarati communities which could prevent seeking help from western services.

Alternative coping strategies

It has been argued that psychological distress may not be perceived as an illness amongst South Asians (Raleigh, 1995) and this can be a contributing factor to not seek help from western medicine and utilise alternative treatments. These include spiritual healing and ayurvedic treatment. The use of complementary

and alternative medicine such as ayurveda has been increasing in the west (Bodeker, 2001; Satow et al., 2008;). Different societies have different ways of dealing with illnesses and in the South Asian culture this has been more pluralistic (Fenton and Sadiq, 1996). Therefore, people will approach people who they feel are the most appropriate and this can range from a family member to the community priest. It is believed that South Asian communities have brought and maintained their traditional culture in the UK but relatively little is known about the use of traditional healing and 'mental health' (Dein et al., 2001; Bhui et al., 2002). The west needs to place more emphasis on understanding the use of traditional remedies because it can improve health services in the UK and broaden its approachability by Asian groups as treatments can be negotiated (Dein et al., 2001). Although, western medicine is available to these communities they are choosing to opt for religion and local healing practices which may be argued as past its era. Dein et al. (2001) argue:

Perhaps this is because local healing succeeds where biomedicine fails by recognizing the links between disease and social, moral and religious events or because traditional beliefs and healing systems are anchors of security for people undergoing the stresses of uprooting, translocation and adaptation to a new society (p. 253).

The use of alternative treatments implies two things: firstly, Asians may not perceive psychological distress as a medical condition but requires spiritual healing or it could mean that the communities find the western 'mental health' services inadequate to meet their needs. If it is this second one, then the medical services can potentially learn from these alternative strategies.

Ayurveda

Ayurveda originates from India, widely used by Gujaratis' and is a traditional remedy that denotes natural substances can sustain good health by ensuring the individual's mind, body and spirit are kept in an equilibrium state (Das, 2012). It is based on promoting health, rather than fight disease (Chopra and Doiphode, 2002). 'Ayurveda, as the name implies (Ayu: life, Veda: Knowledge)

is the knowledge of healthy living and is not confined only to treatment of illness' (Dahanukar and Thatte, 2000, p.2). Its' use is very popular in India; with the sales of traditional medicines being 1.5 times more than medical drugs. It currently serves nearly 75 percent of the population in India which outlines the severity of its dependence amongst the Indian population (Dahanukar and Thatte, 2000). Dahanukar and Thatte (2000) argues that every household in India is knowledgeable about ayurveda and certain plants such as aloe-vera are kept in many houses. Ayurveda is prominent in Indian culture and thus may be widely adopted within the Gujarati communities in the UK.

Additionally, the underlying foundation of ayurveda is that the universe is made up of five rudiments: water, earth, ether, air and fire (Das, 2012). These elements are illustrated in humans by three 'doshas' which means energies: Vata, Pitta and Kapha. Vata is associated with air and ether elements which is the energy needed for circulation and respiration. Kapha relates to earth and water which is accountable for growth and protection. Pitta is linked to fire and water which controls metabolism. If these energies are not kept at the right level, the body will face an imbalance and consequently bad health. In order to maintain balance, ayurveda outlines an explicit diet and lifestyle; which includes the consumption of natural extracts and remedies (Das, 2012). Thus, with regards to 'mental health', if explanations are related to physical health, ayurvedic treatments may be approached. Different societies have different ways of dealing with illnesses and in the Indian culture this may be pluralistic (Fenton and Sadiq, 1996). However, research on the use of ayurveda in relation to 'mental health' is scarce and thus the relationship between the two is unknown (Bhui and Strathdee, 1993, Dein and Sembhi, 2001). Yoga, which is known to be a strand of approaches to ayurvedic treatments will be discussed below.

Yoga

Yoga has become increasingly popular within Gujarati communities in recent years (Das, 2012). The famous Indian spiritual leader in this field, Swami Ramdev Baba advocates that yoga and Pranayama (breathing) has the ability to

cure any illness and provide people with good health and well-being (Das, 2012). He believes that the control of breathing is the biggest medicine of life and it has the power to cure any disease without medicines. Essentially, this type of yoga increases well-being, health and peace (Das, 2012).

Swami Ramdev Baba (2012) suggests:

It is your birth-right to stay disease free, healthy, slim, fit, look beautiful and younger, in complete peace of mind and get back robust health, better than your age. Do not lose hope, do not suffer and stop depending on expensive allopathic treatments, when Indian Pranayama yoga and Indian ayurvedic medicines are there to help you out.

Studies have found that the uses of traditional practices are common with migrants (e.g. Hilton et al., 2001; Niv et al., 2010). Thus, this form of exercise could be an important contributing factor to understanding beliefs and it could also be a reason for not seeking-help through other means. Niv et al. (2010) found people who use alternative treatments do not discuss it with their 'mental health' care specialist and thus individuals can be using more than one treatment. Also, ayurveda is associated with India and some argue that it was historically popular but is now outdated with globalisation and scientific development. Studies have found that the use of traditional practices are common with migrants. For example, Hilton et al. (2001) found that female Indian immigrants in Canada use traditional Indian medicines. This study also found that the women's family and communities influenced them to engage in traditional medicine and put pressure on them to maintain such treatment. Thus, collectivist cultures can be a contributing factor of stigmatising western medicine and thus a reason for the low reported rates of mental illness. Mental illness could be high in the communities and alternative remedies illustrate the true figure is not known.

Summary of chapter

There was an overview medical and social model of health in understanding mental health, inequalities among ethnic groups and management of 'mental health'. These debates and literature has provided the background and an overview of the position of this thesis. This literature review has highlighted that previous studies have lacked an in-depth understanding of the variety factors that influence ethnic communities e.g. social, economic and cultural factors in relation to not only risk factors of 'mental health' but also how it can contribute to understandings of 'mental health'.

Culture serves as the web that structures human thought, emotion and interaction [...] within the multicultural mosaic; cultures shape the conceptions of and responses to mental illness (Guarnaccia and Rodriguez, 1996, P.437)

Therefore, to wholly understand 'human thought, emotion and interaction' a justifiable method was required. Thus, the next chapter will discuss the methodology and procedures utilised to gain and generate this information.

Chapter Three: Methodology and Procedure

Introduction

The context and background to this study has been previously described in the introduction and literature review which directly informed the aims and research questions. These questions were explored through empirical data by predominantly using interviews, but were aided by participant observation. The data generated was thematically analysed in relation to the literature review; fulfilling the aims of this study. This chapter will outline information on the theoretical and philosophical underpinnings, research approach; methods used for data generation, sampling, access, ethical considerations and conclude with personal and wider reflections

Theoretical and philosophical underpinnings

The choice of research method is dependent on ontological and epistemological assumptions (Potter, 2006; Benton and Craib, 2011). Ontology is concerned with questioning the nature of being and how it can be known whilst epistemology refers to what constitutes knowledge and how research can gain this information (Benton and Craib, 2011). This study is qualitative with an interpretivist viewpoint because the underlying focus of the study was to understand phenomena from the Gujarati communities' perspective based on their lives, interactions, history, accounts and behavior (Strauss and Corbin, 1990; Mason, 1996; Marshall and Rossman, 1999). An imperative reason is because this thesis is underpinned by the perspective that meanings are socially constructed by individuals through various interactions in their world.

Merriam (2002) suggests:

The world, or reality, is not the fixed, single, agreed upon of measurable phenomenon that it is assumed to be in positivist, quantitative research. Instead, there are multiple constructions and interpretations of reality that are in flux and change over time (p.3).

Furthermore, individuals construct opinions, beliefs and practices based on their interactions that have occurred in their life which provide them a distinctive interpretation of their realities. Additionally, the literature review established that the meaning of mental illness differs across cultures and disciplines (Cochrane, 1983; Dogra et al., 2005; Patel and Shaw, 2009). Thus, this supports the ontological and epistemological assumptions that meanings are constructed through interactions and in this context, it is cultures. Therefore, a qualitative approach was the most suitable because the focus was to understand interpretations and experiences in a particular context; to focus on Gujarati communities in Leicester. Gujarati communities are distinctive that have their own norms, values and practices, which can influence beliefs. Therefore, this study used the Gujarati communities in Leicester as informants to gain in-depth understanding of their realities and meanings regarding the issues surrounding 'mental health' (Silverman, 2005). The process of exploring how social realities are created and the meanings they have for individuals is far too complex to be understood by positivist approaches and thus a qualitative people-centred standpoint was essential (Rohmann, 2002).

Additionally, other studies in this field have also utilised similar theoretical and philosophical thought. Hussain and Cochrane (2003) conducted a study to explore the coping strategies used by Asian women suffering from depression. The study also employed a qualitative, grounded theory approach within a constructivist paradigm (grounded theory is discussed further below). Hussain and Cochrane (2003) use a constructivist approach. As argued by Charmaz (1995) constructivist assumptions lie on the premise that all meanings are socially constructed and influenced by personal experiences where no one experiences the 'norm' as these are all based on a relativist ontology that is different from one individual to another. Although, I agree to some extent I am also sceptical of this approach and have not utilised a constructivist approach in its' entirety. Predominantly because, as argued, both in the introduction and literature review, the nature of illness and emotions are universal. For example, everyone experiences sadness, but the way it is expressed and managed is

relative to one's experiences of how sadness has been constructed, for example, in a cultural context. As Kleinman and Good (1985) argue emotions cannot be assumed to be the same in different cultures. Therefore, this thesis was asking questions about the universality and/or the cultural specificity of emotions and health and their interpretations.

Research Approach

As clarified above, the nature of this research is predominantly qualitative with an interpretivist epistemology approach. Furthermore, I as the researcher accept the ontological position that meanings and conceptualisations are socially constructed based on interactions and experiences. These meanings are dependent upon context and individuals; and thus, the use of qualitative research methods (Mertens, 1998) to explore these understandings is essential. As stated earlier and argued by Merriam (2002) realities cannot be measured through quantifiable methods but rather require methods that will be exploratory in nature. This is applicable to this study, because the prime aim was to gain an understanding of constructions from the Gujarati population. Due to this, the research strategy that was used is a case study. Thomas (2011) argues that case study research is a popular means that is adopted in research conducted within the social sciences. A broad definition of a case study is:

A research design that takes as its subject a single case or a few selected examples of a social entity – such as communities, social groups, employers, events, life-histories, families, work teams, roles or relationships and employs a variety of methods to study them
(Scott and Marshall, 2005, p.54)

This thesis used a case study strategy in terms of exploring the Gujarati communities that reside in Leicester. Furthermore, it is imperative to note that this thesis adopted Simons (2009) definition:

A case study is not a methodological choice but a choice of what is to be studied...By whatever methods we choose to study the case.

We could study it analytically or holistically, entirely by repeated measures or hermeneutically, organically or culturally, and by mixed methods – but we concentrate, at least for the time being, on the case (p.443).

This approach was the most applicable for this study, not only due to limited funds and time but also because it focused on gaining in-depth knowledge of Gujarati communities on a specific phenomenon and fulfilling Weber's concept of 'Verstehen' (understanding). Furthermore, to understand the perceptions of the Gujarati communities regarding 'mental health' it was essential to consider their beliefs, ideas and values which can influence their actions (Hughes et al., 2003). Therefore, this study focused on the location of Leicester which is densely populated with Gujarati's, more specifically over 25% of Leicester's population is Indian of which the majority are Gujarati.

However, some of the drawbacks of a case study approach need to be considered. A major criticism is its lack of generalisability (Adelman et al., 1977). This study focuses on one ethnic group, which consists of different social attributes, for example migration traits, religious views, caste etc., which can in turn impact beliefs. Thus, it is very difficult, if not impossible, to gain a representative sample which is generalisable from one location. Leicester as a location, is distinctive in terms of its' population and surroundings which contributes to individuals' day to day interactions. As mentioned earlier, meanings are socially constructed through interactions and thus the findings from this study cannot be generalisable. Representativeness is commonly used in quantitative studies based on stratifying on a number of factors and randomly selecting participants. However, this study was interested in understandings, meanings and practices and thus it may not be representative of the wider Gujarati communities, but can be transferrable in parts. Therefore, this study will give an insight of 'one community' in some-depth and could be used for comparisons with other communities and for a reflection of the literature review. Although this element is out of scope for this specific research study, there is still a possibility in the future, to research other communities

that belong to the 'South Asian' demographic in the UK. Therefore, a strong feature of using a case study approach is relatability (Bassey, 1981). Elaborating on this, there are parts of the 'South Asian' cultures that are similar and communities from the 'South Asian' category will be able to relate to findings from this study. For instance, the 'South Asian' cultures tend to be collectivist and thus explorations relating to this could be similar in the Pakistani communities. In addition, the information gained from this case study can be of significance to this research field. Leicester was chosen because of its large and diverse population of the communities, and the sample incorporated these characteristics to ensure a wide cross section of the population was covered in the study.

Grounded Theory

Additionally, the study employed principles of a grounded theory using analytic induction strategy in both methodological approach and data analysis. Glaser and Strauss (1967), the founders of grounded theory, define it as an approach that aims to 'generate or discover a theory' (p.2). This section will provide further details of why only principles of grounded theory were utilised. Glaser and Strauss (1967) argue that grounded theory aims to generate theory purely on the basis of exploring a specific phenomenon using a bottom-up approach; that is one that studies the case study with no hypothesis and generates a theory from that. Additionally, the process of grounded theory is that it prioritizes data collection prior to a literature review or a hypothesis. This is because the research is pure in nature and has no influence from ideas previously conceived.

However, this pure method of grounded theory was not adopted in this study but the aim was to develop theory grounded in the empirical world (Esterberg, 2002) using an inductive approach. This is a method of grounded theory and will be explored below. Shaw (2000) defines Analytic induction as:

Analytic induction, expressed simply, consists of the following stages: a rough estimation and a hypothetical explanation is made

of the phenomenon to be explained; cases are studied in the light of this hypothesis; the aim of testing whether the hypothesis fits the facts of each particular case; if the hypothesis does not fit, then it is reformulated or the phenomena is redefined so that discrepant cases are not included; the cycle is then repeated with the emphasis on seeking cases to disprove the hypothesis (p.22).

This flexibility helped to understand respondents' perceptions and what they perceive as important. Also, analytic induction provided exhaustive knowledge of the situation (Robinson, 1951), unlike a deductive approach, which uses a study to test hypotheses and the findings then determine whether it is accepted or rejected in a linear manner. However, in this study it was impossible to approach the study as an empty vessel as the literature proposed various possible explanations, which were likely to arise in data collection. Ritchie and Spencer (1994) refer to these as 'a priori' codes. Therefore, as Melia (1997) argues, a pragmatic version of grounded theory was adopted in this research. Whilst pure grounded theory approaches studies with an 'empty vessel' and studies the area to generate theory from the findings, this study used literature to define the case study and area of focus, following a bottom-up approach with a specific emphasis on the communities' opinions and perspective.

However, analytic induction entails making a hypothetical explanation of the phenomenon and is studied with the aim of accepting or dismissing the hypothesis (Shaw, 2000). In this study, the factors and explanations outlined in the literature review, determined the focus of the study and looked at the importance of these (migration, racism, religion etc.) in relation to mental illness for the communities. However, these were considered retrospectively in the study through the research questions and did not test a preconceived fixed hypothesis. Therefore, this study was inductive in nature and utilized elements of grounded theory. It is important to reiterate that this study adopted a qualitative standpoint of understanding the perspectives of the Gujarati communities on the matters raised from the literature. Thus, the aim was not

to test a hypothesis but to gain a deep understanding on the subject matter from the perspective of the communities. Therefore, the study was flexible and open to change in direction depending on the insights gained. This is because the research was exploratory which is further defined by Blumer (1969):

A flexible procedure in which the scholar shifts from one to another line of inquiry, adopts new points of observation as his study progresses, moves in new directions previously unthought of, and changes his recognition of what are relevant data as he acquires more information and better understanding (p.40).

This process illustrates principles of grounded theory, which is focused on empirical data leading the direction of the research and generating information (Glaser and Strauss, 1967). Consequently, this study was not purely inductive or deductive but had elements of both. On the one hand, it was inductive in the sense that no preconceived definition of 'mental health' was imposed on the communities, discussions were left open and patterns were explored to answer the research questions. On the other hand, it was deductive because the literature outlined the focus and possible explanations for the low prevalence of mental illness amongst the Gujarati communities, which were further explored. There was a close relationship with data collection, analysis and theory (Strauss and Corbin, 1990). Thus, this approach utilized principles of grounded theory because it was open and flexible in nature, simultaneously using literature to focus the qualitative inquiry.

Data Collection

Access

Reimer (1977) outlines the term 'opportunistic research' that relates to the ways in which a researchers' identity and background contributes to studying, or enhances an 'opportunity' to study an area he or she may belong to. This can indeed translate to a research sample, and when the identity of the researcher and research sample is the same; namely an 'insider', the research sample can be, in many cases, more accessible. The ethical dilemmas and nature of my

'insider' status will be discussed in the reflexivity section in this chapter. This study required first-hand knowledge of Gujarati, as well as a researcher who could gain access and command the confidence of the communities successfully. This is an important factor in gaining access to the communities because the area of study is one that is not only sensitive, but a taboo subject (e.g. see Lee et al., 2009; Masuda et al., 2009). Correspondingly, similarities in identity could amplify understandability in attitudes and cultural opinions. Furthermore, 'insider' status helped in gaining access through practicalities as I knew the appropriate cultural behavior in the various access routes, i.e. how to behave in temples and being fluent in Gujarati, resulted in there being no language barriers during the research.

Access was gained to the research sample using various methods: regular attendance at temples, the Gujarati samaj's which are community organisations (further explored in the following chapter), local community centres, the annual religious mass celebration of 'Navratri' (see glossary) which involves halls and committees and snowball contacts. I used these methods with confidence as this is a strategy that has been used successfully in other research on the Gujarati communities (Patel and Shaw, 2009). Furthermore, I gained access to the various samaj's through two main associations: 'Gujarati Hindu Association' and 'Gujarati Arya Association' in Leicester, which is known to be the leading Gujarati community groups with a membership of nearly 900 families making over 3,500 in population. Various temples, samaj's and associations were approached to enhance the profile of the study and increase the probability of covering a wide proportion of the population to ensure differences were included in the sample (Cohen et al., 2007). Additionally, different temples accommodate different devotional groups (Swaminarayan, Jain, Pranami etc.) and samaj's are formed around geographical location of clustered villages in Gujarat (explored further in the next chapter). It was not only important to have a range of access techniques to increase the likelihood of gaining participants, but also the numerous access routes were used to gain a cross selection of the population. This is vital for this study because different

devotional groups and castes have distinctive beliefs and characteristics which can have an influence views surrounding 'mental health'.

The process of access required attending religious celebrations, community events and proceedings conducted in temples. Whilst it raised the profile of the research and helped me integrate in the communities to build rapport, it also introduced an element of participant observation. DeWalt et al. (2002) suggested that:

For some, in fact, participant observation is an approach to get deeper, more solid contacts with the people and situations rather than a method in it itself. The use of participant observation allows for greater rapport, better access to informants and activities, and enhanced understanding of the phenomena investigated using other methods (p.93).

Therefore, the initial research design anticipated using participant observation as a means of gaining access to my participants. This did develop into incorporating it as a method of data generation, which will be further explored in the methods section of this chapter. Participant observation was also crucial as a means of building rapport and gaining contacts in this context, as the subject of study is one that is sensitive, but also with the potential stigma attached, can be difficult to discuss (Corrigan et al., 2001; Gilbert et al., 2004; Lauber et al., 2007 Lee et al., 2009; Masuda et al., 2009). It also allowed for the potential participants to ask questions and clear any queries they had regarding the research and the expectations of them as participants (Macdoughall et al., 2001).

Sampling

The sample was accessed through non-probability sampling methods due to the study being qualitative and the research strategy utilised was a case study. In adopting this method, the sample was not statistically representative and selection did not occur randomly, but this is a strong feature when conducting

small-scale, in-depth studies (Lewis et al., 2003). Furthermore, the focus was not on generalisation but on in-depth probing to gain detailed descriptions regarding the issues identified in the literature review and the research questions. It was also beneficial because the group is a minority in England (Marsh, 2002) and thus a case study approach of focusing on one location (Leicester) was utilised. The two sampling strategies that were employed were: purposive and snowball sampling. Purposive sampling is when the participants possess specific qualities that meet the needs of the study (Esterberg, 2002; Mason, 2002; Patton, 2002). The criterion of this study was that the sample had to be Hindu Gujarati who have migrated to the UK. In addition to this, there was no list from which the sample could be extracted and thus snowball sampling was employed (Marsh, 2002). This referral scheme through word of mouth was the only permissible option that would successfully maintain the requirements of this research (Esterberg, 2002). Thus, it was an efficient method and allowed for first-hand communication that was required for this study (Cohen et al., 2007). This was discussed in the previous section.

There was also an element of convenience sampling present in this study. Leicester was used as a location not only because of its high Gujarati population but also due to limited funds and time, and I as the researcher, live in the East Midlands. Furthermore, an advantage of choosing Leicester is that I do not belong to the communities and can to some extent maintain a high level of objectivity (further discussed in reflexivity section). Furthermore, there were no language barriers because I can speak Gujarati fluently, making the research population far more accessible.

Methods

Firstly, secondary data was utilised to gain an overview of the debates surrounding the topic of discussion and the background of 'mental health', risk factors and help-seeking barriers the Gujarati communities may face. This includes relevant books relating to this area, academic journal articles and policy documents. These were used because previous academic work has been done in this area and it has been useful in illustrating a gap in the research field

(Rubin et al., 1995). Additionally, it aided data analysis of empirical data that will be revealed in subsequent chapters. Not only has reviewing secondary data provided this study with these advantages but it has also laid out the fundamental structure of this research and the strategy adopted.

Initial changes to method

In the initial proposal of this study, it was anticipated that focus groups would be conducted to explore the first area of understandings and conceptualisations of 'mental health'. A focus group can be defined as a group interview (Hughes and DuMont, 1993; Esterberg, 2002;) which is a 'carefully planned discussion' (Krueger, 1994, p.6) designed and conducted by a skilled interviewer (Krueger, 1994; Litosseliti, 2003) and usually involves seven to ten people. Focus groups are conducted to explore peoples' views, experiences and perceptions on a topic of interest through group interactions (Krueger, 1994; Smithson, 2000; Litosseliti, 2003). Furthermore, it is important this method is approached in a way which is nonthreatening and the discussions are relaxed and participants feel comfortable (Krueger, 1994). However, when I started to gain access to the Gujarati communities by visiting temples and centres, conversations with potential participants suggested that this would not be a possibility. During the initial access period, members of the Gujarati communities were happy to have discussions with me regarding my study and their opinions on 'mental health' but were both hesitant and resistant when I asked if they were willing to discuss their views in a focus group setting. Although I followed Krueger's (1994) views on inviting participants to 'discuss' rather than take part in a focus group to ensure it was not daunting and more comfortable, it did not harmonise with my prospective research group. Whilst, my early thoughts were, perhaps it was due to being an unfamiliar face in the community and that time was required to build rapport; a three-month access period did not alter this. When discussing the access period, I am referring to attending temples and community events to build rapport and recruit my participants.

I recognised that discussing 'mental health' is a sensitive area as it is a personal matter. Gilbert et al. (2004) argue, there may be stigma attached to mental illness in the Gujarati communities. Indeed, participants on a number of occasions expressed their concerns to me regarding this method and they were either too busy or uncomfortable with taking part. Upon reflection, I made an informed decision to not use focus groups as they were deemed inappropriate and incompatible by potential respondents. Morgan (1998) argues focus groups should be avoided if participants are uneasy to discuss the given topic of interest. In hindsight, this period of reflection allowed me to learn more about the Gujarati communities and it was something that I could probe more deeply about in a one to one interview setting. It is significant to note that at this stage I did not assume discomfort was because of stigma and was self-reflexive of my role as a researcher. In retrospect, it may have been due to my age, and that participants did not feel comfortable speaking to someone young. Therefore, I agree with the premise, 'research is a joint product of the participants, the researcher, and their relationship: it is co-constituted' (Finlay, 2002, p.531). This will be discussed further in the reflexivity section, however my interviewing approach utilised Holstein and Gubrium's (1995) term of the active interview. They view the interview method as an approach where data is co-constructed by both the interviewer and the participants and thus the interviewer should identify their role in aiding constructing data. Therefore, rather than using interviews as a method for data collection, I used it as a mode of data generation, which my own characteristics influenced (further discussed under reflexivity). I will now explore the empirical methods that were used.

Interviews

Silverman (2000) suggests that the choice of research method is dependent upon one's research objectives. Therefore, it was crucial to choose a method that was relevant to the research questions, which primarily lie on the foundation of finding out participants' understandings, perceptions and opinions. Therefore, one-to-one semi-structured interviews were used, which suit the exploratory nature of the research and address the study questions

outlined in the introduction. Semi-structured interviews can be defined as an organised conversation between an interviewer and an interviewee to discuss a defined topic with open-ended questions and flexibility (Flick, 1956; Denscombe, 2003; Hoffmann, 2007; Barbour, 2008; Silverman, 2011). May (2001) puts forward that a focused interview is like a semi-structured interview which allows for the research questions to be addressed but does not restrict the possibilities of participants discussing issues that had not been considered when designing the interview template. Although, this type of interview is very similar to a semi-structured interview, the various different 'focuses' that came about in the interviews were discussed in subsequent interviews moving away from the semi-structured format. This flexibility adopts elements of grounded theory and has an inductive approach which has been previously discussed. To reiterate, this method was utilised because the prime aim is to explore opinions and experiences (Byrne, 2004) and generate in-depth information regarding 'mental health' (Walker, 1985; Gillham, 2000) from the Gujarati communities' perspective.

There are several reasons why interviews were the most appropriate for this research. Practicality reasons include: easy to arrange, little resources (Denscombe, 2003) and ability to prioritize topics (Gillham, 2000). The flexibility also provides:

the opportunity for the researcher to probe deeply, to uncover new clues to open up new dimensions of a problem and to secure vivid, accurate, inclusive accounts that are based on personal experience (Burgess, 1982, p.107).

This allows for the process of creating knowledge and uncovers entities the researcher may not have even thought about (Herzog, 2005). This is crucial for because the study was concerned with not only exploring what is happening in the communities regarding mental health, but understanding why and its implications. In proposing the usefulness of semi-structured interviews, there

are a few limitations with this method. It is difficult to make generalisations, it is time-consuming and is criticized for being an artificial construct and thus a lack of truth is provided (Denscombe, 2003; Hoffmann, 2007). However, the study aimed to gain in-depth detail on the communities' views and consequently complete generalizability is impossible. Rapport was built with the communities through the access period which entailed attending group events and social gatherings. This ensured trust was built and respondents were comfortable during data collection because interviews are personal and can cause an invasion of privacy (Esterberg, 2002; Denscombe, 2003; Silverman, 2006).

Furthermore, the initial interview guide was generated through the literature review and can be found in appendix 1.1 for reference. It should be noted that the guide is merely indicative of the structure of the interviews; which were predominantly led by participants' experiences and views. This allowed me to explore what the participants' deemed important and relevant to the topic area and permitted examination of areas that neither I, nor previous studies had considered. Throughout my interviews, I reflected upon the information I was generating and included them in subsequent interviews to gain opinions on the suggested issues. Additionally, it should be noted that alteration to the direction of research based on participants' revelations and simultaneous data collection and analysis, are features of grounded theory (Charmaz, 1990); principles that were utilised in this study. I have implemented components of grounded theory and as Crooks (2001) argues it is ideal for exploring behaviour of groups where there has been little exploration of the contextual factors that affect individuals' lives. Therefore, the second modified can be found in appendix 1.2 for reference. Additionally, because of this on-going data generation and analysis; another change was implemented in my research. I decided to interview second generation migrants because there was distinctive information about cultural change that participants suggested was causing distress and I wanted to explore how second-generation migrants felt about these various matters. The same interview templates were used and modified

as participants took discussions in new directions. This data is further explored in chapter six.

Interviewing was a learning process and throughout the period I was reflexive and kept a research journal; as Newbury (2001) argues, diaries facilitate the research process through recording thoughts and questions as they happen for later use and stimulates reflective thinking. It allowed me to keep a record of initial thoughts and adapt questions to make them more applicable to the data I was generating. For example, an initial challenge I faced was trying to get people to express their past experiences in relation to ideas being discussed rather than discussing 'mental health' broadly. I incorporated the technique of describing other anecdotes and narratives from previous participants which was successful in generating clarity of questions and initiating participants to think about their lives and discuss their views.

Overall, I conducted 45 interviews, 30 with first-generation Gujarati migrants and 15 with second generation migrants and all the interviews were recorded using a dictaphone. This allowed for the richness of data not to be lost and critical for data analysis (Silverman, 2005). Another method related to semi-structured interviews that was used was demographic surveys. For this research, they were not utilised for analytical purposes but rather to illustrate that individuals from the Gujarati communities have characteristics that are different. It was argued in the introduction that previous studies and in epidemiological studies use the category 'South Asian' in their results. This can cause ecological fallacy (Bryman, 2004) where findings based on broad data is related to individuals' and as a result risk making general cultural stereotypes (Burr, 2002). Therefore, I wanted to illustrate that exploring the Gujarati communities in Leicester, does not remove the issue of ecological fallacy but rather demonstrate that I recognize the communities themselves are not homogenous and make up a variety of religious beliefs, family make-up, occupation etc. Thus, a critical justification for using 'communities' in this thesis rather than 'community'. A copy of the demographic survey can be found in

appendix 1.3. The summarised data from these surveys for both first and second-generation Gujarati migrants can be found in appendix 1.4 and 1.5.

Participant observation

As explored earlier, the initial research design did not incorporate conducting participant observation as a method for data generation, but it formed part of the methods used whilst gaining access to the sample. However, due to adopting principles of grounded theory, and analytic induction, the methodology changed in line with the data being generated. During many interview discussions, I was told that the communities hold seminars to discuss 'mental health' and they have a doctor or an ayurvedic doctor present to answer any questions. I gained further ethical clearance to progress with conducting participant observation. The decision was made to do participant observation based on this purposive goal: to establish how and to what depth 'mental health' was being discussed in this environment? It was a means to gain further information on the research questions to this project.

Additionally, in social research where both participant observation and interviews are used simultaneously, studies are often named to be an ethnography or indeed have elements of an ethnographic approach (Emerson, 2009). An ethnographic method examines behaviour that happens in naturally occurring environments 'within specific social situations, including behaviour that is shaped and constrained by these situations, and people's understanding and interpretations of their experiences' (Chaddha et al., 2009, p.549). Although, the development of the methods used resulted in exploring behaviour in a naturally occurring environment, I did not find it suitable to commit myself to doing an ethnography for two reasons. Firstly, the participant observation had a specific and confined aim, I did not observe 'interpretations of their experiences' but rather if and how 'mental health' was being addressed. Secondly, traditional ethnographies occur when a researcher immerses him or herself in each field for a long period of time and interviews informants from this research setting (Fine, 2003). However, I did not do this

and partook in participant observation once, for a couple of hours with a set purpose that was induced from interview data. The observations were recorded in a diary, after the events to ensure the environment continued as naturally as possible. Furthermore, it is vital to note that meanings and experiences cannot be visibly expressed and require interviewing and social interaction (Emerson, 2009). The fundamental aim of this research was to explore meanings and experiences, thus exploratory in nature and interviewing was the primary methodology used to accommodate the epistemological and ontological underpinnings of this study, which have been explored above.

Data Analysis

I approached this research with the premise that data analysis is not a straightforward activity that can be left until data generation has been completed, but rather an ongoing process that occurs simultaneously alongside data generation (Berg, 2001). Therefore, data analysis occurred from the initial stages of the study because as Silverman (2011) argues the flexibility of qualitative research allows for the possibility of exploring ideas that were not considered and can introduce further questions; an example of adopting elements of grounded theory that was discussed earlier.

However, the formal process of data analysis was carried out once the data generation had been completed. This is required to give information produced meaning, as Bryman and Burgess (1994) state, data are 'voluminous, unstructured and unwieldy' (p.216). The two main ways of recording data were from my research diary, where I documented my own emotions, feelings and any other discussions I had in the field with my participants and interviews that were recorded. These interviews were transcribed in full and I thoroughly read through all my transcripts, jotting down notes and codes to begin with. I then started a more formalized approach and transferred all my transcripts to Nvivo, and made codes under the various themes that were created from the interview schedule template, and a codebook was produced (Mason, 2002). However, this was purely for practicality reasons and using a codebook was not

restrictive to the interview schedule, but there was a strong emphasis on letting the themes emerge from the empirical data (Mason, 2002). These concepts were put into minor and major themes and then analysed individually and compared with each other (using cognitive mapping discussed below). Major and minor themes were assessed through the importance the participants gave topics, e.g. if they are explicitly stated in discussions and its' frequency. Drawing on elements of grounded theory, this approach enabled the development of meanings (Strauss and Corbin, 1990) as I analysed my data throughout data generation and modified questions in the light of the findings. This eliminates the danger that Gray (2003) alerts to of codes becoming fixed and data remaining static.

Comparing themes was aided through a method known as cognitive mapping. An example of one I constructed can be found in appendix 1.6 for reference. A thorough analysis was conducted through diagrammatic form which works through a range of patterns and perceptions.

In mapping we are listening for, and seeking to represent, persons' explanatory and predictive theories about those aspects of their world being describes to us. A cognitive map comprises two main elements: persons' concepts of ideas in the form of descriptions of entities, abstract or concrete, in the situation being considered; and beliefs or theories about the relationships between them, shown in the map by an arrow or simple line (Jones cited in Walker, 1985, p.60).

I felt this approach was crucial to the study and in par with my research questions. The focus of this thesis was exploratory in nature and aimed to find out the beliefs and understandings from my participants. Indeed, analysis is a very personal process, but cognitive mapping allowed for a way to identify 'beliefs and relationships' from my participants' perspective. This allowed me to distinguish the relationships participants outlined from the analysis and interpretations I was making from the data we co-produced. Understandably,

a negative feature of this process is that diagrammatic illustrations can represent links and patterns but they may not have a significant correlation. Although an individual mentions two factors it does not necessarily mean they are significant but indeed are interlinked. Therefore, it is vital that this study incorporated data description, interpretation and cross-referencing, with both the literature review and empirical records to allow for a more meaningful analysis.

As a result, after coding, conducting thematic analysis and illustrating these themes using cognitive mapping, I felt that 'stories' and 'personalities' were side-lined with the above approaches. This research was exploratory with an explicit focus on 'mental health', but as the literature has outlined, personal histories can account for 'mental health' problems such as effects of migration (Cochrane et al., 1977; Cochrane, 1983; Kuo et al., 1986; Beiser et al., 1993; Nevo et al., 2006). Therefore, I decided to use 'participant portraits' (Gray, 2003, p.152), as a next measure of analysis. An example of one can be found in appendix 1.7 for reference. Gray (2003) uses participant portraits to illustrate her data. Gray (2003) quotes in her process of analysis:

I further decided that I would quote extensively from my interview material in order to keep the distinctive voices of the women in my text, to enable readers to have greater access to the interview material and in order to make the book readable, potentially for a wide than merely academic audience (p.152)

Although, I adapted and utilised this approach differently. Word limitations in this thesis would not allow me present such extensive extracts from the interview themselves, but the 'participant portraits' were used as a measure of analysis to capture personal narratives that I did not want to neglect in this thesis. It is also imperative to my philosophical and theoretical underpinnings alongside the topic of research. For example, in the Introduction it was argued that various social, cultural, psychological and biological factors contribute to one's 'mental health' (WHO, 2016). As each individual has a different narrative,

which inherently is linked to their own social interactions and thus contributed to the ways in which social constructs were formulated in their lives, it was necessary to capture this. Therefore, I used 'participant portraits' to showcase peoples' stories and their previous experiences which allowed for people's personalities to remain in the research rather than participants becoming an interviewee number that took part in a study.

Complexities in analysing qualitative data

As a novice researcher, the research design of size of sample was left open and directed by access and practicalities of gaining participants. However, once I was in the field, I had no problems with gaining participants, conducted 45 interviews and could have easily conducted many more. These interviews lasted from one to three hours and generated a large volume of in-depth qualitative data in the form of interview transcripts, which in return amounted to timely analysis. However, I did not anticipate conducting this many interviews but did for two key reasons:

1. My research data led me to interview second generation migrants as data generated revealed cultural changes were causing emotional distress. I wanted to explore if the feeling was mutual with the second generation who were born and raised in the UK.
2. A little naively of me, I thought I would reach a 'saturation point', a point at which data becomes repetitive and nothing new is being revealed. This would have been my cue to stop data collection. However, a 'saturation point' never came for me and in fact, each interview I did was different and had new data emerging. Reflecting back, this is expected in qualitative research where every individual's 'story' is different. The implication of this is that, time constraints limited data generation but illustrates that this is an area that requires ongoing research.

The large volume of data that did not reach a 'saturation point' was full of contradictions which raised complexities during the analysis process. The data itself will be explored in subsequent chapters, but here I'd like to unravel the approach I undertook to address these issues. Miles (1979) sums up my difficulty well:

The most serious and central difficulty in the use of qualitative data is that methods of analysis are not well formulated. For quantitative data, there are clear conventions the researcher can use. But the analyst faced with a bank of qualitative data has very few guidelines for protection against self-delusion, let alone the presentation of unreliable or invalid conclusion to scientific or policy-making audiences. How can we be sure that an "earthy," "undeniable," "serendipitous" finding is not, in fact, wrong? (p.591)

Throughout my research, I have learnt that we should not focus on what is right or wrong, guidelines or 'correct' ways of analysis. In fact, we should embrace the contradictions in qualitative data because they are telling us something important. Our lives are not straightforward, but embedded in social, cultural and economic complexities. In relation to my research questions, this meant that a flexible approach needed to be adopted. Although the research questions were formed from the literature review, it could have resulted in them not being significant to the communities'. Therefore, research questions may change in the process of qualitative research, as when one is interested in the experiences and meanings of particular groups, this can divert to other areas that are important to the participants. As a result, we should not be alarmed when this is revealed in social research and of course, these various revelations on other areas such as marriage (explored in chapter six) can contribute to variations in health. Qualitative research highlights the complexity of how different components in our day to day lives impact our health, and thus there may not be a clear pattern which can be improved by policy interventions. But it highlights, real dilemmas people face and I argue

that on-going research is essential in the area of ethnic inequalities and 'mental health'. Continuous research with communities identifies changing views and experiences and this requires on-going understanding by healthcare professionals. This could perhaps improve interactions with different cultural communities and ensure 'mental health' is better managed. Here I have begun to illustrate a reflexive view of the empirical methods that were used in this research and the latter part of this chapter will elaborate on this by focusing on ethical considerations and analysis of myself as a researcher.

Ethical considerations

This research received ethical approval from the Research Ethics Committee in the School of Sociology and Social Policy at the University of Nottingham. I formally followed and fulfilled the ethical guidelines. I ensured I was ethical throughout the research process as 'ethical behavior helps protect individuals, communities and environments, and offers the potential to increase the sum of good in the world' (Hay and Israel, 2006, p.2). However, this section will provide a brief overview of the pertinent factors that were raised as concerns as well as the ways in which I addressed them.

Informed consent

In the earlier section of access, there was an exploration of the ways in which access was implemented in this study. After this stage, contact was made to arrange the interviews usually through several phone calls. The process of arranging interviews and having contact with my participants prior to the interviews, allowed for rapport to be built but also an opportunity to ensure there was no confusion with regards to the study and the interview process. This proved to be critical, as building rapport was crucial to ensure participants were open about a topic that is stigmatized and kept private within the communities (Lee et al., 2009; Masuda et al., 2009). Additionally, I left participant information sheets at temples and organizations but if participants had not seen this prior to their interview, I gave them an opportunity to read through it at the start of the interview and clarify any concerns or questions

they had regarding the study. The information sheet outlined the necessary details of the study, but not in full detail. According to Robinson (2007), this softer approach is beneficial in ensuring participants do not feel pressured to express certain perceptions, which is crucial when the topic of study has been identified as one that is heavily stigmatized within South Asian communities (Gilbert et al., 2004; Anand et al., 2005). Consequently, the information sheet did not outline the various explanations that have been illustrated by previous literature regarding low prevalence of mental illness (e.g. stigma, social capital, help-seeking barriers), but said there have been conflicting ones.

Once participants were satisfied with the information and the process of the interviews, written voluntary consent was obtained; this protected both parties involved and also prevents any exploitation (Ferdinand et al., 2007). It was crucial that participants understood what they were getting involved in, but also to be made aware of their complete freedom to withdraw at any point (Faden and Beauchamp, 1986; Allmark, 2002; Silverman, 2010). Finally, a copy of the consent form was always given to the participant and one was retained by the researcher. Confidentiality and anonymity have also been respected throughout the study and pseudonyms have been utilized in this thesis (Silverman, 2005).

Additionally, when conducting participant observation, verbal consent was utilised due to the environment, and the sole purpose of keeping events completely undisturbed. A further significant point is that participant observation can be unpredictable and thus ethical checklists do not account for situational circumstances. Therefore, it was even more critical that I was self-reflexive throughout the study and assessed all situations faced (Ferdinand et al., 2007).

Interview location: private spheres

Predominantly, the interviews were conducted at participants' homes which are closed private spheres. Alder and Alder (2002) argue that interviews dealing with sensitive issues such as 'mental health' are best conducted in the home

where respondents are comfortable. Due to the area that was being researched, this location was pivotal because it is one where many people can give a lot of time, and it is convenient for participants (Bennet et al., 1981). The ethical issue that surrounds this is indeed the safety of the researcher and several measures were taken. I followed the Social Research Association's (SRA, 2003) code of practice for the safety of social researchers in setting up fieldwork. I ensured that I obtained prior information about my sample by attending temples, as well as engaging in several conversations over the telephone allowing me to observe if there was anything I felt uncomfortable with. I also planned my route in advance to be aware of the location and assess the area and my safety. With time, I became more comfortable with this process as snowball sampling was utilised. I had been in contact with my gatekeepers for a lengthy period of time and good rapport was established.

Whilst conducting the interviews and entering my participants' homes, my safety was addressed by following my schools' 'safety call' procedure. I would give the address, date and time of the pre-arranged interview to a friend and they would call as a safety check once I arrived at the location. This procedure abides by the British Sociological Association statement of ethical practice (BSA 2002; point 8, p.2), which suggests that safety issues need to be considered in the design of research and procedures should be adopted to reduce the risk for researchers. Additionally, I had used these procedures beforehand in another study and thus was confident I was safe whilst visit participants' homes.

Potential involvement of vulnerable people in the research

Whilst ethics are always a concern for researchers, in this project it was especially important that ethical implications were carefully considered because participants who may have a mental illness are considered to be vulnerable (Oliver, 2003). Although, when designing this research, it was not intended to use participants who have had or currently have 'mental health' difficulties, this was certainly a possibility. Therefore, prior to conducting the

research, I had to ensure that procedures were in place to minimise harm and the actions I should take if any problems arose during data collection.

According to the Economic and Social research council's (ESRC) research ethics framework (REF); risk is defined as 'reference to the potential physical or psychological harm, discomfort or stress to human participants that a research project might generate' (Section 2.1.2 p.20). To avoid this ethical issue, as explored previously, I gained and secured written consent. Participants were given an information sheet as well as opportunities to ask questions or clarify any misunderstandings. This process not only enabled me to secure trust and confidence, but gave participants time and ample opportunities to decide if they wanted to take part in the research.

Once consent was firmly acknowledged, if I was interviewing an individual who has/had 'mental health' problems, I approached the interview in a sensitive manner. The procedures taken in case further emotional risk was caused are discussed below, as it could occur with individuals who do not experience any 'mental health' problems but perhaps have family members or friends who do so.

Greater emotional risk

The interviews required participants to discuss their understanding and attitudes towards 'mental health', experiences or encounters, and management in terms of cultural, social and economic factors. Discussing personal experiences and attitudes could have potentially been distressing to my participants as they were revisiting areas that were sensitive, and trigger a range of emotions; positive or negative. Thus, as a researcher, I had to ensure that emotional risk was minimised for participants taking part in my study. Voluntary consent alone does not eliminate my responsibilities of ensuring that participants do not experience greater emotional risk as a consequence of being involved in interviews. I ensured I built rapport during the contact I had with participants prior to the interview and I was completely respectful and sensitive at all times.

During the interviews itself, I began with general background questions of people's history, migration traits and how they found the experience of migration, settling down in the UK and their current situation regarding family structure, marriage, children and opinions regarding living in Leicester. Although, these questions usually entailed a response of factual data such as place of birth and year of migration; it was beneficial in my experience, and aided the set up for rest of the interview. This sort of information required little thought; it was easy to answer and participants were able to familiarize themselves with what the process would entail; making them feel more comfortable. Usually questions that followed explored how people felt when they migrated and experiences of adapting to a new setting. In hindsight, the latter part of the background questions started allowing participants to think about their feelings and opinions, which was essential to the rest of the interview. I think it was important to ask these questions, not only to set up the interview and to provide context, but it also allowed participants time to feel comfortable and ensure the interview continued in a conversational manner.

However, this did not protect participants from feeling greater emotional risk. I reiterated at the start of the interview that they could stop when they wanted to, choose not to answer questions they were not comfortable with and ask any questions throughout. However, if I noticed that a participant was feeling upset or distressed I would follow these steps:

- Stop data collection
- Offer appropriate comfort (tissue, gentle encouragement)
- Give them a chance to talk about their distress and listen accordingly
- Ask if there was anyone they would like to tell or contact about their distress, so they are not left to deal with it alone. If the interview took place outside the home e.g. temple, was there someone they may want to be with that I could call.
- Agree to contact the person mentioned above
- Stay with them until their distress had passed

- Leave a list of support numbers from the NHS, one main one being Open Mind in Leicester which is a talking therapies service and patients can self-refer.
- If the above was not sufficient, have supervisors' number to hand in a case of emergency.

With regards to emotional risk, I only had one participant who cried during the interview due to her discussing a loved one passing away. I followed the above procedures, but she wanted to carry on with the interview after a short break. In fact, by the time I left, she had been happy to take part and the process gave her an opportunity to discuss some things that she was not comfortable doing so with friends and family members.

Self-Reflexivity

One component of the research process that has been given prime attention to is 'reflexivity'. A piece of research is undermined, weak and insignificant if reflexivity is not considered to say the least. Reflexivity has increasingly become a buzz word and a component that is an essential requirement of ensuring qualitative research is critical (Jootun et al., 2009), and thus more credible. There are many variations of what reflexivity means and what the process entails, but these share a key concern with the positionality of the researcher and the influence this may have, either intentionally or unintentionally, on their findings (Fontana, 2004). Reflexivity takes up questions of researcher bias, subjectivity and other influential factors that are present through the process of designing a study, generating data, and writing up research.

However, despite the growing literature that challenges the traditional binary between the 'rational' and 'emotional' in social science research, the 'emotional' continues to be side-lined (Herman, 2010). Whilst lip-service is paid to the importance of reflexivity, which is described as 'a turning back on oneself, a process of self-reference' (Davies, 2008, p.4), in practice, it is often the case that only certain kinds of reflexivity are welcomed, through which only certain kinds and levels of emotion are permissible. Traditionally the focus is on how interviewees respond to factors such as age, gender class and race

(Silverman, 2005). This is known as an interviewer effect and people respond differently to how they view the researcher. In turn, this reflects on the level of detail as well as the depth of information provided (Denscombe, 2003). Whilst I agree that this is an important component of research, it is also important to reflect on emotions as an interrelatedness facet of not only the researcher's identity, but the process of data generation and production. Emotions in the research process erupt from the biographical and social time they are interwoven into, and can influence ways in which data is generated by both the researcher and participants. For example, as explored later, young researchers can often feel insecure in their research roles, or as novice researchers this can bring a range of emotions for instance apprehensiveness as well as feeling excited which can indeed impact the nature of research. Furthermore, researching a sensitive area such as 'mental health' could also bring a range of emotions. As Kemmer et al. (2001) argue, little attention has been given to 'researcher emotions'. Unless emotions in research are acknowledged, not only are researchers left vulnerable, but our understandings of the social world will remain impoverished. I contend that emotions play a central role in the social world, and therefore need to take center stage.

Therefore, reflexivity that is also inclusive of the emotional journey of research is not a process that is static or a tick box activity. Rather, it has been an on-going process that has evolved and is still evolving throughout this process. As a result, the following section that explores components of self-reflexivity of identity and emotions are written for this thesis. These facets will undergo further exploration and thus are subject to evolve and at times even change. This section will provide details on reflexivity with a focus on emotions through three key areas: insider-outsider status, power in the research relationship and researcher as translator.

Insider-Outsider status

Researchers bring a range of social, historical and cultural baggage to the field (Gubrium and Holstein, 1977; Keller, 1984; Harding, 1987) which can influence

the way in which researchers are viewed by participants. To some degree, it can be argued that I am an 'insider' because I am a Hindu Gujarati. This status has positive and negative implications for conducting research and these will be explored below.

Firstly, it was positive in the sense that having shared cultural characteristics as your participants, establishes a similar grounding (De Andrade, 2000). As a result, this made it easier to negotiate access, develop rapport and gain trust within a minority community in the UK (Glassner and Miller, 1977). This allowed for more extensive discussions during data generation. For instance, to gain access to the Gujarati communities, the Mandir (see glossary) was one of the avenues utilized. As I am a Hindu I was aware of the cultural and religious behavior in temples, making approachability far easier. Additionally, many participants felt more comfortable speaking in Gujarati and having an 'insider' status, accommodated this comfort as there were no language barriers. De Andrade (2000) argues that the fewer differences between the researcher and participants, boundaries by the group are much more fluid, which enhances better rapport proving beneficial for research. Data provided by participant was rich and in depth as will be illustrated in the subsequent analysis chapters. Furthermore, being a minority group in the UK, avoids assumptions or judgements by an outsider within the group, because culture is a very personal attribute to research. If there are social distances, then interviewees may not trust the researchers and give limited answers (Glassner and Miller, 1977).

Arguably, this can also have implications for research. It could increase bias, subjectivity and some meanings of words, sayings or cultural traditions that the researcher is familiar with could be taken for granted. Therefore, 'the interviewer must shake of self-consciousness, suppress personal opinion and avoid stereotyping the respondent' (Gubrium and Holstein cited in Silverman, 1977, p.118). This in theory is impossible but I argue not negative but rather an implication that affects all qualitative research. Asselin (2003) suggested that an insider researcher should gather data with their 'eyes open' and assume that they know nothing about the phenomenon being studied. Thus, throughout

this research, I ensured that I started from discussing meanings and understandings of 'mental health', rather than imposing one on my participants. This ensured meaning and shared cultural understandings were not taken for granted but indeed my own emotions and experiences contributed to the data that was generated.

Power in the research relationship

An aspect I considered prior to conducting the research was ways in which being a female researcher would impact the research and indeed how respondents would view me and subsequently approach the data generation. Silverman (1977) argues that individuals respond differently to age, gender, class and race which is a practical reflection. These social differences can cause distances and result in a lack of trust where it is assumed that the 'other' will not be able to understand responses (Glassner and Miller, 1977). This notion of 'us' and 'them' is prevalent in the interview context where 'power is multifaceted and sometimes difficult to assess. Interviewees often perceive the interview as both an "opportunity" but also a "threat' (Hoffmann, 2007, p.321) as power can have dynamic relations. overall, belonging to the same ethnic group, this power dynamic was avoided but gender and age as markers of identity created power dynamics that were apparent during the process of data generation.

In fact, having researched the Gujarati communities previously, I considered myself to some extent, an insider. I have shared cultural characteristics such as language and religion so I was able to conduct interviews in Gujarati, aiding rapport and comfort, whilst also having knowledge of appropriate cultural behaviour and values. Therefore, rather naively, I thought age and gender were not going to be apparent categories during data collection but rather components I would reflect on as a researcher 'turning back on oneself' (Davies, 2008, p.4) and exploring how these identity factors intentionally or unintentionally influenced my findings. However, through the following accounts of 'power imbalances' through age and gender during data collection,

I will illustrate how prominent they were whilst conducting interviews. I will also reflect upon how I responded, which was to some degree, located in culture but the overarching identity that shaped my responses to the power dynamics during interviews was my role as a researcher. Here, I will provide an anecdote of one of many experiences I encountered:

I had just conducted an interview with Ramesh¹, a first-generation 66-year-old male leader of a community organisation in Leicester. I was sat in his office whilst he called some other members of the Gujarati communities to see if they would like to be involved in my research. Whilst providing a brief overview of my research he called me a 'nani chokri'. According to the Collins English dictionary 'nani chokri' translated in English means small girl. During the incidence, I recall feeling uncomfortable and also thinking about the ways in which I was being perceived by my participants.

The following thoughts are a snippet from my fieldwork diary demonstrating what I had written after I had left Ramesh's office.

He called me a girl, well that's interesting. I am clearly being perceived as being young but in this case, it was used to gain participants. I feel like saying I'm young would make them feel sorry for me and that they would help me in my education and I know how much they prioritise education. But it was patronising, almost like helping in a school project. Also saying, a girl, what relevance does that have, would that make people more likely to be involved in my research? [...] Do I behave like a nani chokri? Well yes, I addressed him with the polite 'you' so he would see me as young but nani chokri, I'm not 5.

Here, I reflect on his remarks being patronising and there is a real 'negative' aura surrounding my initial response. I also suggest that I felt uneasy about

¹ To remind the reader, pseudonyms have been used.

participants wanting to help me with my education, and there is a reflection of the incentive for my participants to take part in the research. Is it because they were genuinely interested in 'mental health' and thought the project was worth some value, or were they taking part because it would aid me obtaining a degree. Although I question these elements, they are components that as a researcher are out of my control. However, towards the end of my initial reflection of the occurrence, I begin to unravel that these perceptions could be because of cultural interactions that both Ramesh and I were involved in and contributed to. I conducted Ramesh's interview in Gujarati and addressed him with the formal plural personal pronoun. For example, '*Tu*' is the single you, which is used when speaking to your friends or people that you have informal relationships with. Whereas '*Thame*' is the plural you, and is used when one wants to express politeness or respect, usually when talking to a person one does not know well, especially when that person is older or has some sort of authority. It may have been the case then, that these cultural components aided the perception of me as a '*small girl*'. Also, in Indian cultures generally there is more of an emphasis on respecting elders (Raval et al., 2007) and a hierarchy of power in terms of age, and I respected that by silencing my true feelings.

Additionally, this has been widely written about in terms of 'emotion regulation' and authors such as Joshi and Mclean (1994), and Raval et al. (2007) argue that the regulation of one's emotions is culturally relevant and in many cases, for Indian cultures, this regulation is explained in terms of culture being collectivist and allocentric, thus silencing emotions will avoid conflict and benefit the whole group, or by not saying anything you present yourself and your family in a positive way. For instance, in my example, by not saying anything it suggests I have had a good upbringing, culturally aware of how to treat my elders and by addressing him with '*thame*' I have shown him respect. However, this was not the only instance that age was a prominent factor, the following two are key examples:

Jayesh: *I am really surprised. You look only about 22 or 25. Maybe under 25 I should class it, and you are interested in these things. You know not surprised, I am shocked; I was expecting someone much older than you to knock on my door. Don't feel shy and don't shy off.*

Rupal: *Why did you expect me to be older?*

Jayesh: *This is very complicated thing and people do not want to get into this matter, into this subject you know and you are doing it, make an organisation and go far with it, get representatives and build it up.*

(Male, aged 63, first-generation migrant)

Urmila: *You're so young why are you researching something so boring? These things will come and go, it doesn't matter we have lived now. Our time has gone, you should just focus on your life and bettering it so do well in education.*

(Female, aged 52, first-generation migrant)

On both occasions, age and gender were prominent factors relating to the area I was researching. Participants were shocked that someone so young was interested in 'mental health'. I also wrote words such as '*patronising*' and '*uncomfortable*' in my diary and what made me feel uncomfortable about both situations were not so much the reference to age but it had given participants power to voice their opinion on what I should do with my life. For instance, Jayesh said '*don't feel shy and don't shy off, make an organisation and go far with it*' and Urmila said, '*focus on your life and bettering it*'. But this is not new to me, in fact during most social gatherings, weddings, birthday parties etc. I attend, I will find myself in many situations where an elder is telling me what to do, and I do not remember feeling uncomfortable. Reflecting on this, I put it down to my 'role as a researcher'. Perhaps as a researcher I did not want to cross into these boundaries but it is inevitable in research. I built rapport with my respondents and it could have been the case that they just felt comfortable

enough to say these things to me and due to shared cultural understanding, at times, participants said things because they saw me in a similar way to their children. Whilst age was discussed in my interviews, many also praised me that it was good such a young person was interested in their biographies and stories. I also should take into consideration that I have asked people for very personal accounts of their life and opinions and so for them to be personal with me should not come as a surprise.

Subsequently, I reflect and question myself, did I not say anything because of my role as researcher and many factors influenced this. In the interview setting, you do not want to influence data collection or your participants' opinions and thus as a researcher you maintain neutral in your responses. This also aids the rapport built and I did not want to ruin that trust, nor relationships built with participants. Additionally, I wanted to avoid any means of conflict and this is because inherently there was a power imbalance in the interviewee/interviewer setting. I felt as if my participants were doing me a favour by providing me with data but more importantly taking the time to do so. There was no incentive to do so and I was conscious that on many occasions I was in their house, in their personal space and I did not want to cause any conflict.

Although culture may have subconsciously played a role in how I responded and managed these power imbalances in interviews, my response would have been the same if I was interviewing someone of the same age, race, gender etc. as me. This is because, I viewed my role as a researcher and that results to micro-dynamics of power when interviewing. I do not feel like was an environment or the place to be openly vocal about disagreements or emotions as this could affect the nature of the research and differences in opinion and emotions are worth exploring as critical components of research. For this reason, power dynamics are inevitable in social research because identities are formed by a range of factors, making it difficult to presume how these will interchange during fieldwork.

I think as social scientists we should embrace differences in identities during data generation because the emotions that arise from these interactions are of intrinsic value. For instance, the interaction of age here was key in demonstrating a factor that contributed to the process of data generation. This is inherently significant because if a male in his 60s was to undertake this research, his data generation with the participants would have been different and resulted to differing reactions and emotions. Working through emotions can allow us to explore dimensions of our personal narratives and be critical about where and why these power imbalances are present. In terms of my example, I am able to explore cultural expectations of how to behave when age is considered but also how both the participant and I contributed to that interaction. Also, it told me that whilst I used my cultural knowledge on the one hand, I also felt various emotions on the other hand because of my expectation of the interviewing scenario, and was able to explore how my participants could have felt.

Researcher as translator

Expanding on ways in which aspects of my identity contributed to how my participants viewed me as a researcher and how it contributed to producing knowledge; my role as a translator furthered this production. The debate regarding the researcher as a translator is an epistemological one that generally gives discussion to how the process could potentially introduce bias when a researcher views themselves as objective (Temple and Young, 2004). However, I openly recognise my own position in the co-production of generating data, and thus did not feel the need to recruit professional translators to discuss validity in terms of 'correct' version of text, albeit they would also further contribute to production of knowledge. Furthermore, there is a growing tendency in qualitative research which is traditionally not concerned with 'measuring objectivity' to side-line the translation process and is regarded as irrelevant (for e.g. see Khanum, 2001). Here, my concern is not objectivity, but by discussing my role as both a researcher and translator I want to illustrate the

implications this has on my epistemological framework, which has largely been interpretivist and to some degree social constructivist.

These frameworks put forward that the process of knowledge production is based on interactions made with others and one's location in the social world. Additionally, the researcher's categories of identity and experiences will contribute to the way in which the researcher interprets and constructs knowledge. Therefore, by acknowledging and giving attention to the translation process and the dilemmas I faced, I would like to showcase how this process contributed to the construction of knowledge. Temple and Young (2004) sum this up well:

The translator always makes her mark on the research, whether this is acknowledged or not, and in effect, some kind of "hybrid" role emerges in that, at the very least the translator makes assumptions about meaning equivalence that make her an analyst and cultural broker as much as a translator (p.171).

I openly recognise through the process of translation, that knowledge was being produced by me. This is because certain words do not have direct translations in English and can connote an array of meanings. For example, 'Pagal' was commonly used which can connote several meanings in English, these include: mad, crazy, insane and psycho. Therefore, the translation process is by no means a straightforward one and is an activity of constructing data and thus requires reflexive analysis.

Whilst designing this research, I realised that conducting interviews in Gujarati was going to be a difficult process. Very early on, I did a pilot interview with my mother, who grew up in India and whose mother tongue is Gujarati. During the interview, I noticed two key things, my own vocabulary around 'mental health' was limited as well as my mother's and at times there were no direct translations from English to Gujarati. To tackle the first element of my own vocabulary, I visited India and in particular Gujarat. I got the opportunity to speak to a couple of doctors to discuss 'mental health' and language. This

allowed me to gain knowledge on terms around 'mental health' in Gujarati. Although I suspected that many participants would not know the terminology unless they have experienced or knew someone who had experienced 'mental health' problems; it was vital that I had this knowledge so that I could have the capacity to understand my participants during interviews.

Moreover, with the issue of the meaning behind words, I have decided in many cases to leave words or sayings in Gujarati in this thesis. By no means am I suggesting that this process has ensured that I have removed my own value judgement to my data. In fact, I recognise that my identity and being both the researcher and translator has resulted in me being directly involved in data construction. However, I believe in the premise that language is not solely a premise of expression, but located deeply in culture and as Simon (1992) argues, 'the solutions to many of the translator's dilemmas are not to be found in dictionaries, but rather in an understanding of the way language is tied to local realities, to literary forms and to changing identities' (p.137). I felt that it was most appropriate to leave these to illustrate the cultural depth they hold. Furthermore, this is also pivotal to the study because one of the questions explored in the research included help-seeking barriers. A barrier which has been identified and explored in this study was language. It was crucial to gain participants who had limited English language proficiency as I felt that they were more likely to be affected by this potential barrier. Although this is further explored in chapter 7, Barrett (1992) suggested, researchers 'have accepted to varying degrees the view that meaning is constructed in rather than expressed by language' (p.203). To some degree, I lean towards this premise due to somatic expression being largely adopted by the Gujarati communities. This enhanced my decision to leave sayings in Gujarati. By doing so, I invite native speakers who will read this thesis to interpret the meanings, or have an understanding of the cultural context which the sayings have evolved from. However, for the means of ease and reading the thesis, I have offered my own translation and understandings of the sayings, which are aligned with my own cultural experiences and social world (Please see the glossary for reference).

Summary of chapter

This chapter has outlined the methods used to generate the data that will be discussed in the subsequent chapters. It has provided details on how decisions were made to use certain methodologies, practical factors such as access and sampling, ethical considerations and reflections on the process of conducting research in this area, and how my role as a researcher and identity had an impact on the data generated. Whilst this chapter has provided theoretical information on more of the practicalities of conducting qualitative research, the following chapter will provide a detail exploration of introducing my participants and the theoretical framework used in the analytical chapters. It is important to provide this context because the Gujarati communities are unique, and their journeys provide a narrative to their experiences, current cultures and background. Thus, the next chapter will provide details of the Gujarati communities that reside in Leicester.

Chapter Four: From Gujarat to Leicester

Introduction

This chapter will introduce my participants: The Gujarati communities in Leicester. Using both empirical data and literature, there will be an overview of the demographic profile of my participants and then I will explore the migration history of the communities and an exploration of how the communities felt about migrating. There will be a focus on reasons why the Gujarati communities chose to migrate to Leicester. Additionally, there will be a discussion on the ways in which the communities have settled in Leicester. This descriptive analysis will lead on and justify the theoretical framework that will be utilised; Pierre Bourdieu (1986) and his forms of capital.

Introducing my participants

In the introduction chapter, I outlined the problematic nature of focusing on 'South Asians' as a category in health research due to cultural stereotypes and ecological fallacy (Nazroo et al., 2002). Thus, to omit the extent of these problems, I have focused on one ethnic community; the Gujarati communities. However, it is not correct to homogenise communities that have various dialects, religious affiliations in Hinduism and different cultural norms; hence the usage of 'communities'. Therefore, this chapter will shed light on the communities and in particular the participants in this study. By doing this, I acknowledge that not all of the problems with using 'South Asian' as a homogenous category can be removed by focusing on the Gujarati communities but rather will illustrate the different characteristics of the Gujarati communities gained from the demographic surveys. This will show how multi-faceted culture is. It is beyond the scope of this thesis to explore how for example different religious affiliations, dharma's and beliefs contribute to distinctive 'mental health' beliefs; however, it was crucial to get the information on dharma (see glossary) as it served as a purpose for

contextualising the participants in this research and gaining further data about their background.

I interviewed 45 Gujarati people who reside in Leicester and 30 were first-generation migrants whilst 15 were second generation Gujarati migrants. More demographic information about my participants can be found in appendix 1.4, and 1.5. These tables illustrate several components of my participants: gender, age, marital status, employment status, education, migration, Dharma (religious affiliation) and caste. Initially, these demographic surveys were designed to demonstrate the Gujarati demographic profile which could have been examined and evaluated alongside the key risk factors of mental illnesses. For example, housing was asked because as Evans et al. (2003) argue, a variety of housing characteristics can influence 'mental health'. Therefore, identifying how the Gujarati communities position in relation to the various risk factors of 'mental health' could be beneficial because as Lindsay (1997) argues it can help gain an understanding of risk factors of mental illness but also demonstrate why different ethnic groups have different underlying rates of psychiatric disorders. Furthermore, as one of the research questions addresses this area, it was a prime focus. It was anticipated that in order to understand socioeconomic inequalities and how they relate to ethnic patterning of health, ethnicity needed to be approached as a social identity and recognise variability across contexts and generations (Nazroo et al., 2006). As a result, these factors that make up the socioeconomic make-up of the Gujarati communities and thus shape their identities were explored.

However, through having interview discussions with my participants, these factors were not regarded as key and did not emerge as significant themes. Therefore, through analytic induction in the methodology, acculturation became a pivotal theme and this will be explored in depth in chapter six. Despite this, it is important to cover historical and contextual background of my participants and my data in the appendix 1.4 and 1.5 demonstrates these factors. This is used to illustrate that I acknowledge variations in the Gujarati

communities and that there are a range of professions, religious affiliation and size of families to name a few. However, due to the open-nature of this research and utilising elements of grounded theory, I was not only flexible but interested in what my participants viewed as significant and thus I will explore further the aspects that my participants viewed as most crucial to them. For instance, marriage will be explored in chapter six, and how participants expressed this has had an impact on their emotions and feelings. Thus, here I will offer a brief description of what it means to use 'Gujarati' as one's identity and then go on to explore migration history.

Gujarat is a state which is on the west coast of India. It is bounded by the Arabian sea in the west, the state of Rajasthan in the north and northeast, Madhya Pradesh in the east and Maharashtra on the south and south east. The state comprises 25 districts, sub-divided into 226 talukas, having 16, 618 villages and 242 towns. The local language spoken in Gujarat is Gujarati and it remains the mother tongue for many people all over the world; including Leicester. Additionally, Gujaratis thrive as business people, focusing on financial assets and education and as a result experience good levels of upward social mobility (Bachu, 1985; Patel and Shaw, 2009). For example, this has been illustrated in my empirical data. All second-generation Gujarati migrants were in full-time employment once gaining a degree or are in full-time education. Gujaratis celebrate distinctive festivals such as Navratri which is a 9-day dance festival and have a distinctive cuisine. Other aspects of 'Gujarati culture' entail being religious, and most commonly believing in Hinduism. Leicester has the second largest Hindu community in the UK with 41,248 people identifying as Hindu at the last census and religion plays a fundamental role in their lives (Raj, 2010); all my participants said they were a Hindu. A factor that has assisted religion remaining strong in Leicester has been the distinctiveness of the communities' migration traits and how they responded to moving and settling in a new area. Therefore, the next section will explore ways in which my participants have come to settle in Leicester and their feelings towards migration.

Migration history

East African Gujarati migrants in Britain are a niche group in the body of migration research. This group is interesting to study because they are twice migrants; from India to East Africa and then to Britain; thus, they have unique migration traits and primarily migrated for employment opportunities (Bachu, 1985), although my data illustrates this as indeed only a contributing factor. This section will illustrate the background of their migration to Britain from India via East Africa. This will allow for a deeper understanding of the communities and some insight for the reasons behind the contemporary strong culture among the groups. However, this is also crucial to explore because migration can impact health and health care systems which can be far-fetching for the communities and countries involved (Carballo et al., 1998). Migration which involves relocation can indeed cause stress, isolation, change and a break in family ties. It is these changes that can be difficult to adjust to and cause 'mental health' issues; a prime reason why migration is said to be a risk factor of 'mental health' problems (Cochrane et al., 1977; Cochrane, 1983; Kuo et al., 1986; Beiser et al., 1993; Nevo et al., 2006). Therefore, this area is important to explore and to see how the Gujarati communities have responded and felt about their migratory experiences.

The majority of researchers who have looked at this minority refer to the cohort as 'Asians', a term which covers people from various countries and backgrounds; for example: Indians, Chinese, Bangladeshi's etc. Generally, Asians in the migratory literature refers to people from India and 'the term 'Indian' is still the most neutral and widespread one, as the overwhelming majority of Asian immigrants came in fact from within the present boundaries of the state of India' (Ghai and Ghai, 1970, p.1). Therefore, it will be assumed that previous literature is discussing Indians more specifically Gujarati's when referring to Asians. This conception can be presumed because the bulk of East African Indians are Gujarati-speaking Hindus from Gujarat, Western India. The Gujarati population made up roughly 70% of the total Asian population that

migrated to East Africa (Ghai and Ghai, 1970). However, the use of words in previous literature surrounding this area again highlights ecological fallacy, which was discussed in the introduction and the need to break down such large generalised terminology to describe communities. It has been acknowledged that the data may not extrinsically apply to all the Gujarati communities as some of the population migrated straight from India, or were born in East Africa and migrated to the UK from there.

India to East Africa

The strong professional links between East Africa and India date back to hundreds of years before the British colonial period. The migration of Indians to East Africa primarily occurred due to colonization of East Africa and India by the European powers. Although this stimulated migration and catalysed the process; trade occurred between India and Africa before the English got involved (Ghai and Ghai, 1970). Even before the mass migration flows that occurred during the period of British colonization between the 16th and 19th centuries; Indians had a strong sense of independent control in business and trade with East Africa. As Ghai and Ghai (1970) argue:

For over a thousand years Indians were at the heart of the economic activity which brought the fluencies of a wider world to East coast of Africa. They were not only merchants, but also sailors, financiers and administrators (p.2).

Between the 16th and 19th centuries, Britain had successfully established itself as a powerful empire with many colonies including India and East Africa. The British system was the most influential in linking the three communities together and having a direct impact on migration of cohorts between them. It was during the British colonial period that Indians migrated to East Africa. The British encouraged labour from India to migrate to East Africa (Saha, 1970; Tinker, 1974; Twaddle 1975; Clarke et al., 1990; Goulbourne, 1998). The push for migration by the British was put forward because labour was needed to

build the railway tracks which linked the colonies together and local African labour was considered unreliable.

Furthermore, during this period, Indians had taken advantage of free movement and migrated to take advantage of labour opportunities. 'Enterprising traders from South Asia co-operated and collaborated to their mutual advantage in the economic development of the whole region' (Gregory, 1981, p.259). It was soon becoming evident that Indians had established themselves in the labour market through business ownership. However, this created some conflict between the local Africans and Indians because Indians employed native Africans to work in their small retail outlets and subsequently were viewed as superior. After the end of the railway construction, merchant immigration from India continued until the 1920s, by which time the entire retail trade of East Africa was monopolised by Indians. Indians were successful in East Africa because they possessed the correct qualities required for economic development. These included their dedication to work long hours, consume very little and have a strong desire to make money (Ghai and Ghai, 1965). These qualities were important for their personal development in improving their lives but not necessarily transmitted to other cultures (Ghai and Ghai, 1965).

East Africa to Britain

The successful establishment of the Indian diasporas in East Africa did not last for long. The British Empire became stronger and its power of colonies and commonwealth dominated a large proportion of the world. Countries such as India, Uganda and Kenya were striving for independence.

Britain's colonies in Africa, Asia and the Caribbean came to experience full political independence at roughly the same time, that is, the years after World War Two (Goulbourne, 1998, p.36).

India and Pakistan were granted their independence in 1947 which influenced the dramatic independence other African countries. Strong ethics in policies for

Africanization meant that Indians were finding their stay in East Africa difficult and inevitably became outcasts. In 1972, President Idi Amin Dada of Uganda put forward the expulsion of Asians within two weeks in his country (Jamal, 1976). The strong right-wing policy resulted in the majority of Ugandan Asians, which was 60,000 to be evicted from their homes and occupations (Jamal, 1976). This was carried through because for over a century the Asian communities in Uganda had come to strongly dominate the modern sector; providing skilled labour, capital and entrepreneurship. Consequently, this created upheaval between the Africans and Indians due to a struggle with power and authority in the economic market. These economic patterns caused a racial division of labour in the export industries. The Asians and Europeans became capital leaders and Africans remained their labour for many years (Jamal, 1976). It is also key to put forward that the Indians and Europeans monopolised the skills needed by a modern economy and although they made up 2% of the population, they owned several times their per capital share of the national product (Jamal, 1976). President Amin realised this dilemma and conflict and declared an economic war. Jamal (1976) explains this in more depth:

The first and second phase of this involved the eviction of the Asians and the transfer of their house, shops and industries to the Africans. In the third and subsequent phases, when the African entrepreneurs get to run their newly-acquired enterprises the farmers might well find that they have exchanges one set of rich people for another, perhaps they might consider it more acceptable for the new rich to be Africans (p.615).

It was during this period of Africanization that many Indians migrated to Britain. Under the ownership of colonies and the commonwealth they were granted British citizenship and a large proportion migrated to Britain when they were evicted from Uganda. Although Indians were not directly evicted from Kenya

they were gradually pushed out. In Late February 1968 there seemed to be a sense of universal panic among the Asian communities in Kenya.

The euphemistically termed 'Africanization' policies pursued by the Kenyan government had for several years been designed to drive them out of key positions in the economy. Asians had found that their work permits were no longer renewable; they were restricted to certain sectors of the economy; they were sacked from the civil service (Hansen, 1999, p.809).

This evidently made the economic and social position of Indians in Kenya unstable at the time. Until 1968, Indians were guaranteed British passports which gave them unrestricted entry into the United Kingdom. However, in February 1968, the commonwealth immigrants' act was introduced where home secretary James Callaghan announced that Britain would no longer accept Asian passports (Hansen, 1999). The act prohibited Asians to enter the United Kingdom and needed a reason for entry. They had to have a passport but also a close family connection to the UK (Hansen, 1999). Therefore, it was after this period that Britain had introduced limitations to the number of immigrants that entered the UK. Gupta (1974) puts forward that anti-Asianism had become an important ingredient of African nationalism. The immigration act of 1968 was a test for politicians in East Africa to demonstrate their interests and that they no longer wanted any involvement with Britain (Gupta, 1974).

During the colonial period, Indians suffered a great deal of discrimination and prejudice in East Africa (Gregory, 1981). Indian migrants in East Africa did not have a peaceful stay in the region and were a vulnerable group at the time of independence. East African Indians that then migrated to Britain after gaining independence were striving for a sense of belonging. East African Indian migrants became significant characters in the economic market. This illustrates that Indians that migrated to East Africa who had settled down with virtually nothing had well equipped skills and attitudes to repeat the same pattern when they migrated to Britain. They were an ethnic group that were not very well

represented in politics throughout this period of colonization and consequently made them outcasts. However, this strengthened their culture because they travelled in large groups and families which kept their traditions alive due to not being accepted in the dominant culture. Therefore, their migration patterns illustrate that they had well established transferrable skills to become dominant in the field of work. The Gujarati communities migrated to Britain because they wanted a modern and progressive place to live (Crew and Kothari, 1998). Using empirical data, the feelings participants expressed relating to migration is explored below.

Feelings about migration

In 2001, Leicester had a total population of 279,923 (www.leicester.gov.uk), of which about 40% belong to minority ethnic communities and a third; are Gujarati Indians, whom migrated from either East Africa or India. Migration experiences were discussed during interviews and this section will explore how the Gujarati communities felt towards migration. A key revelation regarding migration was specific reasons for migrating to Leicester over the preference of another city in the UK. The general reasons were families had already migrated beforehand and settled in Leicester, familiar contacts, awareness of a large Gujarati community and marriage. For instance, Pratik (pseudonym used) said:

The reason why I chose to come to Leicester was my parents, my brothers, my sisters had come from Kenya and settled in different parts of the UK but most of them were in Leicester and there was quite a growing community in Leicester. Aah so a year before I came here I had come to the UK to visit my parents and that was the time that I decided . . . that's how I made the decision, so this wasn't difficult.

(Male, first-generation migrant)

Additionally, Ramesh said:

Our community and locality, temples and community centres. We can find all our things here.

(Male, aged 66, first-generation migrant)

In literature Leicester is considered a popular location because of labour opportunities in hosiery, boots and shoes industries (Leicester.gov.uk). However, my empirical data illustrates it was important for the respondents to move to Leicester to be close to families and the fact that there established communities was viewed as positive because adapting to a new environment would be easier. Also as Pratik states the decision of deciding where to reside in the UK '*wasn't difficult*'. overall, when asked how the experience was and felt to the communities, they expressed significant difficulties in changes of weather, environment and language but overall it was made easier due to having family and friends around. The respondents focused on positive aspects of the country such as development in terms of earning money, easier lifestyle, cleaner country and good public services. For example, Kunal, an engineer migrated to Leicester in 2005 on a highly skilled migration visa for job opportunities. He migrated with his wife and two daughters and has lived in Leicester ever since because of the 'community environment'. Kunal expressed times where he felt 'down' but explains that it was a personal issue and worked on it himself. He mainly focuses on positives of life and believes strongly in always having a positive attitude when looking at any situation. Kunal did this with migration too and said:

We had a very good goal right from the beginning and we know especially in the western countries there are so many good things like you know the quality of life, it is cleaner and healthier, very good public services like the health system legal system fire and resources system council system political system. All those are very good plus points that we notice when we were in India and that's why we moved to this particular environment.

(Male, aged 49, first-generation migrant)

Overall then, although there were practical difficulties that participants expressed such as weather and language, they focused on the positive aspects

of migration and Kunal looks at all the good things he has gained from migration. All of the first-generation migrants expressed difficulty in adapting but being close to family and having a wider network made it easier to adjust to the changes they were experiencing. Only one participant expressed racial abuse and discrimination was not openly voiced or expressed by the rest of the participants. Bharat, who was born in Mombasa, Kenya, migrated to Leicester in 1965. Currently Bharat is retired and lives with his wife. He migrated in the 60s and found getting a job to begin with quite difficult. He explained difficulties when he migrated, he had to go and use a public bath, cook for himself and initially spent time with friends until he married and settled down. Bharat said:

Yeah people were quite friendly at that time and there was some racial abuse because of the colour of your skin, you did find a slight problem as the years passed by its slightly getting better but at that time there was some racial views and things.

(Male, aged 69, first-generation migrant)

It is widely documented that the process of migration can result to being rejected by the host country through discrimination such as racism (Harris et al., 2006) and thus aid vulnerability, dislocation and consequently increase mental distress (David and Williams-Morris, 2000; Williams et al., 2003; Araujo and Borrell, 2006; Knifton et al., 2010). However, my participants illustrated that this overall was not the case. Thus, racism is not spoken about in the subsequent chapters as a contributing factor of mental illness. Additionally, Bharat's experiences were that it was a 'slight' problem but this diminished after a few years and he only found it difficult when he initially migrated.

Having explored the Gujarati communities' migration traits and their positive attitudes and feelings towards migration; this could be a contributing factor towards their underrepresentation in mental illness statistics and thus the communities may experience good 'mental health'. For example, it has been demonstrated that Indian migrants travelled in large kinship groups and had

established networks in the UK (Bachu, 1985); in particular Leicester. They live in socially cohesive communities which have allowed for home culture to be maintained and has been shown to be more deep rooted amongst the group (Furnham et al., 2000) through forms of cultural capital (Parikh, 2006; Chaddha et al., 2009). For example, there are now many temples in Leicester and festivals such as Diwali are celebrated in the communities. Additionally, because the communities have travelled with family the risk factors of social isolation, cultural conflicts, poor social integration and identity crisis causing mental illness may have been avoided (Jones and Korchin, 1982; Kuo et al., 1986). Using empirical examples, there will be an exploration of how the Gujarati communities came to live in socially cohesive communities below.

Community organisations

Participants suggested when they initially migrated to Leicester there was not a community feel and people had to work towards this. In the literature, Gujarati communities are regarded as successful in the sense that despite migrating twice, they have remained conservative and religious (Bachu, 1985). This can be argued that this is due to living in large cohesive communities (Bachu, 1985), but the data generated in this study illustrates that community organisations have contributed to the Gujarati communities remaining close-knit and have created a space where religious practices and gatherings can occur. This section will discuss the ways in which this has been permitted, and the journeys' participants expressed they went through to allow this to occur. Jayesh migrated to the UK when he was just thirteen and after staying in Bristol for three months, he settled permanently in Leicester in 1965. He expressed, at that time the situation was somewhat different to the current context. Jayesh said:

when I came to Leicester, people were all keeping to themselves they didn't want to go out, all people were interested in was work because they came from India and from Africa but mainly Leicester a lot of people were from India where we were staying and all they

wanted to do was work, work and work, you give them 24 hours work they will do it but you used to live in one house and someone else would sleep in one bed in the day and someone will sleep at night in the same bed to share because they were really struggling for money to send back home, it was a tough life for everybody.

(Male, aged 63, first-generation migrant)

However, as more people migrated after 1965, the communities got larger in population and as a result strengthened. For instance, although Leicester is a large city, the Gujarati communities tend to live in clusters in confined proximities. For example, the area around Belgrave road which is colloquially known as the Golden mile, houses large numbers of Gujarati families. In doing so, this has enhanced their social capital in terms of networks and the Gujarati population were able to use this to their advantage. Mahesh discusses in depth, how the development of community organisations assisted the ways in which the communities could remain close-knit and practice traditional and religious practices. Mahesh, aged 67 was born in Africa and moved to India to study. He migrated to Leicester in 1978 when he got married. Initially Mahesh found moving to Leicester very difficult because of the cold weather and the lack of shops that sold Indian groceries. He discussed how it required time to adjust to the new environment and one important factor that made it easier was the wider communities and networks. Mahesh is very passionate about the communities and has volunteered for a community organisation since he moved to the UK. He told the story of how the community organisations were created which enabled the communities to come together and benefit from doing so. Mahesh states:

We used to call meeting in everybody houses in turns you know, and gradually from that we build it up. So, the associations were into existence before that, then we saw that the Muslim community, the Christian community, they are getting more benefits and they are benefitting more from the government than us because we are

there, but we are all divided. So, we formed a Hindu association; now we have become their affiliations. Today you see so many communities they have got their own properties, their own community halls and everything you know. In those days, except for one or two communities no other community had halls to meet or do things; it was generally very difficult yeah.

(Male, aged 67, first-generation migrant)

Mahesh illustrates that although the communities faced difficulties in adjusting to a new environment when they initially migrated; people found ways to bring the Gujarati communities together, predominantly through religion. As Mahesh explains, the Gujarat Hindu Association in Leicester is known as the parent body overlooking many samaj's (groups) that are affiliated to the association and for example, the Gujarat Arya Association is one of them. The individual samaj's that are under this parent body are based on the class system as well as villages in India which provides further sub-categories within the caste system. Although, the Gujarati communities can be separated in smaller categories based on the caste system, Mahesh explains they found a way to bring the communities together in Leicester through religion which benefitted them. He went on to explore that alongside 'togetherness' and 'social' benefits they benefitted financially as they were able to apply for grants from the council. Therefore, from initially having meetings in houses, the communities used their social capital to aid opportunities for financial funding (economic capital) and create community halls to 'meet or do things'. Therefore, although a large body of research argues that migration increases the risk of 'mental health' problems due to stress, isolation, break in family ties and changes in culture (Cochrane et al., 1977; Beiser et al., 1993; Nevo et al., 2006); these changes did not occur with the Gujarati communities as they migrated in large kinship groups and had established networks in the UK (Bachu, 1985).

Consequently, religion has helped create organisations, and it is these organisations that organise religious gatherings and have worked towards

building temples for the communities, which has been suggested to be good for people's 'mental health'. Rashmi, aged 53 did not follow the conventional twice-migratory route as she migrated in 2003. Overall, she accentuated that settling in Leicester was easy due to the city feeling like a 'mini India' and she suggested:

With our community, people who are old and retired go to the temple to spend time with others because we hold a lot of functions. But with white people they don't have this; they just sit at home so I think that they are more likely to get depressed. Even in our community if people were suffering and if they were sad, they can forget about it by going to these functions and it would make them better.

(Female, aged 53, first-generation migrant)

Rashmi explores how religion has been positive, because it promotes social cohesion which means the communities are less likely to face problems of loneliness. overall, both Rashmi and Mahesh also compare the Gujarati Hindu community to other communities, which they label 'White' and 'Muslim' etc. This demonstrates that they are protective and proud of belonging to the Gujarati communities. In this instance, it showcases that 'religiosity' has been identified as a positive attribute to have which impacts positively on people's 'mental health', and other communities may lack this positive characteristic. Similarly, Nayna, who is 62 and works as a care assistant initially migrated to London but moved to Leicester a few years later because her husband liked 'the community feel' and it was more religious. Therefore, through working together and building networks the Gujarati communities in Leicester have been able to build community organisations, develop economically and build places of worship. This has benefitted the communities to ensure they are able to experience a 'community feel' in Leicester. It is because of the emphasis participants placed on their networks and more specifically other community members that I will be drawing on forms of capital and in particular 'social

capital' and 'cultural capital' as an analytical and theoretical framework for the subsequent analysis chapters which is further described below.

Analytical framework

I have illustrated narrative experiences of the Gujarati communities setting up organisations and communities in Leicester post-migration, which contributed to the Gujarati communities remaining close-knit and religious in Leicester. Additionally, I demonstrated in the literature review, it has been well documented that Gujarati communities are well integrated, religious and tend to be middle class and show good signs of upward mobility due to their strong work ethic (see Bachu, 1985; Patel and Shaw, 2009). This demonstrates that the Gujarati communities face high levels of social, cultural and economic capital (further discussed in detail below); both illustrated in the literature and empirically through the data generated in this thesis. Furthermore, this also suggests that the Gujarati communities are likely to experience good 'mental health' (Kawachi and Berkman, 2001), due to high levels of support. However, having highlighted the difficulties in defining 'mental health' and also the influence culture has on how 'mental health' is conceptualised, understood and managed, I seek to illustrate these complexities through my data analysis in the subsequent chapters.

Due to the complexity of these interactions, I will draw on Pierre Bourdieu's (1984; 1986) work to provide context to understanding my data and when answering my research questions. I have utilised Bourdieu's (1986) classifications of social, cultural and economic capital to demonstrate how these forms of capital are at the core of understanding the area of Gujarati communities and 'mental health' more broadly. In chapter five which addresses attitudes and understanding of 'mental health', I explore how interactions formulate social constructs of 'mental health' which is inherently linked to the communities' cultural and social capital. Chapter six then goes on to explore the communities' current situation of cultural differences between first and second-generation migrants and at the heart of how this is managed is

embedded in the communities' social and cultural capital which can result to 'mental health' difficulties. The last analysis chapter (seven) focuses on the ways in which the Gujarati communities promote 'mental health' management and certain limitations of this which results in help-seeking barriers that are rooted within the communities' social and cultural capital. Before I delve into the exploration of this, it is necessary to briefly provide some theoretical background to Bourdieu's work to provide context to the analytical lens used.

Pierre Bourdieu, a French sociologist was interested in power, both in terms of inequalities and reproduction of power in society. Bourdieu (1986) argued that one's position in society was at the heart of capital; the more capital one had, the more powerful their position was in social life. According to Bourdieu (1986), capital is a term that relates not only to economic and monetary value, but also to other aspects (discussed below). Building on the work of Marx (1867), who based his ideas solely on economic capital, Bourdieu (1986) went further by arguing that power is symbolically and culturally created and maintained, through other forms of capital, namely social and cultural capital. Bourdieu suggested:

A general science of the economy of practices that does not artificially limit itself to those practices that are socially recognised as economic must endeavour to grasp capital, that 'energy of social physics'... in all of its different forms... I have shown that capital presents itself under three fundamental species (each with its own subtypes), namely, economic capital, cultural capital, and social capital (Bourdieu, in Bourdieu & Wacquant, 1992: 118–9).

Here, Bourdieu defines capital under three fundamental species: economic, cultural and social. Working definitions of social and cultural capital that will be used in the analytical chapter are to be anticipated further below. Bourdieu (1986), argues that it is impossible to account for the structure and functioning of the social world unless, capital is introduced in all its' forms and not only economic theory. Although he does not neglect economic capital and puts

forward that it provides a key definition of the historical invention of capital. However, in relating all exchanges to economic value and maximising profit, other forms of exchanges are viewed as disinterested (Moore, 2008), and for Bourdieu this is problematic. Additionally, Bourdieu (1986) argues that these 'disinterested' forms of capital can present themselves in the immaterial form of cultural capital or social capital which contribute towards economic capital. Thus, for Bourdieu, not only is economic capital, but also social and cultural capital are key to producing power and inequality in society as they favour some social groups in certain social places. Although, Bourdieu is interested in power and inequality in terms of capital, which is based upon profitable returns, this research is focusing on ways in which the forms of capital (economic, social and cultural) can have health returns in particular good 'mental health'.

Additionally, Bourdieu (1985) suggested that these different forms of capital make up one's habitus and power is created and enforced through the interplay of agency and structure and he argues that this is predominantly done through one's habitus. One's habitus is made up of different forms of capital (cultural, social and economic). The habitus is the resources that an individual has gained through these different forms of capital and have been transferred because of the social and physical spaces people occupy. Therefore, the habitus is identified as a structured form of interaction, perception, estimation and practice, which influences the disposition of interacting and being (Maton, 2008; Bourdieu, 1990). Furthermore, Maton (2008) explains Bourdieu's ideas arguing that habitus is associated with the structure of practices that people have, which 'focuses on our ways of acting, feeling, thinking and being' (Moore, 2008, p.52). Thus, rather than focusing on how one's habitus plays out in various fields, I will focus on how the habitus influences 'ways of acting, feeling, thinking and being' (Moore, 2008, p.52) in relation to 'mental health'. In 'The forms of capital' written by Bourdieu (1986), he addresses these new concepts; social and cultural capital. Here, I will offer an overview of how Bourdieu defined them.

Social Capital

Bourdieu (1985) defined social capital as ‘the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual; acquaintance or recognition’ (p.248). Bourdieu also puts forward that being a member of a group does depend on the other forms of capital (economic and cultural). Furthermore, social capital is then not only a combination of relating factors but also something that is developed for a purpose, it is a ‘product of investment strategies’ that are ‘directly usable’ and thus Bourdieu’s definition of social capital is an instrumental one. Bourdieu (1986) put forward:

In other words, the networks of relationships is the product of investment strategies, individual or collective, consciously or unconsciously aimed at establishing or reproducing social relationships that are directly usable in the short term or long-term, i.e., at transforming contingent relations, such as those of neighbourhood, workplace, or even kinship, into relationships that are at once necessary and elective, implying durable obligations subjectively felt (feelings of gratitude, respect, friendship, etc.) or institutionally guaranteed (rights) (p.85).

Here, Bourdieu (1986), makes clear that social capital in terms of ‘networks of relationships’ is the product of ‘investment strategies’ that is established due to wanting benefits, those may be resources which can be based around economic capital, and there is a clear interlinked relationship, or other non-monetary benefits. Furthermore, Bourdieu’s definition makes clear that social capital can be broken down into two key elements: firstly, the social relationship itself allows individuals to claim access to resources possessed by their associates and secondly, the amount and quality of those resources (Portes, 1998).

The link between social capital and 'mental health' is not a new one. As discussed in the literature review, this dates to Durkheim's (1951) study on suicide, who argued there is a strong link between social isolation and reduced psychological well-being. Thus, smaller networks, fewer close relationships, and lower perceived adequacy of social support have all been linked to depressive outcomes (Barnett et al., 1988). Additionally, social cohesion and communities have been discussed to have a link with psychological well-being; they are somewhat different to social capital. Although they are used interchangeably (Putnam, 1993; Wilkinson, 1996; Kawachi et al., 1997; Lomas, 1998), social capital is not synonymous with these other concepts. For instance, social capital comprises of several dimensions, while social cohesion and a sense of community can be viewed as outcomes of social capital.

This is a prominent reason why Bourdieu's framework is being utilised in this research. 'Relationships and networks' cannot be measured purely based on the amount and size of the network. Bourdieu (1986) gives attention to not only the benefits gained from networks but also the quality of these relationships. Bourdieu (1986) acknowledges acquired networks can also result in 'durable obligations subjectively felt' and as far as 'mental health' is concerned, it may have negative consequences. This is because people, who are bound by a social network, will behave a certain way due to their obligations and thus this can have an impact on their 'mental health'. Thus, having a large network and being in a community that experiences close social cohesion may not always be beneficial for one's health. With the Gujarati communities who prioritise the importance of social capital may behave in certain ways and thus have social obligations that are appropriated through belonging and community membership. In the forthcoming analysis chapters, I will focus on ways in which social capital amongst the Gujarati communities have amounted to benefits, but also ways in which it can have negative consequences and be detrimental to one's 'mental health'.

Additionally, as stated in the previous methodology chapter, this thesis has been approached with utilising principles of grounded theory. To remind the reader, Glaser and Strauss (1967) advocate that this methodology is when research is approached with an 'empty vessel' and theory is generated from the data or case studied. Theory here is associated to feelings, experiences and attitudes that are deemed important to the Gujarati communities. As a result, both the methodology and analysis itself was flexible in nature and open to change direction according to the data generated. As a result, of social, cultural and economic capital being significant in the interview discussions a further research question has been explored in the following analysis chapters:

- In what ways does social and cultural capital influence how 'mental health' is conceptualised, experienced and managed in the Gujarati communities?

This is an underlying question that links all four research questions stated in the introduction and thus will be drawn upon in all the subsequent analytical chapters.

Cultural capital

In his book *Distinction* (1984), Bourdieu draws on cultural capital as cultural knowledge that would signify identity to groups; namely class distinctions. The notion of cultural capital evolved when Bourdieu was conducting research to explain the unequal scholastic achievement of children from different social classes (Bourdieu, 1986). Bourdieu (1986) argues that cultural capital can exist in three forms: embodied state, objectified state and the institutionalised state. Cultural capital in the objectified state refers to cultural goods (pictures, books, dictionaries, instruments, machines) and the institutionalised state of cultural capital refers to educational qualifications and institutional recognition given by these qualifications; both are largely not relevant in this study. However, embodied cultural capital will be the focus and below I will provide a description.

Embodied cultural capital is in the form of long-lasting dispositions of the mind and the body. Bourdieu (1986) defines it as:

The accumulation of cultural capital in the embodied state, i.e., in the form of what is called culture, cultivation, bildung, presupposes a process of embodiment, incorporation, which, insofar as it implies a labour of inculcation and assimilation, costs time, time which must be invested personally by the investor (p.85).

Bourdieu (1986) goes on to use the example of acquiring a muscular physique, requires time and work on oneself. Thus, Embodied cultural capital is things we learn and acquire over time primarily from socialisation. This process involves both conscious learning and passively learnt culture. For example, in relation to the Gujarati Communities, speaking, writing and reading Gujarati can form part of one's embodied cultural capital. Bourdieu (1986) goes on to argue that this form of cultural capital is an integral part of the person that makes up their habitus and cannot be 'transmitted instantaneously' (Bourdieu, 1986, p.85) like exchanges of money can.

Evidently, this is the form of cultural capital that is most apparent in this study and will be discussed in relation to 'mental health'. Furthermore, the Gujarati communities have embodied cultural capital; where individuals have invested time throughout their lives where they have learnt cultural values, traditions and behaviour. This form of embodied culture is so integral to individuals that they behave in ways that appropriate their embodied cultural capital. For example, behaviour in a mandir (see glossary) becomes embodied through time and people have acquired the knowledge over time that become part of their habitus. In the following chapters I will discuss ways in which embodied cultural capital can contribute to a distinctive attitude towards 'mental health', and have negative impacts on 'mental health' management. For example, the cultural view of 'madness' can be lived realities for communities such as the

Gujarati one and this is as a result from ones' cultural system that they have been surrounded by throughout their life.

In 'Forms of capital', Bourdieu (1986) emphasised that the ultimate reduction of all forms of capital to economic capital, thus the 'outcomes of possession of social or cultural capital are reducible to economic capital; the processes that bring out these alternative forms are not' (Portes, 1998, p.4). overall, it is these processes that I will focus on, for instance Portes (1998) argues that 'transactions involving social capital tend to be characterised by unspecified obligations, uncertain time horizons and the possible violation of reciprocity expectations' (Portes, 1998, p.4). Furthermore, there will be a focus on how these 'unspecified obligations' shape the way Gujarati communities conceptualise, experience and manage change after migration that could cause 'mental health' problems. Whilst, Bourdieu (1986) was interested in power and inequality; I will focus on the ways in which the forms of capital contribute to behaviour and attitudes in relation to 'mental health' and how people belonging to the Gujarati communities draw on forms of capital for their understandings but also how they subsequently manage 'mental health'. An example of this is possession of Goddess Durga which is viewed as religious and the Gujarati communities have cultural capital that acquires this knowledge and thus it is expected in a religious setting. Furthermore, because this is viewed as religious, many people who are possessed by Goddesses are viewed religiously and tell other humans what to do to get rid of troubles, or pass on messages from God. In this case individuals may feel an 'unspecified obligation' to act upon what they have been told by 'God'. Bourdieu (1986) argued that through social capital, actors can gain direct access to economic capital, which can increase cultural capital. This did occur with the Gujarati communities as explored earlier they used their networks to heighten their means to build places of worship which inherently allowed for cultural capital to flourish in Leicester.

Habitus

The habitus is created through long-lasting interactions in a social environment which teach us ways to behave, think and act. Bourdieu (1984) argues that the habitus is created and reproduced unconsciously; practices are so engrained in our minds that we no longer have to think about them. For example, in terms of cultural capital, being a Hindu is part of one's habitus and through socialisation Hindu's are taught the right cultural codes enabling them to have appropriate knowledge on how to behave in religious settings. Through repetitive practices, the expected behaviour becomes embodied and thus translates in schemas. This is when an individual learns the appropriate behaviour in various cultural and social situations. Through repetition, these become so internalised that they are normalised and individuals no longer actively think about how to behave. For example, Hindu's will be taught how to behave in a Mandir (see glossary) and with time these behaviours no longer require thought and acted upon unconsciously.

Furthermore, these different types of capital are transformed to symbolic capital and taken with individuals to fields in society. Bourdieu (1986) positions actors in a social space based on their economic, social and cultural capital. As, Anheier (1995) argues Bourdieu's field theory is constructed at a mesolevel. Societies are made up of multi-dimensional spaces of fields and to name a few these include work, education and networks. Fields are various social and institutional arenas in which people express and reproduce their habitus and where they compete for the distribution of different kinds of capital. However, fields have their own appropriate norms and values which Bourdieu terms 'doxa'. In 'Outline of a theory of practice' Bourdieu (1977) formulates the concept of 'doxa' as knowledge, practices and behaviours 'that which is taken for granted', the 'self-evidence of the common-sense world' (p.166). For Bourdieu, the interplay between one's habitus and 'doxa' illustrates a person's position in society and thus their power. As Anheier (1995) put forward:

Fields encompass the relations among the totality of relevant individual and organisations actors in functionally differentiated parts of society, such as education, health, and politics (p.860)

Furthermore, Bourdieu defines the structure of a field as a 'network, or a configuration, of an objective relations' among positions (Bourdieu and Wacquant, 1992, p.97). It is in these various fields that you can see the interplay of structure and agency and how this places individuals in terms in power imbalances in society. For instance, one's habitus will impact on how they are suited to the norms and values of fields and thus this inherently contributes to how much capital (social, cultural and economic) an individual has in society, which reflect power inequalities.

I will use Bourdieu's forms of capital to demonstrate how the Gujarati communities have used social capital to enforce cultural capital post migration. This allowed for cultural reproduction and thus awareness of their habitus moved from an 'unconscious' to 'conscious' state and has been reinforced to overcome change due to dislocation. Bourdieu (1977) terms this transition is occurred by a crisis:

The critique which brings the undiscussed into discussion, the unformulated into formulation, has as the condition of its possibility objective crisis (...). It is when the social world loses its character as a natural phenomenon that the question of the natural or conventional character (...) or social facts can be raised. (...) Crisis is a necessary for a questioning of doxa but is not in itself a sufficient condition for the production of a critical discourse. (p.168)

However, through forms of capital this 'crisis' has been avoided and arguably, returned to an 'unconscious' state as the communities settled into a new environment (Leicester). But, it is the process of this and the ways in which it is being subsequently managed by cultural changes that are occurring through acculturation rather than moving to a new location that is indeed interesting in relation to 'mental health'. As a result of using social capital, the communities

benefit from integration, networks and collectiveness. Despite residing in a new setting these benefits ensure their 'habitus' can endure a different environment which to some degree allows for their 'normality' to continue. Subsequently, the communities benefit from continuing community practices that make up their habitus and promote 'mental health' management.

Although, Bourdieu (1986) argues that social capital can be positive and have both economic and cultural benefits of belonging to a network, there are pitfalls. The different fields that make up the communities' habitus have their own 'doxa' of cultural traditions and expectations. For instance, religion will have its own doxa and people will behave in certain ways when in a religious environment. Consequently, these hold power and the Gujarati communities may feel like they have a 'social obligation' to behave and act in certain ways. In relation to 'mental health' this is at the core of the ways in which 'mental health' is understood, attitudes towards the phenomenon and help-seeking behaviours that can influence access to 'mental health' care. Furthermore, as explored earlier there are 'unspecified obligations' in different forms of capital that will symbolise power over an individual's actions. In relation to 'mental health', if the cultural norm in the Gujarati culture is that it is a private phenomenon that should not be spoken about, community members will respond by keeping 'mental health' problems hidden which is problematic as they are not managed.

Primarily, this is the reason why I am using a Bourdieusian framework to analyse my data. It identified in the literature review, social capital has been widely discussed and studied in 'mental health' (e.g. Greenberg and Rosenheck, 2003; Kelleher, 2003; Muntaner, 2004; Almedom, 2005). Although I agree that social capital can be significant for understanding 'mental health', previous studies lack the cultural and economic dimension. For instance, although high levels of social capital may be beneficial to community members, the impact may be felt differently by minorities. Here I use minorities, in the sense that individuals may be 'othered' or stigmatised based on cultural attitudes of what is considered to be deviant behaviour. Additionally, communities 'that often

score highly on existing measures of social capital are sometimes characterised by an intolerance of 'deviant' behaviour, lack of autonomy and unwritten demand for obedience to norms' (McKenzie et al., 2002. p.281). Therefore, close-knit communities are bound by cultural norms and for those who do not conform to these may experience marginalisation. Therefore, close-knit communities are not necessarily healthy, particularly for outsiders (Baum, 1999). The key reason, for using Bourdieu (1986) is his acknowledgement of the interplay between the forms of capital and thus this is significant for the Gujarati communities in relation to 'mental health'. Additionally, Bourdieu's (1986) work as a theoretical framework is significant in the sense that it draws on both structure and agency. For instance, Dobbin (2008) argues:

Bourdieu's great power comes from its integration of a theory of the individual (habitus), a theory of social structure (the field), and a theory of power relations (the various forms of capital) (p.53).

In relation to the Gujarati communities and 'mental health', by using Bourdieu's (1986) theoretical framework, a thorough analysis is given to this context. In the following analytical chapters, there is recognition of how individuals, social structures and power relations all contribute to how 'mental health' is understood, experienced and subsequently managed.

For instance, previous literature suggests that participation in community organisations, involvement in social networks, and relationships enhances the likelihood of accessing various forms of support, which in turn protect individuals against emotional distress (Kawachi and Berkman, 2001; McKenzie et al., 2002). However, for the Gujarati communities, who have their own 'doxa' of cultural traditions and expectations relating to how they should behave in a 'community' setting and also cultural attitudes towards 'mental health' restrict them accessing support from their communities. Therefore, as Bourdieu (1986) suggests individuals will feel they have a 'social obligation' to behave a certain way in their communities. Thus, although the communities may experience high levels of social capital, it is bound by cultural capital and thus both need

exploration. Although Bourdieu, separated them into forms of capital I will not utilise the forms of capital as discrete categories, but rather interchangeable forms that intersect and overlap (as identified above). I inherently will focus on social and cultural capital but economic capital contributes to the ways in which the community organisations were set up and the emphasis the communities place on being financially successful.

Summary of Chapter

This chapter has outlined the contextual background of the participants who took part in this research; providing an overview of their migratory routes and experiences. Their experiences also demonstrate the ways in which participants took on an active role in ensuring the communities experience high levels of social capital and remain socially cohesive. This then led on to justify and warrant the use of Bourdieu's (1986) theoretical framework of forms of capital which the latter half of the chapter explored.

This Bourdieusian framework will be utilised in the subsequent analysis chapters. There will be an exploration of attitudes and understanding of 'mental health' (Chapter 5), cultural changes that could result to 'mental health' difficulties (Chapter 6) and community practices and management of 'mental health' (Chapter 7). As well as exploring my research questions outlined in the introduction there will be an underlying exploration of:

- In what ways does social and cultural capital influence how 'mental health' is conceptualised, experienced and managed in the Gujarati communities?

Chapter Five: Understandings and attitudes of ‘mental health’

Introduction

To remind the reader, in the Introduction and the literature review, I argued culture is a contributing factor towards feelings and different cultures have distinctive beliefs which not only affect meanings of mental illnesses but how they are dealt with (Fenton et al., 1996). In saying so, I am not dismissing a universalist position of ‘mental health’ that mental illness can be defined in a range of contexts and siding with a relativist position of permitting understandings of mental illnesses only in a social and cultural domain (Fenton et al., 1996). Rather, I find the dichotomy of perspectives here problematic and want to illustrate that universal constructions of illnesses do exist but cultural specificity contributes to how they are viewed. For instance, sadness, depression, isolation etc. are inherently universal and do exist universally but are given different labels, in different cultures which also contribute to how they are understood and this complexity cuts across the universality/specificity binary. Therefore, it was crucial not to invoke a medical model definition of ‘mental health’ to the participants but rather explore how the Gujarati communities understand and conceptualise ‘mental health’.

Therefore, this first analysis chapter will offer an exploration and address the question of ‘in what ways does the Gujarati communities understand and conceptualise ‘mental health’? And how does Bourdieu’s (1986) forms of capital; social and cultural capital shape these understandings and conceptualisations of ‘mental health’ in the Gujarati communities? It is crucial to begin analysis here because if the communities do not view ‘mental health’ as a problem, they will not seek to manage it, be it in a community setting or medical help. Thus, understanding and attitudes of ‘mental health’ are pivotal to gaining information on whether the communities view ‘mental health’ as problematic and if so how they respond and manage it. Both of which are further discussed in the succeeding analysis chapters. Additionally, this

exploration focused on allowing information to emerge from the data, which illustrates components of grounded theory and analytic induction in practice.

Although inherently related; this chapter will be broken into two main categories that will be explored: Understanding and meanings of 'mental health' and attitudes towards 'mental health'. Various aspects were put forward from the participants that were prominent under these categories and in turn, I will explore them. Below, I provide an overview of the layout of this chapter but it is crucial to reiterate that these categories indeed do overlap, interrelate and interdepend on one another. However, for ease and clarity of analysis the separate factors have been considered. Firstly, there will be an exploration of understandings and meanings of 'mental health' in relation to: limited understanding, depression, language and use of words, religion and causes of 'mental health' problems. Secondly there will be a consideration of attitudes towards 'mental health' and the different factors that will be explored are: not openly discussed, denial and acceptance of 'mental health', personal issues and othering.

However, before these two areas are delved in, it is crucial to provide an analysis of the background and biographical information that was revealed during the interviews. Namely, migration history was explored and although these questions were used to set up the interviews; they are significant in demonstrating where understandings and meanings of 'mental health' arise from but how attitudes towards 'mental health' are shaped and continue in Leicester, where the communities have settled.

Background/Biographical Information

All my interviews began with general background questions of people's history, migration traits and how they found the experience of migration, settling down in the UK and their current situation now in terms of family structure, marriage, children and opinions regarding living in Leicester. Although these questions usually entailed a response of factual data such as place of birth and year of migration; it has been in my experience beneficial and aided setting up the rest

of the interview because this sort of information requires little thought, easy to answer and participants are able to familiarize themselves with what the process of the rest of the interview will entail. Usually questions that followed explored how people felt when they migrated and experiences of adapting to a new setting. In hindsight, the latter part of the background questions allowed participants to think about their feelings and opinions which was essential to the rest of the interview and thus I think it was important to ask these questions not only to set up the interview but contextualisation is important to gain for the interview and data analysis. Crucially this became even more significant in the analysis process and I will set out the reasons below.

As explored in the previous chapter, all participants had migrated from India, East Africa or both and thus they had experienced migration once, if not twice. There were a few reasons suggested for migration such as marriage, better life in the UK and due to the political state of East Africa at that time. Indeed, the emotional and physical burden of migration has been experienced twice by many participants which increases the chances of mental illnesses (Bhui et al., 2003); nonetheless as explored in the previous chapter, participants conveyed positive attitudes towards moving. Additionally, Harris et al. (2006) argues that migration can result to being rejected by the host country through episodes of racism which can increase mental distress (Williams et al., 2003; Araujo and Borrell, 2006; Knifton et al., 2010) was not expressed by my participants, thus significantly as this thesis is person-centred and focused on an inductive approach, race and racism has not been explored because my participants did not regard this as relevant nor important. This is an interesting finding, because critical psychiatry assume that ethnic minorities are oppressed through the above means such as racism and this results in higher rates of mental illness does not appear to apply to the Gujarati communities' due to their unique migratory traits.

The Gujarati communities that reside in Leicester are unique in not only their migratory patterns but moving in large kinship groups and establishing wide networks in the UK, in particularly Leicester. The development of creating

community organisations resulted to socially cohesive communities and high-density areas which allowed for home culture to be maintained and has been shown to be deep rooted amongst the group (Furnham et al, 2000).

Using a Bourdieusian framework, this migration trait can be further analysed. According to Bourdieu (1985) different forms of capital; namely economic, social and cultural make up one's habitus. The habitus is the resources that an individual has gained through these forms of capital due to social and physical spaces people occupy. Therefore, the habitus is identified as a structured form of interaction, perception, estimation and practice, which influences the disposition of interacting and being (Bourdieu, 1990; Maton, 2008). Furthermore, Maton (2008) explains Bourdieu's ideas arguing that the habitus is associated with the structure of practices that people have, which 'focuses on our ways of acting, feeling, thinking and being' (Moore, 2008, p.52). Therefore, migrating in large kinship groups, where communities value their social networks, strengthens their social, cultural and economic capital. In doing so, and creating a habitus that is culturally located contributes to 'ways of acting, feeling, thinking and being' and this will be explored in relation to 'mental health'.

Indeed, literature reflects that a possibility of the underreported rates of mental illness could be because of strong forms of social capital amongst the communities' due to family and community support (see Barnett et al., 1988; Muntaner, 2004; Almdeom, 2005). As a result of this support, people experience good 'mental health'. For instance, Shah and Sonuga-Barke (1995) found in their study that children fared better emotionally in extended families' due to extra familial support. There is a significant point to be made here. Social capital has largely been written about in terms of its benefits and negative consequences. For example, Portes (1998) argues there are three functions of social capital; a source of social control, family support and benefits through extra-familial networks. Additionally, Halpern (2005) argued that the academic interest in social capital focuses on the relationship between the quality of people's social networks and influences on a range of elements such as

economic growth, educational performance to name a few (Halpern, 2005). Here, again the focus being on 'relationships' and what social capital can cause, be it benefits or negative consequences. This is indeed not a new phenomenon in sociology and dates to Durkheim's (1893) study on suicide who argued that an individual act such as suicide can be best explained by 'social forces external to the individual' (Halpern, 2005, p.5). Durkheim illustrates that suicide was more common in societies which have loose social bonds and social dislocation; whereas in societies that had a higher level of solidarity, more social support and social cohesion, suicide rates were lower.

Inherently, Durkheim's (1951) work on suicide illustrates a positive relationship between social capital and 'mental health'. However, in this chapter I will illustrate that social capital and the other forms of capital, namely cultural capital should be paid far more close attention instead of analysing their causal relationships to other factors such as 'mental health'. Rather than presenting or analysing social capital in terms of 'relationships', there are complex impacts social capital can have on an individual. Through my data, and using Bourdieu's forms of capital (social, cultural and economic); I will demonstrate, that indeed these forms of capital contribute to one's habitus and also to reiterate shape 'our ways of acting, feeling, thinking and being' (Moore, 2008, p.52). Therefore, forms of capital also impact how individuals come to understand and their attitudes towards, in this case 'mental health'. Also, I am not denying that social capital and support can be positive for 'mental health', but in the forthcoming analysis chapters I will illustrate that these 'causal' relationships presented in previous literature is far too simplistic, and the impact of social, cultural and economic capital on 'mental health' is far more complex.

Furthermore, in the previous chapter, I explored how the community members took on an active role in building community organisations to help remain socially cohesive and build a base where community gatherings can take place as well as religious practices. Despite this, my data illustrated that it is now increasingly becoming common for families to be living apart from one another

and the common reason for this is marriage or job opportunities (Ballard, 1990).

Pratik stated:

²Then as soon as each brother qualified got married and moved away to different parts of the country. So, both my brothers are outside Leicester, my third sister got married and lived in London umm so we were left with my parents, myself and my wife and my child and then my child went to university and became a medical practitioner so he's moved back now to Manchester and he's married off there. My parents have unfortunately died now so we are left with just me and my wife here though my son, daughter in law and grandchildren are in Manchester.

(Male, first-generation migrant)

Pratik explains his family situation and indeed fragmentation occurred as his siblings got married and moved to other parts of the country and now his children have moved due to university and job opportunities. Therefore, it seems that families are increasingly becoming more fragmented but the first generations that initially migrated and settled in Leicester remain there. Shaw (2004) also states that this fragmentation of immigrant families in the UK, in particular South Asian families is becoming far more common. However, the participants made it clear that they would see their children or extended family at least fortnightly if not weekly. Furthermore, the first-generation that remain in Leicester, often see the wider communities through social gathering which often is due to religious festivals. Therefore, family ties may be breaking and extended family settings may be in decline but this does not mean that social capital is diminishing. In fact, social capital is much wider than just individuals'

² All extracts that have been used from participants have been kept as they were spoken and thus some grammar mistakes may be evident. But this was crucial for exploring conceptualisation of mental health.

family and first-generation migrants can socialise and interact with people through wider networks in the communities. For example, Urmila said:

In the temple if there is a festival during the year we go and meet and we just take part in the puja, in the prayers and everything, all the functions we attend and in our community if there is any community programme then we surely attend there. We go and meet everybody and my close family comes like umm all my in-laws comes every two weeks and we have dinner and a get together so things like that, its on-going.

(Female, aged 52, first-generation migrant)

However, this does not apply to all the communities; my first few interviews occurred with organisation leaders as this is how I gained access and thus snowballed contacts (explored in the methodology chapter). There seems to be a divide in terms of people who are heavily involved with wider community activities, social events and gatherings. There are many people who are not involved in these events which suggests that the communities in Leicester are fragmented and perhaps not as close-knit as previous literature has anticipated. This could mean that the Gujarati communities in Leicester may be large in numbers but is fragmented through not only organisations but according to people who choose to get involved with these different groups.

Despite the commonality of fragmented families, there was a great emphasis placed on family networks and transmitted to the communities more generally. Indeed, some families are geographically spread out in the UK, but significantly they prioritise a 'community spirit' and those that remain in Leicester who may not even get involved in community gatherings, are still part of the communities as participants expressed pride in living in an area that housed a large Hindu Gujarati population. Furthermore, this is at the heart of what has allowed for understandings, attitudes and responses to 'mental health' remain the way they are. Although, geographically and physically it may be the case that families are living apart, cultural and social capital remain strong in the

communities. Some have moved away due to bettering their economic capital for job opportunities as again, that is viewed of importance in the communities. Despite some changes, in people moving this has not altered views and attitudes around 'mental health' because the communities value their habitus so highly, and the frequent contact ensures social and cultural capital remain strong in the communities. This was powerfully depicted in the interviews and a reason why it was at times difficult to discuss 'mental health' or a subject that can be viewed negatively in the communities. This is further illustrated below.

To begin discussing the topic around health, I usually started the conversation by asking questions relating to broader health issues in the communities. It is interesting to note that although the participants acknowledged an awareness of broader health issues such as diabetes and obesity there was a common pattern of comparing with other communities and a reluctance of discussing the Gujarati communities alone. Furthermore, comparisons usually followed a similar theme of suggesting that the Gujarati communities fared better than other Asian communities. For example, Jayesh stated:

I think that if you look at the Gujarati community because we don't have like marriage with siblings and things which exist in the Muslim family some of our illnesses are not transmitted. You'll find if you look at the Muslim family 13 people are having diabetes, so I think that that's a good bit about Gujarati's.

(Male, aged 63, first-generation migrant)

This could be a distinctive personality trait that the communities acquire and has been a recurrent theme throughout respondents' answers. Similarly, to viewing the positive aspects of migration the communities tend to have a similar outlook when discussing health issues. This attitude reflects Allen's (1994) arguments of awareness of ethnicity signifying in contexts such as migration and discrimination which can undermine it. It may be the case for the communities through notions of cultural and social capital the strength of their ethnicity has increased as a strategy of adaptation due to experiencing

migration twice and having their identity threatened. The communities have responded by reinforcing their own identity through remaining close knit, building places of worship, celebrating festivals and remaining religious (Bachu, 1985).

Answers also reflect a notion of the 'other' and always viewing the positive aspects of their own communities. Furthermore, Jayesh 'others' the Muslim population in the sense that even though some problems may exist in the Gujarati communities, they are not as bad as the problems the Muslim communities face. He also gives an example of intermarriage practices in Muslim families which mean that illnesses are more likely to be inherited. Additionally, the Muslim marriage rules permit first-cousin marriages (Shaw, 2004) and this has continued amongst Muslims that reside in the UK, also expanding to distant relatives. Thus, type 1 diabetes which is insulin dependent and hereditary is more likely to be transmitted in such communities. This is interesting to note, because by 'othering' specific communities in a negative light they are signifying their own social and cultural capital. As explored earlier, the Gujarati communities tend to have a positive outlook on migration and thus it has also been transmitted to other areas of their life such as health. These attitudes can be culturally located and thus even if health problems may exist in the Gujarati communities they may still try to view these in a positive way by comparing themselves to other communities who could be worse off. Although this potentially is a way to manage 'mental health' problems, it can also contribute to health issues not being viewed as problematic and thus not being addressed.

Overall, the communities are very protective of their own communities and this could reflect strong forms of capital. This is crucial to this thesis because, I will demonstrate that it is this strong social and cultural capital the Gujarati communities value that can potentially shape, strengthen and signify understandings, meanings and attitudes towards 'mental health'. If a community experiences strong social capital, their cultural capital can heighten and thus this can also shape attitudes around 'mental health'. For example, if

the Gujarati communities view 'mental health' as 'madness' which is culturally located, due to strong forms of social capital this opinion can remain significant as communities will reinforce this perception. Therefore, the migration history of the Gujarati communities, who place a large emphasis on social networks, is significant in contributing to the ways in which the communities understand 'mental health', how these opinions remain in a western environment but also shape attitudes towards 'mental health'. The complexities in this, is explained well by Poonam:

On the whole the generalisation is that the Gujarati community is affluent, prosperous, close-knit successful community and hardworking um pretty money minded and money smart, very ambitious but quite stressful at times because of those high expectations of themselves and togetherness drives them to put pressure in them and others to perform and meet their expectations so when things go wrong then the communal spirit helps them but at the same time it pressures the communities so if they have weak points then sometimes they come to breaking points um and then there is a stigma attached to the breaking points so they cannot say anything and acceptance I think in accepting things that are different to themselves, or to the community expectations then they will have a problem so the community is bad and good in so many ways.

(Female, first-generation migrant)

Here Poonam, illustrates that there are two parts of belonging to a community and that is one which can be positive in providing support but indeed one that is negative that it can put 'pressures' on members to behave in a certain way. This relates to what Bourdieu (1986) termed as 'social obligation' and being part of a community may mean individuals feel socially obliged to behave in ways that permit that communities' norms and values that are inherently shaped by their cultural and social capital. Additionally, Poonam highlights that if an individual does not meet the communities' expectations they could reach

a *'breaking point'* connoting some sort of 'mental health' problems which are stigmatised and consequently cannot say anything. Additionally, she states, *'togetherness drives them to put pressure in them'*, thus strong forms of social capital can cause 'mental health' problems. This is because; strong forms of social capital will mean that the communities have norms and values that are appropriate in their culture as well as expectations. An example of this could be a particular profession e.g. doctor and it is the *'togetherness'* that puts pressure on people to aspire to achieve or expect to be in certain professions such as a doctor. However, if this is not achieved, it could be detrimental influences on 'mental health'. Therefore, utilising Bourdieu's concepts of social, cultural and economic capital I will demonstrate how this plays a crucial role in shaping meanings of 'mental health' and attitudes towards 'mental health'. The next section will explore the understandings of 'mental health'.

Understanding/meanings of 'mental health'

Exploring understandings of 'mental health' was a difficult area to tackle. This study found that most of the participants did not have a clear understanding of the term 'mental health' and often I had to rephrase the question to ask what participants understood by bad 'mental health' and many attempted at providing an explanation for this. It is significant to note here, that language played a very crucial role. Many participants were only able to answer these questions when asked bad 'mental health' rather than 'mental health' or good 'mental health'. This shows that it is potentially viewed as something 'bad' or 'negative' or it was easier to think about it in this way. Furthermore, it also illustrates that it is potentially a term that is stigmatized and 'othered' and this could be rooted in the communities' social and cultural capital which is further explored below. There was confusion between 'mental health' and mental illness and similarly Dogra et al. (2005) also found this. These definitions and conceptualisations were broadly categorised to do with feelings – feelings of not enjoying their life and feelings in the sense that an individual is unable to express their emotions or generally things they want to say. The following demonstrate some of the understandings that were revealed:

Rita:

When a person is withdrawn and doesn't want to talk to anybody and doesn't want to get involved in any activities, or is not enjoying their life to the full.

(Female, aged 63, first-generation migrant)

Alka:

Bad 'mental health' means who can't express their feelings, they can't get what they want to achieve their goals and neglecting from the community and either in wherever they situate in the group or circle that is called back 'mental health'. I didn't even hear a word about it when I was in India, I didn't know what it was or that it existed then I came to this country and my father-in-law had it, that why I know about it. Otherwise I don't know about it this 'mental health'.

(Female, aged 43, first-generation migrant)

These statements indicate that bad 'mental health' is conceptualised in a way that focuses on lacking the ability to do day to day things in life such as 'get involved in activities' or 'express their feelings'. Unlike the study conducted by Dogra et al. (2005) who looked at Gujarati young people and their parents found that participants expressed 'mental health' in terms of as a brain deficiency or dysfunction and abnormal behaviour; my study presented different findings. Additionally, what is interesting about Alka's response is the comparison made to India. It could be the case that these issues increased because of migrating and being in a new environment but also the use of 'community' illustrates the value placed on being integrated into the Gujarati communities and if an individual is not or is neglected they may suffer from 'mental health' issues; illustrating the significance placed on networks gained in the communities.

Broadly speaking, there were three definitive areas that conceptualised the communities' understandings of 'mental illness' and they will now in turn be explored. These were depression, usage of language and religion. Additionally, using these separate categories to formulate the communities' understanding of 'mental illness', they suggested themselves' that they have a limited understanding to what it means. Additionally, due to this limited awareness and understanding, the accounts presented relate to common mental health disorders rather than more severe illnesses such as schizophrenia or psychosis. This could be because of limited understanding and as Gujarati communities have heard of depression they largely discussed this. Additionally, it is not due to an artefact of the interview structure as such, but perhaps the approach taken in this research. As discussed in the literature review and methodology, 'mental health' can differ culturally and socially and thus, participants were not asked about specific illnesses such as psychosis or dementia but rather mental illnesses as a broad term keeping the research exploratory. The revelations overall suggest there is a limited understanding and thus it could be a concealment from participants because they do not understand various diagnoses or it could be that psychosis is stigmatised and thus kept hidden. Additionally, it could be the rates of psychosis are low and as a result not discussed. However, it is beyond the scope of this thesis to infer why other diagnoses of mental illnesses were not discussed. Below, the understandings of mental illnesses are presented.

Depression

The common answer I received was to refer to mental illnesses as depression. This could signify that knowledge around mental illness amongst the first-generation Gujarati migrants is quite limited or as Alka suggests gained this knowledge post migration. Similarly, this was found in a study conducted by Dogra et al. (2005) which explored understandings of mental illness and 'mental health' in the Gujarati communities in Leicester. Additionally, the communities relate to depression as a 'mental health' issue; for example, Kunal, who works

as a full-time production engineer and moved to Leicester in 2005 with his family for work opportunities stated:

If you ask me, one is worry if somebody is in a worried state I'm not calling as a bad 'mental health' it's just temporary kind of things then the other level kind of thing is stress levels. That's the second level in our kind of thing. Stress level is again 50/50 you can say it's bad 'mental health' but at the same time you can say it is a short-term kind of thing and the third level is depression. And I always say that if you are in depression then it's a bad 'mental health' but if you are in a worried stage or at the stressed stage or stress level with the stress kind of thing then you haven't got bad 'mental health' it's not a 'mental health' issue basically. But depression is definitely a 'mental health' issue so yeah so, I can say that depression is a bad 'mental health' issue.

(Male, aged 49, first-generation migrant)

Kunal suggests emotions that come prior to depression may not be considered as a 'mental health' problem and in fact a way of life. Therefore, being worried and stress which could be triggers for depression may not be viewed as problematic among the Gujarati communities. Kleinman and Good (1985) argue that emotions and how they are perceived vary in different cultures. These understandings are important because they contribute to perceptions and whether it is problematic or require assistance or management. Kunal has outlined that the feelings that come prior to depression are not viewed as bad 'mental health'. Furthermore, this could mean that prolonged periods of sadness and anxiety are then not viewed as problematic in Gujarati communities and management is not required. However, in the diagnostic and statistical manual of mental disorders (DSM-5) which is used in psychiatry there is a classification of anxiety disorder and in this category, are panic disorders, stress and general anxiety. However, if 'stress' is not considered as problematic it will not be managed or help will not be sought to overcome it. Additionally, this illustrates that understandings are key in shaping help-seeking behaviours.

In saying so, I am not suggesting that the intercultural meanings of these emotions and experiences should be accepted and left unaddressed but rather both the medical model and cultural components in understandings of 'mental health' are complementary and must work together to provide a more appropriate and nuanced framework to support managing 'mental health'. This is critical because Alka suggested earlier, she only became aware of depression post migration and due to it being a term that is widely used in a western setting, the culture has contributed to the knowledge and understanding of it in this environment. However, if terms such as stress or anxiety are not viewed as problematic in Gujarati culture and strong forms of social capital and cultural capital have allowed these opinions to remain in the UK does not mean they should not be addressed.

Other reflections of 'mental health' and depression were:

Mahesh:

With a little bit, you know it's like depression is like you are floating in the vast ocean, you are trying to grab something and there's nothing there, there is no land but suddenly you find a piece of wood or something which can float and then you come to the shores and make progress from there, this is what it is, you need something to grab onto and yourself out of it.

(Male, aged 67, first-generation migrant)

Sarla:

We have got televisions nowadays, computers, smartphones and iPhones' and iPads' and laptops and things. People are just sitting on the settee and just not doing the physical exercise, so that's why the kind of food we eat I think it's not appropriate for us to have it in this country and people become depressed don't they, once you sit and become a couch potato you have got nothing else to do,

nobody to talk to apart from your phone and your television or your radio.

(Female, first-generation migrant)

In both extracts, Mahesh and Sarla were describing what they understood by depression. Mahesh uses a metaphor of floating in the sense that depression is when you are aimlessly floating so you may not have a purpose in life, or know what direction you are heading towards. Sarla associates depression with not having anything to do both in terms of an activity and talking to people. Interestingly, these were predominantly the common responses by many participants; whereas Kunal associated 'mental health' with different emotions of worry, stress and then depression. Kleinman (1996) argues the chief symptom of major depression is sadness where depression is a psychological, emotional problem. Nevertheless Kleinman (1996) further explained that:

In most societies, most people experiencing clinical depressions do not complain mainly of sadness. Instead they talk about fatigue, headaches, backaches, stomach upset, insomnia, loss of appetite, and so on. For most depressed people, this physical experience is most real. As a result, they visit primary care doctors rather than 'mental health' professionals, and usually their depression is neither diagnosed nor effectively treated (p.17).

Similarly, participants reflect responses which focus on other aspects of life other than emotions such as direction in life or unable to take part in activities. Although, earlier Alka explained that bad 'mental health' was to do with not being able to express your feelings, she went straight on to discuss not being able achieve goals. Kleinman (1996) argues that this can be a problem in terms of diagnosing depression, which will further be discussed in the third analysis chapter under somatic expression. However, I argue that this reflection of understanding and conceptualising depression in this way is indeed culturally located. Emotions are something that are rarely discussed in Gujarati communities which will further be explored in the attitudes section below.

However, the consequence of not discussing emotions and feelings in the Gujarati communities can lead to conceptualising depression as 'unaccepted' forms of behaviour. For instance, the communities have strong forms of capital where they prioritise their relationships and connections with others and if an individual behaves in a manner that is outside the norm, this can be explained in terms of '*something is wrong with that person*'.

Furthermore, these understandings also illustrate the complexity in understanding 'mental health' in terms of the mind-body dichotomy. It is a characteristic of western culture to separate the physical and emotional components of depression which is heavily focused on emotions. However, participants indicate that in understanding 'mental health' and in particular depression, the mind and body are not binary opposites or a dichotomy but rather inseparable entities. This understanding of the two can indeed impact the way in which 'mental health' problems are conveyed to GPs or 'mental health' professionals. Kleinman (1996) argues:

Probably none of us living in western societies would be surprised to be asked by a 'mental health' worker if we felt 'blue' or 'down'. The terms seem natural as a description of depression. However, all such linguistic categories are derived from cultural models of the world, the person, or the illness. Down makes sense to us because western culture has regarded depression as a result of the soul moving downward in the body (Jackson, 1986). The word depression itself derived from Latin roots meaning to press down. Belief and experience are so intertwined that we consider a downward inner feeling natural and universal. Most of the 80% of our planet's people who live in non-western societies would be baffled by this (p.17).

However, the Gujarati communities have illustrated that these 'feelings' are rarely discussed and depression is viewed more as not being able to achieve the goals you set in life or not having a purpose in life. Thus, if the understanding around depression is linked to no purpose or unable to do things

in life, these could be what is discussed if they choose to seek help which could influence diagnosis or it could perhaps mean that help is not sought for at all. Overall, perceptions and understandings of mental illnesses such as depression can impact experiences and how these are managed.

Language and use of words

Using depression to explain 'mental health' problems is also related to language and the use of words. There are two areas in relation to language that will be discussed; firstly, limited knowledge on mental illness language affects expression and secondly, language in terms of how 'mental health' is perceived and expressed.

Many of the interviews were conducted in Gujarati and when participants were asked what 'mental health' meant to them, they had a tendency to say depression in English. I have spoken further about translation issues in the methodology chapter. When I probed further, participants could not explain what depression was in Gujarati and the interview extracts have suggested that language surrounding mental illness is not common in everyday language in Gujarati and thus they know more about depression post migration as Alka said earlier *'I did not even hear about it in India'*. Additionally, it poses three problems. Firstly, participants demonstrated that they were unclear on what is meant by depression and may use the word incorrectly as they were aware of it post migration. Secondly, if they are unable to express their emotional wellbeing clearly in Gujarati and language is limiting for the communities to express 'mental health', it can be difficult to understand, express and diagnose; this could be a reason why the communities commonly express symptoms somatically (Kleinman, 1986). Thirdly, understandings and opinions can be mistranslated from Gujarati to English; meaning different things and thus making it difficult to understand the true nature of 'mental health' with the communities. Literature suggested two points regarding interaction with GP's, one where members of the South Asian community use somatic expression and thus GP's may not be able to recognise mental illnesses and the second is

language barriers when patients go and see doctors (Kleinman, 1986). Statistics illustrate that mental illnesses are low among the Gujarati communities and thus interactions with GP's could influence this. (Wilson and MacCarthy, 1994). The management issues of language and how illnesses are conveyed will be discussed in the last analysis chapter (seven).

Furthermore, limited words relating to 'mental health' in people's everyday language in Gujarati affects knowledge but also using words such as mad, crazy and slow results to 'mental health' being stigmatized, not being openly discussed in the communities and denial. Alongside the negative attitudes towards mental illness; other reasons for not openly discussing the matter was due to people gossiping and stories travelling fast amongst the communities which would hinder reputation. These social attitudes among the communities can potentially act as a barrier to seek help (further discussed below). Furthermore, this suggests that the cultural view of madness may still be lived realities. Participants did not know what 'mental health' or 'mental health' problems were in Gujarati. For instance, mental illness translated in Gujarati is 'mansik bimari' and the majority of participants did not know this, as I asked how do you say mental illness in Gujarati? Additionally, when I did use it, many participants asked me to rephrase this in colloquial language that was more relatable or understood. Furthermore, language that has been accessible to the communities and how 'mental health' has been expressed is inherently linked to the communities' attitudes which will be explored below. I will illustrate some of these conceptualisations below which demonstrate using certain language results to the cultural view of madness being currently relevant within the communities.

For example, participants suggested:

Pratik:

I think because for many years mental illness has already been kind of given a label that this guy is crazy. They don't know that there are

many different things happening within the mental issues and many can be corrected if they seek help.

(Male, first-generation migrant)

Amit:

As I say it not an illness to them, it is like that are gando but if you get dementia and stuff that with old people they will see it as diseases. [...] And like my wife who is from India doesn't understand it, they don't recognise these things in India at all, it's all very different, we only understand it a little bit after coming here, but not really.

(Male, aged 58, first-generation migrant)

Jayesh:

Because they're scared, they're scared that people saying you are pagal, that's how they see it and understand it, that's how they are; if you say things they will say things like that to you.

(Male, aged 63, first-generation migrant)

These extracts reflect that the communities' view mental illness as crazy and mad. A way in which this cultural view of madness has been permitted to remain among the communities can be due to their strong forms of social capital which strengthen their cultural capital. This can be due to the 'community environment' because if communities migrate together then it is likely that these values or opinions transfer with them as they remain close knit. Thus, people are unlikely to talk about their emotions or indeed keep their 'mental health' problems hidden because they would not like to be labelled as crazy and mad.

It is also interesting to note the terminology used between illness and disease. Amit suggests that if someone has dementia people will view this as a disease but other mental illnesses that may not be that severe are labelled as not an illness but rather as 'gandho' which means are viewed as 'silly', 'mad' or 'crazy'.

This illustrates that severe diagnosis such as psychosis, dementia and Alzheimer's are recognised as an illness but other less severe illnesses are given cultural labels of 'madness'. Participants suggest these attitudes have been sustained in Leicester post migration due to strong forms of social capital which has enhanced cultural values to remain. However, as Bourdieu (1986) argues it could be that these understandings form part of individuals' embodied cultural capital which is in the form of long-lasting dispositions and thus these understandings are not easy to change as it forms part of an individuals' habitus. The next section will explore the ways in which religion has contributed to forming an understanding of 'mental health'.

Religion

Religion was a key thread that was revealed in my empirical data that impacted 'mental health' in many ways. Broadly speaking, there were two categories where religion both affected the way in which 'mental health' is conceptualised and help-seeking behaviours. This has also been found in previous studies (see Furnham et al., 2000; McGrother, 2002;) In this section there will be a discussion of the ways in which religion contributed to an understanding of 'mental health' and the help-seeking behaviours and management is discussed in the third analytical chapter (seven). To make clear from the outset, all participants involved in this study identified themselves as a Gujarati Hindu and their 'religiosity' was not mapped in any way but rather focused on the ways in which beliefs and practices in Hinduism played a significant role towards 'mental health'.

Leicester has the second largest Hindu community in the UK with 41,248 at the last census and religion plays a fundamental role in their lives (Raj, 2010). Despite being twice migrants, Gujarati's have generally remained conservative and religious (Bachu, 1985); both documented and revealed in my empirical data. It can be argued that due to living in large cohesive communities the Gujarati population have been able to maintain religiosity because together they have formed places of worship and practice collectively enhancing their social and cultural capital (Gale et al., 2003). The link between health and

religion has also been well documented, where studies have found that better health is linked to being religious. For example, Hummer et al., (1999) found that church attendance increases life expectancy and Dervic et al. (2004) found that religious affiliation is associated with less suicidal behaviour in depressed in patients. However, literature on religion and how it influences understandings of 'mental health' have been scarce, and thus there will be an exploration below.

Karma

Religion has helped the communities come together, build organisations, places of worship and continue religious practices. One particular belief in Hinduism is karma which in its simplest form is a belief that stands on the premise of 'the past determines the present which combined with the past determines the future' (Sharma, 1973, p.349). Karma was discussed on a few occasions in the interviews and Rashmi discussed it to some length and said:

I think some people still believe in that and also they get consolation from it, the Gita it says whatever happens in your life, It's because of your past Karma's either in this life or in your previous life, the people who do strongly believe in it or who want some sort of a consolation from it from what's happening in their life and into overcome or cope with the situation they will say this is not going to stay with me forever and I might have done some bad bits in the past so I'm suffering the consequences of that so there is some sort of compromise and acceptance of the situation and I think that, that helps to get on with life.

(Female, aged 53, first-generation migrant)

Rashmi also shared how believing in 'Karma' allows for people to get on with their life when they are suffering which will be explored in the third analytical chapter. However, the other aspect of 'Karma' is that its premise could be used to justify illnesses and influence help-seeking. There was consensus that the thought God had destined people to go through certain struggles, pain and

worries is old fashioned and that it is changing post migration whereas Anand et al. (2005) found that this opinion was common amongst South Asian women. Overall, this explanation of illness is viewed negatively because participants suggested that it could mean that people do not get help and their health will continue to deteriorate. For example, older members of the communities such as Miland, who have a number of illnesses, believe that they are coming to the end of their life and thus have a view that it is not beneficial to seek medical assistance and praying is comforting. Although it is viewed as a coping strategy for the individual and it can be helpful, others such as family members and friends may find this attitude difficult to deal with.

A separate area relating to religion that in many ways is highly respected but misunderstood is the notion of the possession of God which in Gujarati is called having 'Mataji'. The possession of Goddess Durga in individuals is perceived as a blessing which was mirrored by participants. Additionally, Bhugra and Bhal (1999) argue that 'cultures encompass a variety of different beliefs about 'mental health' and its origins, ranging from supernatural models, to religious models and naturalistic explanations' (p.36). Pratik explores the notion of Mataji in considerable depth. Pratik is a retired GP and migrated to Leicester in 1974 and has lived there ever since. Pratik was born in Kenya, but travelled to India to do his medical degree and migrated from India to Leicester. Since moving to Leicester, Pratik has always had a significant role in the community organisations and feels proud to be part of helpful and close-knit communities. Pratik explored this notion of 'Mataji' and said:

I think there is obviously the Mataji issue when there is a religious function someone will say that she is getting Mataji, so she starts standing up and dancing and this and that yeah and then people who have a problem will go and bow and oh 'you have to give one sari to someone', yeah you have to do this, you have to do that and then they touch/hit their head, do all of this. So that's how they do it and fortunately if the lady feels better after doing whatever she will then think that this was my problem and it's not a mental illness

[...] so the person is who is going through a rough time any help is help and if that person then feels better, because that was a good day or that was a good week then the person feels that this person has helped me.

(Male, first-generation migrant)

Pratik explains how, people view individuals who get 'mataji' very highly because when they are possessed by God, they are seen as religious icons themselves. However, the issue is that they can tell the person to do things which is viewed as a message from God and once that person has done it they may have a few good days and assume that their mental illness is cured. But this may only be temporary and the issue will not be resolved. There is an ambiguity around 'mataji' as many participants suggested that they do believe in it and view it as important because of its 'religious upholding' but they are apprehensive about it because they do not fully understand it.

Supernatural causes

Bhugra and Bhal (1999) argue, another explanation that can be given to 'mental health' is supernatural ones. A thread that came out in relation to this was a belief that a mental illness is someone putting a spell on you and some believed that it could be due to being cursed and in Gujarati this is named as 'najar'. Talking about his experiences and involvement with the Gujarati community, Pratik discusses 'najar'.

Pratik suggested:

Before even the professional gets involved because we feel that 'someone has done something' so you go and see some mata ji's (priest) and this and that. All that occur in I think in all cultures that they believe that someone has done a spell on them and then they will go here there and everywhere [...] they believe that a spell has been done, someone has put something in the food.

(Male, first-generation migrant)

Pratik's response suggests notions of 'supernatural' causes or someone casting a negative spell on someone and as Furnham et al. (2000) argue this places the cause to be supernatural and thus western services are not approached. Having this view can mean that mental illnesses are not viewed as an illness but symptoms that are as a result of supernatural causes (Furnham et al, 2000). This was also found by Livingston et al. (2003). However, Pratik goes on to say that although religious leaders are approached and people believe that it is a spell it does not mean that the Gujarati communities will not seek help, they eventually do tend to seek medical help. 'Indian health beliefs have been described as holistic, incorporating physical, psychological and social factors and the supernatural' (Dalal, 2000 cited by Jobanputra, et al., 2005, p.352) which include spiritual healing, discussions with religious leaders and ayurvedic treatment. Overall attitudes towards mental illnesses affect not only perceptions of mental illnesses but it plays a significant role in help-seeking which in this case with the Gujarati communities suggests it would be more pluralistic in nature rather than monopolised (further explored in the third analytical chapter).

However, some participants stated that spiritual explanations in terms of 'najar' or someone putting a spell on someone is viewed negatively. For instance, Neha said:

Because they think that have been cursed, they think it's a bad thing if I told somebody, I know for a fact that this woman had a disabled child okay and people wouldn't go to that person's house because thinking it's this mentality that Asians have, that you'd catch it's just mentality. It's happening in my own family I know, my cousin was disabled and people wouldn't go to my aunt's house thinking if you go there, something is going to happen to them. Nothing is going to happen to them, it's just unfortunate that some poor child has a mental illness.

(Female, first-generation migrant)

Neha, explains that many people in the Gujarati communities view mental illnesses or explain illnesses in terms of someone cursing another individual and this attitude has many negative consequences related to it and as a result is stigmatised. Overall, in explaining mental illnesses that relates to supernatural causes is somewhat declining in the communities but those who do believe it also face negative responses and attitude towards it.

These understandings and meanings of 'mental health' are inherently culturally located. 'culture serves as the web that structures human thought, emotion and interaction' (Guarnaccia and Rodriguez, 1996, p.437). These understandings are intrinsically linked to the communities' interactions with one another and due to their cultural capital, they can be enforced or remain strong in Leicester due to the strong forms of social capital the communities have. Here, these understandings are developed and shaped from embodied cultural capital. As Bourdieu (1986) argues embodied cultural capital is in the form of long-lasting dispositions of the mind and the body. For example, the Gujarati communities have been raised as Hindu's, time has been invested in their faith from birth and the cultural norms they are taught from this become embodied. Similarly, through interactions in the communities, if 'mental health' has been associated with 'mad, crazy and slow'; through investing time with the communities over a long period of time, these opinions and understandings become an integral part of a person and thus makes up their habitus and cannot be 'transmitted instantaneously' (Bourdieu, 1986, p.85). Therefore, social and cultural capital can contribute to how these understandings have been shaped in the communities. The next section will discuss the causes of 'mental health' problems that the communities suggested.

Causes of 'mental health' problems

Understandings of 'mental health' problems were related to issues surrounding loneliness, worry, stress and personal problems. Similar ideas were identified by Li and Browne (2000) who studied 60 adult Asian Canadians and defined a 'mental health' problem in terms of lacking purpose in life, feeling lonely, and

difficulties understanding and dealing with a new environment. Loneliness was a recurring factor and seemed most prominent amongst the participants. Likewise, Dogra et al. (2005) found loneliness as a described characteristic of people who are mentally ill. Equally Urmila suggested:

'mental health', 'mental health' uhh some people kind of depression because they are living alone all the time inside the house especially there is no sunshine you know and all the time it is darkness and some personal problems they don't success so they got disappointment and that kind of things.

(Female, aged 52, first-generation migrant)

A linked factor to the causes of 'mental health' problems and loneliness was that people were not experiencing the social aspect to their lives that they would have got in India or East Africa because the environment was somewhat different. For example, Mahendra said:

The biggest main problem is that after coming here, the love you should get from meeting people and socialising with them you don't get that here. People don't have a lot of time and particularly our elderly people don't want anything they don't want money but they want people to spend time with them for a little time but that's not what it's like here.

(Male, aged 60, first-generation migrant)

This illustrates the change in culture from how society previously was in East Africa and India. In both these countries doors would be kept open and the community culture was far more open than it currently is in the UK. It has been illustrated in the previous chapter and through literature that the Gujarati communities experience strong forms of social capital due to being large and close-knit. Although, the Gujarati communities in Leicester are large in numerical value and this would suggest strong forms of social capital, Mahendra argues that people do not socialise as much due to restricted time and thus loneliness is still a problem. As discussed

in the literature review, academic interest in social capital focuses on the relationship between the qualities of people's social networks and the benefits gained from these networks (Halpern, 2005). It is interesting to note that although the communities face strong forms of social capital, in the sense that the networks are large in Leicester, the quality of those relationships could be weak and may contribute to 'mental health' problems for two reasons. Firstly, the quality of links is weak and thus loneliness is still a problem which could cause 'mental health' issues. Secondly, the links may be weak on the ground level but due to strong forms of capital, these community relationships and expectations are highly valued and respected in people's minds, attitudes and daily practices. As a result, people may feel there is a 'social obligation' to act in certain ways which contribute to added pressure because not meeting these expectations could be stressful. Therefore, as Durkheim (1951) found in his study on suicide that close communities result to strong forms of social capital and thus lower levels of suicide, it could be the opposite for Gujarati communities. The quality of networks may not be strong and thus as Mahendra argues, people do not socialise as much and experience loneliness, whilst simultaneously having 'social obligations' which increases pressure and consequently could cause 'mental health' issues. This illustrates the complex relationship between social capital, cultural capital and behaviour.

The only other cause of 'mental health' problems that was suggested was people's diet. Jagdish said:

Maybe because of the diet as well you know it maybe that diet as well because they don't get enough exercise. I mean some of the people are getting older so they don't get to go out a lot and they sit alone at home so yeah lack of exercise I would say.

(Male, aged 67, first-generation migrant)

Although Jagdish suggests a cause for 'mental health' problems could be diet, he goes on to say that people are getting older and this is resulting to not going out and being lonely. Therefore, a prime reason for the cause of 'mental health' problems initially given was loneliness. This is surprising considering, the Gujarati communities in Leicester is large and experience good levels of social capital. Additionally, participants went on to advocate that the communities faced low levels of mental illness, but in later discussions revealed contradicting patterns and notions of worry and stress due to cultural changes which will be discussed in depth in the next analysis chapter. Urmila went on to say:

But I think especially Gujarati people has less problem less 'mental health' problem you know . . . and also family support this is very good and main is family support and also include every day's fresh homemade food is makes a difference so it is very good. Food and family support and they are carrying each other is very very excellent thing and it also effects good effects in the health and 'mental health'.

(Female, aged 52, first-generation migrant)

For example, Urmila suggests that 'mental health' is good in the Gujarati communities due to good family support but during her interview also put forward that family problems such as divorce are on the increase in the Gujarati communities which has been stated by Das (2011). Furthermore, Pratik acknowledged it was good but there are other problems such as acceptance and taking medication. During the interviews, other issues were revealed such as causes of tensions between generations, uneasiness and sadness. These will be discussed in the next chapter where people perceived them to be increasing problems, creating unhappiness and a certain degree of 'mental health' issues.

Attitudes towards 'mental health'

Attitudes towards 'mental health' has been an interesting aspect to explore and resulted to contradictory responses. Overall, personal attitudes depicted participants feeling sympathetic, offering help and being supportive of others'

needs. Conversely, this was largely not applicable to the wider communities whom participants believed to be unsympathetic, negative and blaming individuals for the position they find themselves in. There was a clear difference illustrated in the interviews of participants suggesting a difference in attitudes towards someone experiencing a 'mental health' problem. For instance, Ramesh highlighted this well by saying:

Personally, I feel sorry for them, sympathy, I got sympathy for them but many many people think the reason for the person reaching this stage, their bad health is because of themselves. For example, they shouldn't have put all these pressures on their children, or been money minded or on them and if they hadn't then these problems would not have been created and many people think this.

(Male, aged 66, first-generation migrant)

This negative attitude has suggested there is stigma associated to 'mental health' and could potentially be a reason why members of the communities would choose to keep it hidden. Previous studies have discussed the issue of stigma being attached to mental illnesses (Corrigan et al., 2001; Gilbert et al., 2004; Lauber et al., 2007) As Sussman (1997) highlighted, all societies have struggled with the impact of mental illness, and rejection of mentally ill people are common. Furthermore, Wolff et al. (1996) suggests that it is likely that Gujarati young people and their parents reflect wider community attitudes to mental illness that are, in general, negative (Wolff et al., 1996). These generally negative attitudes will be explored further below.

Negative stigmatized attitudes labelled to mental illnesses could be because of a limited awareness of what mental illness means (explored earlier). For example, the quotations below demonstrate that initial responses from the communities tend to be words such as 'mad' and 'crazy', which were used in a western setting before medicalization occurred. Arguably in theory, psychiatry may present to us a medical model of mental illness which transformed the

cultural view of madness into a coherent scientific entity (Skull, 1979); but participants suggest that cultural views are still very much real in lay communities and can have a significant impact on the ways in which mental illnesses are experienced and managed. The following quotations are some examples of this from the Gujarati communities:

Kunal said:

If I say I have got some issues and a 'mental health' problem in our wider community people will say 'ah ghando varu che' (he is silly/mad) people will think like this number one.

(Male, aged, 49, first-generation migrant)

Pratik stated:

I think if you tell someone you have got cancer you know they accept it and as soon as you say the word mental illness you know it's like are they telling me that I am crazy? And you know I think they go right at the end of the spectrum to say you know I have lost my marbles and I think that is and say for example a couple comes who are having issues and you find that one person, it's not me it's the other guy who needs treatment and never me and I think those are the issues and I think because for many years mental illness has already been kind of given a label that this guy is crazy.

(Male, aged 49, first-generation migrant)

Kunal explores, how the 'number one' response to mental illness is silly or mad. These negative attitudes towards 'mental health' have been shaped by the communities' embodied cultural capital. Over time, these views have surrounded the communities and as a result become part of their cultural capital. But strong forms of social capital and social cohesion in Leicester has allowed for these opinions to remain strong. Bourdieu (1985) defined social capital as 'the aggregate of the actual or potential resources which are linked to possession of durable network of more or less institutionalised relationships

of mutual; acquaintance or recognition' (Bourdieu, 1985, p.248). Thus, in this case the resource that is being gained through close-knit networks is strengthening cultural capital, and thus continuity in opinions towards mental illness that are surrounded by words such as madness, crazy, silly and slow continue to remain in the communities.

Pratik takes this a step further and suggests that cancer is more likely to be accepted as an illness but people tend to associate mental illness with words such as 'crazy'. Due to these words being associated with mental illness, people are likely to disassociate themselves from it, such as Pratik put forward that people will tend to respond with '*it's not me*'. This denial or reluctant to accept a 'mental health' problem is further explored below. Accordingly, if attitudes overall are negative towards mental illness, it would suggest that this view is not openly discussed in a community setting. This positive relationship between negative attitudes towards mental illness and unlikely to discuss 'mental health' or illness in a community environment has been voiced by the participants in this study. These opinions will be discussed below.

Not openly discussed

This area was contradictory in the first few interviews and was a subject that changed. Initially I interviewed community organisation leaders who suggested that 'mental health' is openly discussed. However, this could have been due to their roles of organisation leaders and strong forms of social capital. According to Bourdieu's (1986) concept of 'social obligation' community leaders may feel that they have a role to perform that entails presenting their communities and organisations in a positive way. However, many interviews proceeding from the first few put forward notions of negativity as a reason for not disclosing information regarding 'mental health' to the communities.

For example, Ramesh argued:

Yes, there is fear in the community about the way in which people are viewed, their impression to the community. People may lose their prestige so there is that fear.

(Male, aged 66, first-generation migrant)

Neha said:

They might not open up and say anything about it. it's a taboo subject, anything with mental illness is such a tight thing that you don't tell anybody, you keep it to yourself even in this day and age, I think the generation for me don't understand it's a thing that you don't tell, they keep it amongst themselves, I know a lot of people even in our community who suffer from depression and they have kids who have mental disabilities but you don't see them out into the community because they think oh my gosh what is somebody going to say, you know they won't sit next to you because you have got a kid with mental disabilities, it does happen which I think is awful.

(Female, first-generation migrant)

Both Ramesh and Neha, put forward that mental illnesses are viewed negatively and stigmatised and this is a reason why people do not openly discuss 'mental health' problems. Ramesh suggested there is fear of how people may be viewed and Neha said that 'mental health' is indeed a taboo subject. The distinctive attitude that was presented was '*what will people in the community think?*' and Ramesh, also suggested that '*people may lose their prestige so there is that fear*'. 'Izzat' is prominent in Indian culture and Gilbert et al. (2004) found that the respondents in their study described 'izzat' as 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 et al., 2004, p.109). Furthermore, as Indian culture tends to be collectivist, there is a belief that individual behaviour reflects on families and the communities and thus people may be less likely to seek help to protect the 'izzat' of family members;

more so if the communities are expressing a negative attitude towards mental illnesses. If values, such as maintaining one's families' honour by keeping mental illness hidden in Gujarati culture is part of one's embodied cultural capital; then these attitudes are indeed subconscious and are practiced because they form individuals' habitus. Therefore, understandings and attitudes of 'mental health' has a complex but critical relationship with both social and cultural capital where they are indeed interdependent and interrelated.

Alongside the negative attitudes towards mental illnesses; other reasons for not openly discussing the 'mental health' was due to people gossiping and stories travelling fast amongst the communities which would hinder reputation. These social attitudes among the communities can potentially act as a barrier to seek help and could potentially be a contributory explanation to the low reported rates of mental illnesses among the Gujarati communities. Similarly Dogra et al. (2005) found that more than half their interviewees preferred to keep 'mental health' problems to themselves, because they feared being labelled and stigmatised. For example, Ramila said:

In our community that's another issue that if I tell you something and if it's not confidential you will go and tell that third person and then that third person will go and tell the fourth person and then it goes around and that's another issue why people don't why people keep it to themselves, they don't talk because they know that if I tell somebody they'll go and tell somebody else and somebody else somebody else and it will go around to ten people with different stories not the same story so that's a big issue really in our community.

(Female, aged 58, first-generation migrant)

Due to the strong forms of social capital and cultural attitude that are largely negative in this context, there is a conflict between the two. Although in literature social capital is spoken about in terms of having a positive

relationship with 'mental health' as there is a close support network, in this case it is somewhat different due the relationship between social and cultural capital. In terms of the communities' cultural capital, 'mental health' problems are stigmatised, viewed negatively in terms of madness, crazy etc. Due to these attitudes, the communities may not tell others, but indeed the strong forms of social capital add another layer of complexity where a 'double stigma' or 'double burden' may be occurring. Due to strong forms of social capital, gossip within the Gujarati communities is a factor and thus a deterrent to discuss 'mental health' problems with community members. Therefore, not only is mental illness a stigmatised topic, gossip is part of Gujarati culture and thus people may not openly discuss these issues with individuals from the wider communities because they will be given a negative label or seen as not fulfilling their 'social obligation' to be inclusive in the Gujarati communities.

Denial/Acceptance of 'mental health'

Similarly, another attitude towards 'mental health' is denial of 'mental health' problems. This is heavily reliant upon the overly negative attitudes towards mental illness and thus individuals respond in way in which they disassociate themselves to the negative attitudes and stigma associated to 'mental health'. Respondents suggested that people in the communities tend to be reluctant to accept that they have a 'mental health' issue. Other studies have also found denial to be a strong element of coping and responding to mental illnesses among Asian communities (Thara et al., 1998; Kumar et al., 2010). For instance, Kunal said:

Number two is that ok what is this; it's not a 'mental health' issue just a bit of pain so they are not perceiving it as a 'mental health' issue, even at depression as well . . . Now again in that particular things some of the people they may not perceive even if they are in depression is they may not be recognising or I am in depression number one and even if they recognise I am in depression they are not admitting, that it is very difficult in Gujarati it is a characteristic.

(Male, aged 49, first-generation migrant)

Similarly, participant Pratik put forward:

Pharmacist gives them the correct saying and says you are taking an antidepressant suddenly you know you might find a few of them will stop taking and will also come challenging to the practice you gave me an antidepressant I am not depressed. And I think those sorts of issues still happen now, that they will deny that they are depressed or they are having an anxiety.

(Male, aged 49, first-generation migrant)

Additionally, Cohen et al. (2002) suggest that the public have mistaken beliefs that mental illnesses are not real and disabling conditions and hence it discourages people from seeking help. This could be a possibility with the Gujarati communities as knowledge surrounding mental illnesses has been shown to be limited. In fact, Furnham et al. (2011) reported that most literature has found that 'mental health' literacy among the general public is poor. If this holds true with the Gujarati communities, it can have a real impact on how 'mental health' is perceived and managed.

Alka said:

If we are refusing to say them they are not mentally ill and you keep pressing then it will be because they are not having the right medication, not having the right kind of support there and it will be go to mental and then they will say that this person is mental. you know like dementia, or alzheimer's that kind of things in Asian communities they don't want to give that label, they don't want that label, either they want the big label either no label at all that's my opinion.

(Female, aged 43, first-generation migrant)

Alka also introduces the dimension that some labels are more likely to be accepted than others. This also links to the medical model of illness, and not all attitudes or understandings are cultural. For example, Alka suggested that

dementia and alzheimer's are more likely to be accepted and thus they are accepted as illnesses. However, other more common mental disorders such as depression or anxiety is a label that people do not want. This could be because illnesses such as dementia and alzheimer's have some symptoms that are physical or occur more among the older population. On the other hand, depression on many occasions cannot be physically seen or are not understood or labelled as an illness. Additionally, in terms of Bourdieu's concepts of 'forms of capital' acceptance or denial of 'mental health' is inherently engrained in the communities' cultural practices of what is accepted and what is not. These opinions and attitudes can be formulated due to shaping one's habitus, through long forms of dispositions and interaction with other community members that creates social constructs and has given meaning to which illnesses are accepted and others that are not.

Othering and Personal issue

A distinctive attitude towards mental illness was the notion of 'othering'. Participants expressed that individuals who experienced mental illnesses were inherently 'othered' in the communities due to the negative attitude towards mental illness. As mentioned earlier Sussman (1997) argued that all societies struggle with the impact of mental illness and the rejection of mentally ill people is common. The Gujarati communities, also reflect these attitudes and it could be a reason why people are reluctant to discuss mental illness or their 'mental health' widely with community members. For instance, Vijendra suggested:

In 'mental health', If you are speaking to someone and if they are suffering, they won't understand what you are trying to say, or what you are asking, they are like lost people, they may have depression.

(Male, aged 85, first-generation migrant)

Here, Vijendra suggests people who suffer from depression are 'othered' because they are incapable of understanding things in conversations and thus 'othered' in a way in which makes them different from people who do not have

a mental illness. Ramila also put this forward and suggested people who experience mental illnesses are viewed as not 'normal'.

That person is very fragile and you got to really understand them, you got to make sure that you do look after them and they could be violent because some of the autistic children are they could be violent is they do not understand things. So, I think a person at the other end should understand what they are going through rather than us just thinking they are normal people but they are not.

(Female, aged 58, first-generation migrant)

These kinds of attitudes have resulted to people viewing 'mental health' problems or emotional distress as a personal issue that should be tackled individually and not discussed with others. For instance, Kunal said '*most of the people will try on their own without revealing or describing the thing's*'. Kunal suggests that an attitude towards 'mental health' may be that experiences of emotional distress are individual issues that should be tackled privately. This could be because the external factors that have been discussed throughout this chapter, including stigma and izzat. However, this does not mean that it is problematic as such, if it is dealt with and managed. However, it may mean that having this attitude towards 'mental health' is engrained culturally and thus 'mental health' problems may be kept under the radar. Thus, there is an intrinsic relationship and dependency on understandings, attitudes and management of 'mental health' problems.

Summary of chapter

This chapter has discussed and answered: 'In what ways does the communities understand and conceptualise 'mental health''? Using social and cultural capital this chapter has explored the ways in which the Gujarati communities come to understand and construct meanings of 'mental health'. This covered limited understanding, depression, language, religion and causes of 'mental health' problems. Overall, it was demonstrated that these understandings are intrinsically linked to the social and cultural capital that the Gujarati

communities have. This also plays a crucial role in attitudes towards 'mental health' and these were explored in relation to not being openly discussed, denial and acceptance, personal issue and othering.

The next chapter will address the second research question by focusing on exploring what are the perceived experiences of 'mental health' problems within the Gujarati communities? The focus will be on drawing on an acculturation-gap with the first and second-generation Gujarati migrants. More specifically, the focus will be on the ways in which first-generation migrants are responding, managing and coping with these changes. This will be done by exploring various values and beliefs of Gujarati culture that participants revealed.

Chapter Six: Parents Vs Children: The role of cultural intergenerational discrepancies

Introduction

The previous chapter introduced the Gujarati communities' understandings and attitudes towards 'mental health'. Using a Bourdieusian framework, the chapter highlighted how the various understandings are inherently expressed and articulated through participants' cultural and social capital. It not only illustrated that these relationships are complex and multifaceted but also as a result numerous understandings are existent in the Gujarati communities. I would like to begin this chapter with a snippet of Ramesh's feelings when discussing 'mental health' problems which mirrored the feelings across the majority of the first-generation Gujarati participants. Ramesh is traditional and would describe himself as a 'community man'. Due to him being a trustee in one of the organisations, he is very well-known in the wider communities. When asked his opinion on if the community faced bad 'mental health', he assertively said:

The reasons for creating 'mental health' problems are because of family tension, health problems and because of family problems. Our mentality, the older generation thinks like that when our children are born they have to speak our language, obey our customs and religious ceremonies. Some people are pressured, like children may do in our culture. They insist marriage should be within our community and religion. Nowadays community marriages day by day are occurring less and parents worry about this problem and children's age limit. Our belief is that boy or son he has to marry within a certain age limit but nowadays younger generation do not want to marry and don't take a decision yes or no and that tension is on parent's mind. That sort of worries parents and makes people

depressed. In many cases it is going to a high level and needs attention by practitioners or hospitals.

(Male, aged 66, first-generation migrant)

Ramesh outlines that 'mental health' problems are created because of family problems. He specifically focuses on several cultural changes that are occurring with the first-generation migrants and their children. There are a few significant areas that Ramesh discusses here. Firstly, by suggesting '*they have to speak our language [...]*' he demonstrates that to some degree the older generation may be putting '*pressure*' on their children to behave in ways that reaffirms their cultural background. For instance, Knight et al. (1993) argue that migrant parents transmit ethnic identity to their children by the process of enculturation. This is when parents indirectly reinforce ethnic behaviours by directly teaching their children traditions, values and behaviours from their cultural background (Knight et al., 1993). In this case, Ramesh suggests a few of these among the Gujarati communities are language, customs and religious ceremonies. Secondly, he also outlines that there is some disagreement between first and second-generation Gujarati migrants by suggested that '*community marriages day by day are occurring less*'. A second-generation migrant Payal agreed with the change and said:

Years and years ago when people used to get married and it was arranged marriages it was all within the same samaj but nowadays it is all mixed.

(Female, aged 27, second-generation migrant)

By community marriages, Ramesh is referring to marrying within one's caste or within the community that person belongs to. Endogamy was traditionally prevalent in the Indian communities where marriages were only permitted within the limits of local communities and among the same ethnic group, religion and caste. Kalmijn (2008) argues:

What makes intermarriage sociologically relevant lies in its inherent dynamic: It is not just a reflection of the boundaries that currently

separate groups in society; it also bears the potential of cultural and socioeconomic change (p.395).

It is this cultural and socioeconomic change that this chapter will discuss. These changes in cultural norms suggests that the parents of second-generation Gujarati migrants may be using forms of enculturation, but their children are opting to behave in different ways, ways that is perhaps more aligned to the UK culture that they reside in. This difference can be named as the parent-child acculturation-gap. This is when levels of acculturation differ between parents and their children. Namely, migrant parents decide to hold on to their cultural background and their children assimilate to the indigenous culture where they reside. Thirdly, Ramesh puts forward that these changes *'worries parents and makes people depressed, in many cases it is going to a high level and needs attention by practitioners or hospitals'*. This is an example of the acculturation-gap distress hypothesis put forward by Lau et al. (2005). The hypothesis explicates that the difference in acculturation levels may be associated with a clash in values and preferences that may result in conflict. Lau et al. (2005) suggest that parent/child differences in acculturation can be a risk factor for 'mental health' problems. Deepak (2005) argued a test for families through migration is intergenerational conflict and families cope with certain challenges in various ways. For some it will heighten conflict, whilst others will compromise and these have varying impacts on 'mental health' for all of those involved.

Therefore, drawing on acculturation literature (e.g. Berry, 1990; Deepak, 2005; Lau et al., 2005) this chapter will provide an analysis of the three areas revealed above: the expectations parents have of their children in various cultural facets (e.g. as Ramesh stated knowing how to speak Gujarati), the opinions of second-generation migrants on these elements which will demonstrate an 'acculturation-gap' (second-generation have different perspective) and thirdly, how this could impact their 'mental health'. More specifically, the focus will be on ways in which first-generation migrants are responding, managing and coping with these changes. This will be done by exploring various values and

beliefs of Gujarati culture that participants revealed. Ramesh stated two facets; language and religion and this will be expanded on, to cover other areas that were revealed during interview discussions: importance of organisations, taking care of elders and marriage practices. The next section will provide an overview of acculturation and explore its relevance in generating intergenerational discrepancies which can be a risk factor for 'mental health' problems.

Acculturation

The migration experience creates a set of challenges and difficulties when dealing with threats of, exclusion, isolation, relocation and loss of cultural identity to name a few. Consequently, as argued previously migration is widely perceived as a trigger for 'mental health' problems (Cochrane et al., 1977; Cochrane, 1983; Kuo et al., 1986; Beiser et al., 1993; Nevo et al., 2006). As discussed in chapter 4, the Gujarati communities have used forms of cultural and social capital to maintain cultural identity and social cohesion. As a result, when the communities initially migrated in the 1970s/80s they did not face a loss of cultural identity or isolation. However, as Ramesh explained a cultural transition is occurring, with the younger generation who *'do not want to marry and don't take a decision yes or no'*. Here, Ramesh is highlighting that there a potential threat of losing cultural identity and at the heart of this is differing rates of acculturation.

Broadly, acculturation theory is concerned with the ways in which ethnic minority communities adapt, or react when in contact with another dominant culture (Phinney, 2003). Furthermore, this is measured through exploring changes in beliefs, values and behaviour that is caused through being in contact with a new culture that vastly differs from one's habitus (Berry et al., 1986 cited in Farver et al., 2002). John Berry (1990), one of the leading scholars in acculturation psychology created a model of acculturation which will be utilised in explaining the two modes of acculturation adopted by first and second-generation Gujarati migrants. Significantly, this has been chosen due to the

clarity in his model and the distinctive relation it has to the process participants have undertaken in this research. Berry (1990) advocated that acculturation strategies accessed by ethnic minority groups is examined in terms of two facets: 1) retention of one's cultural traditions and 2) the establishment and maintenance of relationships with the larger society. Throughout this chapter there will be an exploration of how both 1 and 2 interlink through the means of social and cultural capital. Additionally, the first facet refers to cultural capital, in particular embodied cultural capital which is learnt over time and forms part of one's habitus, whilst the second facet refers to the ways in which social capital can influence the maintenance of cultural capital and vice versa. Berry (1990) put forward that when these two factors are considered simultaneously, a conceptual framework can be generated to illustrate four main routes of acculturation strategies: assimilation, integration, separation and marginalisation.

Furthermore, to provide further context these routes will be defined. Firstly, separation is when ethnic minority groups reject mainstream culture and exclusively identify with one's cultural identity (Berry, 1990). To some degree first-generation migrants went through this. As explored in chapter 4, it has been illustrated that first-generation Gujarati migrants utilised social and cultural capital to ensure they were able to continue cultural and religious practices post-migration and this will be explored throughout this chapter. Secondly, assimilation refers to the rejection of the ethnic culture and identifying predominantly with the indigenous culture. Thirdly, marginalisation is rejecting both cultures and lastly integration is when you retain many cultural values of your ethnic culture whilst also adapting to parts of the dominant culture (Berry, 1990). This latter route was expressed by the second-generation Gujarati migrants.

Furthermore, measuring and exploring the process of acculturation is based on the premise of adapting, changing or responding to culture. Culture being the heart of acculturation; Betancourt and Lopez (1993) argue that previous studies

fail to define culture when their conclusions are based on cultural differences. To make clear, when discussing 'culture' in this context I am referring to the values, beliefs, expectations, norms and cultural practices that my participants have outlined as important. Hall (1997) puts forward that:

Culture... is involved in all those practices... which carry meaning and value for us... the ways we classify and conceptualise them, the values we place on them (p.3).

Therefore, the areas of culture that have emerged are language, taking care of elders, education and marriage practices. Domains that could affect socioeconomic status as argued by Nazroo (1998). In the subsequent sections of each of these areas, I will identify the 'meanings' the Gujarati communities associate to them and it is these values that form part of the Gujarati culture. Furthermore, Williams (1981) argues 'culture is the signifying system through which...a social order is communicated, reproduced, experienced and explored' (p.18). Therefore, through the meanings associated to values, expectations and practices that form culture, social order is transmitted. This may be the very reason that culture continues in different environments because of the 'meaning' attached to the values but also cultural practices and cultural production 'are not simply derived from an otherwise constituted social order but are themselves major elements in its constitution' (Williams, 1981, p.19).

To mirror this with the Gujarati communities, first-generation migrants have outlined that having strong forms of social capital has allowed for their cultural capital to continue and for their habitus to remain almost unchanged to pre-migration. Thus, by continuing cultural practices and cultural production, the migrant communities have contributed to its own constituted social order. However, as argued by Fernando (2002) cultures are not static, especially in environments where there are people from different cultures living side by side. Acculturation, can contribute to this change and thus it could have potential negative impacts (Deepak, 2005). Alongside, dealing with these negative impacts, Cochrane (1983) argues that culture itself can influence

mental illness. This next section will set up the current challenge faced by the Gujarati communities which will be explored in detail throughout this chapter.

Setting up the Challenge

The current situation which will be explored in this chapter is termed well by Poonam who states:

The Gujarati community have the challenge, there are three generations and I think there may even be four generations where the Gujarati people who came here, they had their children and their children are becoming grandparents so their now becoming great grandparents and being raised here. So it's such a mix [...] and it affects your wellbeing, your emotions and your culture and if everything is fine then your 'mental health' is good but if there are issues and unresolved conflicts, changes or challenges um then your emotional wellbeing your family wellbeing and sometimes your mental wellbeing is brought into play isn't it.[...] There are definitely different perceptions and then how those perceptions are met by the different groups in the family and culture is discussed or accepted or not, is where conflict has potential you know because the future is so different for the different generations. You know Gujarati that were born here and brought up in education here a lot of them think that this is their home whereas some of the generations such as the first generations that first came here like my parents, this became their home but they still don't necessarily think this is their home, they still have roots in India [...] What is Gujarati culture now, you have to ask because a lot of those Gujarati may speak Gujarati but don't think like Gujarati's so problems can rise'.

(Female, first-generation migrant)

Poonam explains that the prominent challenge with the first-generation communities is that there are a number of generations, and due to different perceptions, it can be difficult dealing with this. This is termed as an 'acculturation-gap' where different generations have chosen different routes of acculturation. The routes that participants have expressed are overall common with young Asian migrants whom opt for integration rather than the other strategies (Ghuman, 1999). Additionally, it is acknowledged that first-generation Asians employed 'separation' as a mode of acculturation when building a home in Britain. This was usually because of differences in languages, religion, family values and general lifestyles (Anwar, 1998; Shaw, 2000; Robinson, 2003). Moreover, Poonam refers to the reasons why this is the case and it is predominantly their '*surroundings*'; for instance, '*Gujarati's that were born here and brought up in education here a lot of them think that this is their home*'. Additionally, Bacon (1999) found that in constructing ethnic identities, second generation Indians appropriate and reinterpret the rhetoric of the first-generation. This chapter will explore the ways, in which second generation Gujarati's have done this, to illustrate intergenerational discrepancies and how this may be a risk factor for 'mental health' problems.

Moreover, a primary focus will be on what Poonam terms '*the challenge*'; the challenge of dealing with different perceptions and how culture is discussed or accepted. She puts forward that this is where '*conflict*' can arise and if that is the situation then as Poonam suggests '*your emotional wellbeing your family wellbeing and sometimes your mental wellbeing is brought into play*'. This is potentially since first-generation migrants are witnessing a change in their culture which can be difficult to deal with. Furthermore, it was demonstrated in chapter four that the first-generation Gujarati communities put a lot of emphasis on maintaining cultural traditions, values and beliefs. The nature of migrating in large kinship groups allowed them to use forms of social capital to continue their cultural practices (Bachu, 1985). As previously argued, this process has allowed for their habitus to remain unconscious, which is when their cultural practices are so engrained that they no longer think about them

and their habitus which is made up of different forms of capital (cultural, social and economic) (Bourdieu, 1984) remains untouched. For example, Jagdish who is retired and lives with his wife said:

I don't know how to explain but in our Gujarati, we try and be very close to each other and see each other all the time and that's not changed here, we are family people.

(Male, aged 67, first-generation migrant)

Although one of the consequences of migration is moving away from social networks, Jagdish explains that the nature of his migration traits has allowed for familiarity with the Gujarati communities to remain in the UK. Despite migrating, being '*Family people*' is part of Gujarati culture and has continued in the western setting.

Consequently, migration may not be viewed as a period of crisis for the first-generation Gujarati migrants. But, using Bourdieu's (1986) work, intergenerational discrepancies that come as a result of an acculturation-gap can be viewed as a period where their habitus is undergoing a period of crisis. It is at a period of crisis because through this process, their children view cultural beliefs, values and practices differently. Thus, as Bourdieu (1986) argues when the habitus undergoes a period of crisis, it moves from an unconscious state to a conscious state, and this can be shown in Poonam's account. She begins to question '*what is Gujarati culture now, you have to ask because a lot of those Gujarati may speak Gujarati but don't like Gujarati's so problems can rise*'. By questioning '*Gujarati culture*' which forms part of your cultural capital that contributes to your habitus; it becomes conscious. By doing so, it can be difficult to deal with because ones' '*normality*' is being questioned. Thus, the ways in which first-generation Gujarati migrants respond to these challenges will be considered.

Therefore, this chapter will explore the intergenerational discrepancies faced by the Gujarati communities by focusing on the acculturation-gap.

However, it is crucial to note that as described in chapter five where there was a reluctance to discuss 'mental health' problems due to the collectivist culture among the Gujarati communities, the same happened with cultural change. Initially participants suggested that the cultural change was due to first-generation participants reflecting on what life was like pre-migration and how this has changed in the UK. For example, Sarla said:

People are still trying to be a Gujarati but the environment is not supporting them and the family situation is not supporting them so somewhere in the back of their head they are thinking my god this is how it used to be but it now has changed and they just think about the olden days, or the past and future and think what's going to happen, what's happening and not looking at the present situation and fit in with the environment.

(Female, first-generation migrant)

As Sarla suggests the environment is not allowing people to carry on Gujarati culture and the conversation continued to discuss 'British environment'. However, discussions have suggested that first-generation have been able to maintain Gujarati culture but it has been shown that it is changing due to second and third-generation. Similarly, the collectivist Gujarati culture also reflects the ways in which the communities have responded to the change which will be discussed in the latter part of this chapter. Thus, this chapter will focus on cultural change by exploring aspects of culture that were raised as important by the communities: organisations, religious practices, language, taking care of elders and marriage practices. Attention will be given to how the attitudes towards these practices have changed over time among the two generations. It will then go on to examine the role of these, by looking at the ways in which first-generation migrants deal with it and how it could be a risk for potential 'mental health' problems.

Samaj's/Organisations

It seems most applicable to begin analysis here as organisations are the foundation of allowing Gujarati communities to maintain their culture by bringing the communities together. These organisations have set up mandirs (see glossary), organise religious events, and gatherings. As discussed in chapter four, first-generation migrants are very proud of this system and it is an essential contributing factor towards their culture continuing. By having a committee that are responsible for maintaining events and organisations it has given the communities a platform to continue religious and traditional practices. Many studies that have explored Asians in Britain (e.g. Anwar, 1998; Shaw, 2000; Robinson, 2003) found that the first-generation migrants adopt a 'separation' route of acculturation. The studies found that the prominent reason for this was different languages, religion, family values and lifestyle. The setup of samaj's has aided the process of 'separation' acculturative strategies. Separation acculturative techniques can be detrimental for 'mental health' because it can cause social isolation, cultural conflict, poor social integration and identity crises (Kuo et al., 1986). However, organisations and samaj's reduce these negative impacts. Social capital indeed reduces social isolation and poor social integration whilst also enabling Gujarati communities to take part in cultural and religious practices enhances their cultural identity. Therefore, as Raleigh (1995) argues community support systems are significantly important in reducing the risk of mental illness.

However, first-generation Gujarati migrants have suggested that they have a fear that this will no longer continue because younger generations are not interested in the organisations. For instance, Mahesh who is involved in a community organisation said:

It is a big problem we definitely have at the moment. The younger generation have got no time. I have been trying to get younger people, get involved into it we can train them they can watch us how, what we do, how we do it and get some experience from there

and then take it over from us. we have worked very hard, we had no money to begin with, we raise some funds extremely great difficulty we bought a small asset, a small property of a terrace house to make it a community hall. But the thing is now we are afraid that the younger generations will come and just blow it off. It does happen, who doesn't like money for free, we put our own pocket money in that hall and although we want to get out we are retired and get out but nobody wants to take over [...] so what, our culture will disappear then.

(Male, aged 67, first-generation migrant)

Mahesh expresses concerns with the longevity of the organisations and what the future will bring. He worked passionately with members from the communities to set up these organisations and outlines the struggles they initially faced. Mahesh draws on finance being an issue and they are afraid that the younger generation will take the money that they have invested. Additionally, Dogra et al. (2005) conducted a study on the Gujarati communities in the UK and found, alongside cultural and family factors contributing to stress and 'mental health' problems among first-generation migrants, economic factors were prominent too. Mahesh also says that '*I have been trying to get younger people, get involved into it*'. It is well documented, that first-generation migrants tend to revolve their parenting around culture and identity (Leonard, 1997; Pettys and Balgopal, 1998; Srinivasan, 2001; Deepak, 2005). Although, this is not parenting as such, Mahesh is emphasising teaching the younger generation because it is central to their cultural identity and he goes on to suggest that without these organisations 'Gujarati culture' will disappear. Not only are there worries about having younger generations involved in the management of these organisations but participants expressed that they felt their children also had a lack of interest in terms of involvement and they have got no time. For instance, Rita said:

I think at this stage now with the boys growing up, they have changed their ideas and they don't participate as much as I would

want them to so they are sort of segregating now and going their own ways. I'm happy that they are settling down in their own lives but I would have wanted them to be more volunteers and spend more time with the community so that they would know what's going on in the community and be helpful there as well in the centres as well.

(Female, aged 63, first-generation migrant)

Rita suggests that her sons have changed ideas about these organisations and do not get involved. The key word Rita used is 'segregation' which was mirrored in many discussions and first-generation migrants put forward that by not having these organisations prosper; it will result in the communities segregating. In terms of acculturation, by the second-generation not opting for a separation strategy, it is viewed among the first-generation Gujarati migrants that they will 'segregate' (separate) from the Gujarati communities. This does not sit well with them because it is at the heart of their success and by having the support from the communities, they have been able to set up comfortable lives in Leicester.

Rita's attitude was largely mirrored by the second-generation migrants and all participants put forward that they are not directly involved in these organisations and are unlikely to go to events organised by samaj's. There were various reasons put forward for this. Firstly, it was thought that these events were social events where first-generation migrants met their friends and their ties lied with other Gujarati's in the communities. Furthermore, Levitt (2002) put forward that due to shared experiences of migration; their sense of community is based on norms and values they have in common and thus their social ties have been formed within the communities. Consequently, for first-generation Gujarati migrants who have experienced migration which can hinder cultural identity, community gatherings can perform as a means to reinforce cultural practices which would allow their habitus (Bourdieu, 1986) to remain unconscious and thus their 'normality' to continue in a new environment. However, for second-generation migrants who have not

experienced migration, or been exposed to a new environment do not value these organisations in the same way. Their friends and networks lie in the remit of work, education and locality and thus tend to socialise in other settings. Understandably, these organisations do not continue to play the same role they did for their parents. Secondly, change in lifestyles results in individuals being busy and second-generation migrant suggested they have no time for these events. Thirdly, it is generally associated with the older population and as Payal suggested in her interview it is not the 'cool' thing to do. Lastly, second-generation Gujarati migrants do not seem interested in these organisations and increasingly it seems as if there is not a need for them or it does not hold the same meaning as they do for the first-generation migrants. Below are some examples expressed from second-generation migrants:

I'm just not into doing that kind of stuff, if like the whole family is going and then it's like ok I will go, it's going to be something that I'd be interested in and it will be fun but if it's like something like a Diwali show for the whole community, I don't tend to go to those just because I find it quite boring and to be honest you're just sat at a table listening to people on stage, I rather just go out with my friends to be honest or sit at home.

(Female, second-generation migrant)

I think nowadays a lot of children sort of jump on the bandwagon and go out and socialise so I think there is a decrease in the need for children to be sort of getting involved in things like that.

(Anish, aged 20, second-generation migrant)

Yogita explains that she finds some of the events organised by Samaj's boring and she prefers to 'go out with her friends'. Similarly, Anish suggests that there is no need to go to such events as socialisation can happen through other means.

However, this is worrying for first-generation migrants because these organisations are the base for preserving cultural heritage and as Dasgupta (1998) argues first-generation Indians affirm their ethnicity by reinventing Indian culture on foreign soil. However, with second-generation migrants choosing to acculturate through 'integration' strategies, it poses a threat to these organisations and if they are no longer sustainable cultural traditions will start to diminish. Although 'integration' involves retaining many cultural values of your ethnic culture, association with samaj's is one that has not occurred with second generation and the reasons have been explored above. This demonstrates a typical example of the 'acculturation-gap' where there are different opinions with the generations. Additionally, in terms of risk factors, 'mental health' problems may be restricted amongst the first-generation because these organisations provide support (Raleigh, 1995; Todorova et al., 2010)., or can cause distress if an increased level of support causes 'social obligations' to behave in a culturally appropriate manner. Additionally, in this instance the acculturation-gap is causing the first-generation to worry and question the continuity of Gujarati culture like Mahesh did referring to it as a *'big problem'*. As illustrated in chapter five the Gujarati communities associate worry and stress as factors that contribute to 'mental health' problems and thus, this change in involvement with samaj's could be a potential risk factor to causing distress. Berry (1997) names this as 'acculturative stress' which is hardship due to cultural and environmental changes. Additionally, Wilkinson and Marmot (2003) argue that stressful circumstances that make people feel worried can be damaging to health and these psychosocial risks increase the chances of poor 'mental health'. Therefore, acculturative stress can be a risk for 'mental health' problems.

Religious Practices

Religion is another identity marker that helps Indians to preserve their individual self-awareness and group cohesion (Rayaprol, 1997; Sahoo, 2006). The main way the Gujarati communities did this was through creating samaj's that brought the communities together through religion. The two main avenues

are worship at a mandir which were built by samaj's or through religious celebrations organised by these samaj's for the communities which can take place in community halls or the mandirs themselves. As explored in chapter four, for the first-generation religious practices were used as a way to bring the communities together and through this they benefitted from social capital whilst signifying their cultural capital (Bourdieu, 1986). For instance, through events organised by samaj's which would revolve around religion, the communities would come together to celebrate festivals such as Diwali. Coming together, enhances their social capital which is their community networks undergoing social cohesion and their cultural practices continue in a new environment, allowing them to enrich their cultural capital. What is important here is locality, in the space of communities and locations. Due to the Gujarati communities migrating in large groups to Leicester has allowed for religious practices to continue, thus both social and cultural capital are intrinsically linked. Kim Knotts (2005) work on locality and religion is significant. Knott (2005) has done a lot of work exploring the Hindu community in Leeds and argues that locality is key in the way in which religion operates. Knott (1998) argues:

Our interest is in the effective locality – the arena in which interactions commonly take place and institutions recognize one another and engage meaningfully (p.284).

Thus, the locality in terms of the communities themselves and spatial locality of Leicester has allowed for religious practices to continue and this is of intrinsic value. As Williams (1981) puts forward, generally immigrants are more religious post migration because it provides important identity markers that help to perpetuate and preserve individual self-awareness and cohesion as it has been identified occurred with the first-generation Gujarati migrants. As It was explored, in the previous chapter that, religion plays a crucial role in their lives, and they suggest it provides a way of life rather than religion simply providing a means of identity. This has been found previously by Modood (1994) who argued that for the majority of first-generation South Asians, religion is

important to the way they lead their lives. In relation to 'mental health', religious beliefs can result to a loss of worry and as a coping mechanism of negative experiences (James, 1975). Thus, according to James (1975), as the findings in this study illustrate first-generation migrants are religious, they are likely to experience good 'mental health'.

However, in relation to second-generation Gujarati migrants and acculturation, first-generation migrants suggested that religion which once used to be collectivist is becoming more individualistic. Religion is becoming a phenomenon that is individualistic and 'praying' is done as and when individuals feel it suits their lifestyle. For first-generation Gujarati migrants, daily practices have been shaped by religion whereas second-generations are not using religion as a denominator that brings people together through practices and the first-generation share their concerns about this change. They are worried that their culture is disappearing. For instance, when Mahesh said:

Our culture is disappearing and instead of going to the mandir, people go to the nightclubs, more interested in that. Mandir ahh I went there on Diwali and I will go there next Diwali. So, this is what I can say they just aren't interested.

(Male, aged 67, first-generation migrant)

It should be noted that for the first-generation Gujarati migrants, going to the mandir was part of their habitus and in this field (religion), it was the norm to go to the mandir. As Mahesh indicates, a cultural expectation would be for the next generation to continue this and go to the mandir but it is changing, thus 'our culture is disappearing'. Although, this trend was indeed reflected by the majority of the second-generation migrants, it did not mean in their opinion they were not religious. For example, Veena said:

I'm religious, so I believe in that there is a God but I don't sort of practice, I mean like I know the Hanuman Chalisa and the Arti and

whatever but I don't go to the mandir every Monday, I believe sort of but I don't go to the Mandir, I don't go out of my way to do it.

(Female, aged 22, second-generation migrant)

The distinction being made here is the role of religion from the two different generations, illustrating an acculturation-gap. For the first-generation, being religious is associated with going to the temple and partaking in religious practices and this is part of their culture, however second generation view this differently. For Veena, believing in God is being religious, whereas first-generation migrants expressed a different attitude. Religion was more about the lifestyle you led and it shaped the way you thought and behaved daily. Veena also represents the changing notion of religion from collectivist to an individualistic phenomenon (Triandis, 1989). Mishra (2012) found that with Indian youth, traditional values coexist with modern individualistic values. Additionally, this is an example of the second-generation Gujarati migrants appropriating and reinterpreting their own identities (Bacon, 1999). Veena said that she does not go out of her way to go to the mandir and in later conversations expresses that she will use religion when she feels she needs it. However, this does not necessarily mean the change in views towards religion will affect people's 'mental health'. For instance, the 'social' aspect of religion has changed and indeed it has been previously argued that social support can reduce effects of 'mental health' problems (Raleigh, 1995). But, it may be the case that the second-generation migrants gain social support through other means, e.g. networks at work, school, university etc.

However, the acculturation-gap itself may be a risk factor for 'mental health' problems for first-generation Gujarati migrants. The difference in opinion demonstrates that there are intergenerational discrepancies based on both religious beliefs and religious behaviours. Furthermore, Das Gupta (1997) argues that narrow parental interpretations can result to intergenerational conflict which is based around a lack of communication between the two generations (Segal, 1991). In this case, Mahesh indicates that in the field of

Religion, going to the temple is a prominent part of religion, but for Veena, and other second-generation Gujarati migrants believing in religion and God is enough and there is not a need to practice. However, as it will be argued in the latter half of this chapter, conflict is not apparent as such because these differences in opinion are not voiced openly. A prime reason for this is based around the Gujarati culture and for first-generation that means being collectivist. Triandis (1989) and Markus and Kitayama (1991) argue that in collectivist cultures where interdependence is emphasised, to avoid conflict, opinions may be muted. For example, Mahesh went on to say, *'they're not interested but what can you do, it's different here, it's a different society'*. Thus, I will go on to argue that it is not the intergenerational conflict that is posing a threat to 'mental health' problems, but the way the first-generation respond and manage the change. This usually involves silencing their opinions and emotions; they worry and stress about these changes, which they have suggested may cause 'mental health' problems.

On the Contrary, Riya a second-generation Gujarati migrant did feel that the role of religion was different but she felt as if she wanted to know more about Hinduism. She expressed that she had been raised to be a Hindu, but felt she did not know much about Hinduism and decided to an A-level in Hinduism. Riya suggests:

To be honest, I felt like I was a Hindu that didn't know much about Hinduism, so why we do a lot of our practices where did this all come from and I want to be able to be confident about what I am not just so when other people ask me questions in the future, if I had kids they will ask me questions but also for me just to be more aware about it.

(Female, aged 29, second-generation migrant)

Riya is emphasising a change in the role of religion for the two generations. By suggesting *'I felt like I was a Hindu that didn't know much about Hinduism'*, she is illustrating that religion was a marker of identity among the second

generation but practices hold a different meaning. Although, she does partake in the practices, she is unclear on the meaning of these and this was reflected with the second-generation Gujarati's. Thus, Modood et al. (1994) found that for first-generation South Asians religion was important to the way they led their lives and by second-generation, this importance was considerably lower. A lack of religion may lead to common mental disorders in some vulnerable people who are seeking existential meaning for their lives (King et al., 2006). The data, presented, that for first-generation, religion contributed to a way of life as well as beliefs, whereas for second-generation it was based more around ethnic identity and there was a lack of knowledge on practices. However, Riya was different in the sense that she was actively doing something about it and not knowing the meanings was not enough for her; whereas for Veena being a Hindu and not practicing was.

Alongside, religion not holding the same role for second-generation Gujarati migrants in the sense that it is not a platform they seek for social networks, there were other components that contributed to the lack of interest in religion. Riya suggested that she wanted to be able to answer questions about Hinduism and if in the future her children asked, she would be confident enough to provide answers. Riya went on to explore this as a reason why people are losing interest in religion, because cultural values restrict the older generation having answers to questions that the second generation ask. For instance, she said:

From my mum's personal experience, she would say that a request from an elder back then was an order so you wouldn't question why, questioning was disrespectful so you would carry out that order and not ask why. also you are a female so that put's you lower so you don't ask and nowadays people are more equal so there's not this female seen as lower [...],there's more of a friendlier relationship with and less formal relationship with the elder community umm and people want to ask why and I think priorities like I said have changed so when it was their generation they had to provide food,

they had to look after 8 kids they didn't have the time or the luxury to read books or learn things or whatever they just did what they were told and got on with the day to day and struggled whereas we have the luxury [...] so we want to be able to stand on our own two feet and be able to answer some of those questions because we ask those questions um in the workplace or whatever why have you got those bangles on, why have you got this, why have you got that red thing on your head, why do you celebrate Diwali oh I don't know I am a Hindu who doesn't know why I celebrate Diwali and I think that's where these questions get put back to the elders and if they don't know then people lose interest.

(Female, aged 29, second-generation migrant)

She put forward that from her mother's experience she would say *'that a request from an elder back then was an order so you wouldn't question it'*. Questioning elders was previously viewed as disrespectful but for Riya relationships have evolved and have become less formal. Thus, the second-generation do tend to ask questions but because of the lack of answers, many people decide not to get involved in religious or cultural practices because it is not justified. She also suggested there is a difference in lifestyles and priorities. Her mother's and grandmother's generation had to provide food and take care of numerous children. This meant they did not have the time nor the luxury to read books and learn things but got on with life with what they were told to do. It has been documented that despite migration and the existence of different generations, many Indians hold relatively collectivist orientations; and part of this can involve traditional gender roles and obedience to elders (Segal, 1991; Sadowsk et al., 1995; Patel et al., 1996). Whereas today younger generations have the luxury and thus ask questions because the obedience to others may take shape in different forms.

And so, there are three key things here for second-generation migrants. Firstly, religion can hold a different meaning between the two generations as Veena

highlighted. Secondly, many reasons can explain why this is the case but the two main ones that were discussed in interviews was a lack of needing religion in day to day lives and the necessity of having justifications for why certain religious festivals are celebrated or reasons behind believing certain values. Thirdly, this very reason could push for younger generations having an interest in religion. However, Riya was an anomaly who is undertaking an A-level in Hinduism. Furthermore, second-generation respondents expressed that younger people are more likely to turn to religion when they need it rather than it being a way of life. For example, Anish said:

I have always seen people turn to religion when they're in a bad state of mind and I have always found that a bad thing um why go back to bhagvan when you're in need why not go to bhagvan when on an everyday basis when you know that everything is alright and you're thanking him for what you have got now um yeah.

(Anish, aged 20, second-generation migrant)

This shows that needs of religion play a different role for first and second-generation Gujarati migrants. Additionally, meanings and questioning of religion also led to another interesting component. Nisha explores further and said:

Why don't you wash your hair on a Wednesday again I don't get it - you see and I think also another thing is that half of us umm we kind of we can split what's cultural and what's religious which are completely two different things, whereas the older generation they kind of amalgamate it to one thing oh its religious you have got to do it. no, it's not religious its cultural, it's something that someone in a village in the middle of India somewhere made it up and its spread like wildfire. so, religious, would I carry it on, there are certain aspects that I do think are more important than others and so I would carry them on and I do think it's decreasing absolutely.

(Female, aged 30, second-generation migrant)

Nisha, discusses another acculturation-gap as far as religion is concerned and that the younger generation are able to make a distinction between 'what's cultural and what's religious' whereas the first-generation do not. As explored earlier on in this chapter Hall (1997) put forward that culture is involved in those practices that carry meaning. For first-generation, they hold the same meaning around these practices and it is these collective beliefs that have allowed for cultural beliefs and practices being a major element in its own constitution of social order (Williams, 1981). Thus, as Riya suggested, the first-generation did not question what they were told and thus different traditional norms and values became part of their habitus. Also, with the importance first-generation attach to religion, these cultural practices indeed became 'religious' because they viewed religion as a way of life, rather than a faith.

Berry (1997) argues culture needs to be considered as something that is subject to a fluidity of movement, and it has been demonstrated, that culture is changing. Culture is based on the premise of shared values, knowledge and beliefs, there needs to be a consensus of meaning attached to these (Hall, 1997). However, for second-generation who have been exposed to another culture, and have the capacity to ask questions can identify the difference between culture and religion. Nisha, explores that culture is based on a shared belief and tends to be manmade; *'it's something that someone in a village in the middle of India somewhere made up'* whereas religion is associated with God. Furthermore, although Nisha acknowledges that there is a decline in religiosity among the second-generation Gujarati migrants, she is likely to carry on the religious practices rather than the cultural ones. Furthermore, for first-generation migrants, witnessing both their culture and religion practices change may be difficult to deal with. There has been an exploration in chapter four, of the ways in which religious institutions have been used as a source to not only sustain homeland culture but remain as communities in foreign countries. Therefore, religion and these cultural beliefs are 'critical sites shaping the identity construction processes of immigrants and their descendants' (Kurien, 2005, p.438). However, with the increase in questions

and change in beliefs from second-generation, who choose to retain and adapt these cultural and religious values can have a detrimental impact on the first-generation; because their ethnic identity is being questioned by their children.

Language

Language is another component that was an important part of Gujarati culture. First-generation migrants have suggested to some extent second-generation migrants have learnt Gujarati but with the third it is disappearing. Sarla, who is a head teacher at a Gujarati school in Leicester discusses the importance of knowing Gujarati and puts forward:

How I said I had to learn English when I came but that doesn't mean that I have left Gujarati I had held on to Gujarati as much as possible and both my sons have done a GCSE in Gujarati as well and this is the only reason we have this school that people need to be aware that you must keep your own mother tongue because learning your own mother tongue is every child's birth right and they should be aware of their mother tongue and it's very important because there are some messages convey in Gujarati and you can't translate it and say it in English so yeah.

(Female, first-generation migrant)

Sarla addresses some key issues surrounding learning and knowing Gujarati which is an element of your identity, knowing your roots and more about your cultural heritage. Secondly, there are messages that are distinctive to each culture and Gujarati is no exception. There are certain sayings that are commonly known in Gujarati culture which are difficult to translate or do not make sense when translated in English. Therefore, it is important to know Gujarati to be able to communicate these as they would come more naturally to the first-generation migrants. The majority of the second-generation migrants who were interviewed knew how to speak Gujarati and some could read and write. This was because they were sent to Gujarati school when they were younger and there was

a strong emphasis on knowing the language to some depth. Studies of young Asian people have shown that most young people prefer the integration mode of adaption in term of language and are bi-lingual (Ghuman, 1999; Robinson, 2003).

However, second-generation Gujarati migrants acknowledge that language is diminishing and the third-generation can barely speak it. Jay expressed this concern and said his two nephews speak in English to everyone. Although his parents (their grandparents) continue to speak to them in Gujarati, they will still respond in English. They understand it because Jay's parents speak Gujarati but Jay said in the next few generations you will find no one speaking Gujarati which *'is a shame'*. Oonk (2006) conducted a study with the Gujarati diaspora in East Africa and found that the local Gujarati youth in Tanzania do not use Gujarati language and use Swahili in their day to day lives which can be a threat to the preservation of homeland culture (Oonk, 2006).

Similarly, this was reflected in this study. Payal put forward that because future generations will not speak Gujarati *'they'll have a disconnection from their roots from India, from Gujarat and you know for a lot of people, that doesn't bother them'*. This is crucial because the second-generation recognise that language is associated with your roots and by not knowing the language you move further away from your 'Gujarati' heritage and thus identity. Identity refers to 'our sense of who we are and our relationship to the world' (Kanno, 2003, p.3). Identities are social constructions, and here is an example of how the second-generation migrants are using the 'integration' model of acculturation to shape their identity. Integration strategy of acculturation involves retaining many cultural values of your ethnic culture, whilst adapting to parts of the dominant culture (Berry, 1997). Payal, alongside other second-generation migrants associate language as a strong cultural facet that shapes your identity and Gujarati heritage. However, cultural traditions such as *'not washing your hair on a Wednesday'* are easily dismissed. Also, it is

interesting that Payal makes the distinction of Gujarat and not India. Although she says India, she goes on to say Gujarat and this shows that being specific, illustrates the importance it has for her identity. Although, the recognition of language contributing to identity is held just as importantly to first and second-generation migrants, there is consensus that this is disappearing with the next generation.

Taking care of elders

Traditionally in Gujarati culture it is perceived that care and support should take place within families. For instance, both Patel et al. (1996) and Sodowsky et al. (1995) argue that emotional dependency occurs in the family which involves children remaining physically close to parents long after marriage, employment and leaving home. Historically in India, it was expected for children to take care of their parents which entailed children staying with their parents even after marriage; this network promoted care to occur within the household and thus extended households were common in Indian culture.

However, the assumption that minority groups 'look after their own' is now questioned (Iliffe et al., 2004). In this research, the expectations and culture around younger generations taking care of their elders has also revealed a change is occurring in Leicester. First-generation migrants acknowledged there are expectations that children will take care of their parents when they are older. Similarly, Grewal et al. (2004) found that in Gujarati families there was still an expectation that their children would look after the home. However, there was sadness prevalent with their respondents because these traditions were not as strong in England. Also, first-generation Gujarati migrants expressed that this tradition was occurring less because Gujarati families have become more fragmented due to marriage and it is more common for families to be living apart from one another (Ballard, 1990). Redekunghys and Shah (1997) acknowledge that the extended family is becoming more fragile and perhaps not the prominent family structure among Indian communities. Traditionally, in India it was expected that the eldest son will take care of his

parents (Jamuna, 1993; Jamuna and Reddy, 1993), but due to separation with children, this is changing. Participants expressed that the first-generation migrants who initially migrated are staying in Leicester and thus due to loneliness this could be negative for their 'mental health'. For example, Bharat says:

Yeah, its depression because now people like me who came in the 60s they are getting old and they are like my age and the children have gone so they are on their own and that is depressing because before we have children we have each other we have family to look after us but they are not always around.

(Male, aged 69, first-generation migrant)

Thus, as Bharat explores, the older generation would want support to be provided in households and the family setting to continue but children are moving away and this is causing loneliness and thus depression. First-generation Gujarati migrants expressed that this system of support is a positive aspect of Gujarati culture and take real pride in it. Additionally, Barret and Turner (2005) argue that families are a platform where social support can be provided and thus fewer 'mental health' problems. Vijendra said:

If there was a white person here he would not have a car if you had got a car, it's a stolen car, and they may be living rough somewhere. Look at the Indian community you hardly see anybody living rough you know. Look at the whites, you find it everywhere. we do get ups and downs, I agree there, there's a certain percentage but generally there's one good thing in our culture is we look after our generations downwards, it should be in the reverse order as well. We used to but we are forgetting that reverse order. We give our children a very good stable platform already there and from there they have to make the progress. Look at the white community there's no support whatsoever to their children you know, so the elders also expect

something in return from the children, some love, which the younger generation is forgetting.

(Male, aged 85, first-generation migrant)

Vijendra 'others' different ethnic communities to illustrate the positive aspects of Gujarati culture. This has been explored in chapter five. Also, the care that Vijendra is discussing is a cultural trait of being allocentric, where the self and the family are integral rather than separate concepts. Furthermore, Indians are expected to make sacrifices on behalf of their family and the welfare and integrity of the family always supersedes individual needs (Mulatti, 1995; Das and Kemp, 1997; Segal, 1991). However, according to Vijendra this aspect of being allocentric is deteriorating and the younger generation are not performing their duties of providing support and are '*forgetting*' to provide this care. Vijendra argues that the older generation provide their children with a '*good stable platform*' and arguably this has increased opportunities for the younger generations. Grewal (2004) found that due to increased social and upward mobility among second-generation Indians, resulted to geographical scattering of families which indeed makes this process of 'physical support' difficult. For example, Vikram said:

I think that is the expectation that we will get our own places and we will live separately but we will support each other if that makes sense umm so yeah you know I feel I don't feel that it's an expectation from the parents it's just it's not really I don't want to say duty but it's something that you do for your parents that you know they have done so much for you this is the least kind of thing that you can do for them kind of thing.

(Male, aged 28, second-generation migrant)

Vikram's response highlights miscommunication between first and second-generation. For example, all of first-generation Gujarati's highlighted that this is what they would like, but for second-generation it was not so much an expectation but something that '*you do for your parents*'. This could be because

first-generation migrants may view this 'tradition' as an expectation that does not require discussions but has caused different opinions. Second-generation Gujarati migrants had a different view and acknowledged the importance of support within the home but suggested the way in which this occurs has changed. Thus, families are more segregated but they would still provide support to their parents when they need it. Thus, Phillipson et al. (1998) found that social support for elderly Indians was still located within multigenerational households and children and spouses were the primary source of support for elderly people. Furthermore, this is still the case but the way in which this 'care' and 'support' takes place has changed. Second-generation migrants could see how this expectation could lead to 'mental health' problems and Vikram went on to say:

My gran on my dad's side lives alone by herself umm and my gran on my mum's side lives with her son essentially um I can certainly see how it could lead to depression to feeling lonely umm not feeling accepted in some respect umm I can see that it would be very very difficult to maybe have your own independence when you've always got an elder around you know when you're married. the mentality is certainly in this country that you want independence you want to spend time with that person you know umm and it's almost like whether people mean for this happen but it's almost like their parents have now become a burden by living with them. I can understand how it can be very difficult but certainly not a burden. and once I think they start to feel like they are a burden the depression the loneliness that kind of stuff umm comes into play especially if their partner is no longer here with us.

(Male, aged 28, second-generation migrant)

Vikram expresses dilemmas of acculturation and adopting an integration strategy. On the one hand, he understands that 'care' and 'support' is necessary but on the other how independence in the UK is also wanted. Thus, by ensuring

he achieves both, the process and dynamics of which 'care' takes place has evolved. There are two key factors here than can affect the 'mental health' of the elderly population; firstly, due to the evolving ways care is taking place they may experience loneliness and thus undergo periods of distress if they feel like *'they are not accepted'* and secondly, the acculturation-gap, and the changing dynamics of care may be difficult to deal with.

Marriage practices

In terms of cultural traditions changing, the most prevalent one that was discussed was marriage. Previous studies that have focused on marriage and acculturation tend to focus on types of marriages and make a dichotomy between the two that occur. For example, second-generation Asians are associated with 'modern love marriages' whilst first-generation Indians prefer 'traditional arranged marriages' (Ballard, 1977). There are two key problems with these studies making such simplistic cultural dichotomies. Firstly, there is an assumption that this will result into a 'culture clash' or 'conflict of cultures' (Anwar, 1976; Ballard, 1977) which can inherently cause 'mental health' problems because second generation may feel like they are between two cultures (Brah, 1996). However, both Ballard (1977) and Brah (1977) found that their respondents preferred love marriages but were not willing to reject arranged marriages. Secondly, the dichotomy ignores the possibility of marriage practices evolving and changing and thus assumes Indian culture is static and unchanging (Prinjha, 1999). On the contrary Raj (2003) and Prinja (1999) have found evidence of second-generation Indians negotiating new forms of marriage with their parents.

Therefore, this dichotomy model of modern vs. traditional culture was not adopted in this study and there will be minimal focus on 'types' of marriages here. Similarly, to Raj (2003) and Prinja (1999), the data illustrated that first-generation Gujarati migrants understood that culture has evolved and the type of 'arranged marriage' they had in their time is probably more than likely non-existent. Thus, as Alexander (2002) argues, following the dichotomy approach

is far too simplistic and worrying because Asians have been typified as 'too cultural' and traditional and therefore incompatible with modern British culture. Rather, in interview discussions there was more of a focus on other aspects of marriage that have changed. The different components of marriage that were discussed were caste, marrying people from other ethnic backgrounds, career orientated individuals which impacts the age people are deciding to get married and independence. Therefore, questions arose regarding the changing needs of marriage which many suggest has resulted to a decrease in marriage practices.

Caste/other ethnic backgrounds

Most participants acknowledged that traditionally the norm was people married within caste (endogamy) and it was viewed as a taboo to marry outside one's caste. Dumont (1980) argues the very existence of caste grouping is reinforced by the practice of endogamy. This was due to several factors; firstly, communities were based on caste in India and thus individuals were more likely to interact with people of the same caste and thus understand them. Therefore, marrying in the same communities was more successful due to heightened similarities. This also meant dowry was given appropriately and unreasonable demands were not made. Also, arranged marriages were organised by parents and families who had a long history of knowing each other and thus usually occurred within caste due to interaction. However, not only is this changing in the UK, but also in India. In terms of marrying outside caste, first-generation Gujarati migrants were generally understanding of this. For instance, Nayna discussed her situation with her children who are all married:

Before you had to marry in caste but not so much anymore, parents have to understand these things. Both of my children have married in different naats, if they didn't marry Gujarati's then I would have felt really bad, I initially didn't want my son to get married to someone from a different naat but I had to let him in the end, my son used to say if I'm going to get married I am going to get married

to her or I won't get married and then how do you feel as parents, so the parents have to agree don't they or they won't get married and you will lose your children so as parents you have to do these things and understand that you won't be alive for long so it's their life, and then we had to let them get married and they are both happy. Some people understand and some people don't, not everyone is the same, our five fingers aren't the same, so everyone is different. There are some things that for children you have to do, you have to compromise and accept it.

(Female, aged 62, first-generation migrant)

Nayna explains that the boundaries of caste are diminishing. She explicitly stated not everyone is the same and used the metaphor of 'fingers' to exemplify that some may not approve of inter-caste marriages. My sample illustrated that it was becoming more common to marry outside one's caste but it had to be someone Gujarati and not belonging to another ethnic community. Corwin (1977) who did a study in India found that inter-caste marriages are tolerated with little difficulty because although they break traditional rules requiring caste endogamy, they do not come into direct conflict with other concepts involving social stratification. However, marrying in other ethnic groups does, and these conflicts were expressed by Jagdish:

When the faith group moves from one faith to another group, naturally that would have serious issues and implications to everybody concerned because there is nothing wrong with a person making that choice as far as I'm concerned but what happens is the link, the traditions, the faith, the language and everything is broken then, that link is broken. Naturally when people are from two different faiths get married, in the initial days everything will be fine but when they have children and an addition to the family the issue would be is how do you raise those children, which faith do the children follow.

(Male, aged 67, first-generation migrant)

There are two key important facets here that could cause 'mental health' problems: 'compromising' and 'naturalising'. Corwin (1977) argued that inter-ethnic marriages are not tolerated because they are subject to conflict and Jagdish suggests some are: religion, language and parental guidance. Additionally, Nayna puts forward a critical component of compromising in relation to inter-caste marriages is the risk *'you will lose your children so as parents you have to do these things'*. This reflects the importance the Gujarati communities give to social capital and ensuring that social integration is continued. I will argue further below, that Bourdieu's conceptualisation of social capital (1986) is crucial in ensuring cultural conflict is not caused by the presence of an acculturation-gap but rather is managed by the ways in which the first-generation migrants respond. In this case, Nayna is illustrating she has accepted inter-caste marriages to ensure her family is not segregated. It is usually documented that an acculturation-gap can cause conflict and thus negative impacts (Deepak, 2005). However, it does not mean that by accepting these changes, the negative impacts have been avoided. Nayna silenced her opinion due to keeping her family together and she stated, *'I initially didn't want my son to get married to someone from a different naat but I had to let him in the end'*. Silencing true opinions manages conflict but a lack of communication results in first-generation Gujarati migrants predominantly doing the 'compromising and negotiating' which can impact their 'mental health' because they suffer in silence. Previous studies that have discussed negotiations between the two generations in terms of marriage (Prinjha, 1999; Raj, 2003) but have not explored who negotiates and why.

An additional component that could potentially heighten the risk of 'mental health' problems among the first-generation migrants is the 'naturalisation' of Gujarati culture. Above, Jagdish 'naturalises' the outcome of people from two different ethnicities getting married. Further below, Danesh 'naturalises' careers and the prospects of marriage. This is interesting because culture is formed part of the communities' embodied cultural capital, where their habitus becomes unconscious but also 'naturalised'. This can influence one's access to

social capital. Although discussed in relation to migration, Anthias (2008) argues:

Collective places constructed by imaginings of belonging, however, are constructions that disguise the fissures, the losses, the absences, the borders within them. The imagining also refers to their role in naturalising socially produced, situational and contextual relations, converting them to taken for granted, absolute and fixed structures of social and personal life. They produce a 'natural' community of people and function as exclusionary borders of otherness. Belonging therefore tends to become 'naturalised' and thus invisible in hegemonic formulations (p.8).

Thus, naturalising is social produced and contextual relations contributes to viewing social structures as fixed. By Gujarati communities 'naturalising' elements of Gujarati culture causes 'otherness' if people do not meet these elements. Thus, in terms of marriage, if practices are not met, individuals are at risk of losing social capital. As discussed above first-generation migrants silence their opinions to not lose social capital but also obey these 'hegemonic formulations'. As a result, it will be argued below that it could indeed put more stress on community members and cause 'mental health' problems.

Career orientated (Age and independence)

There were two issues that were explored in terms of second generation becoming more career orientated which was worrying first-generation migrants: age and independence. First-generation migrants expressed that their children are career driven and thus deciding to marry later. Although positive, parents are worried about this because by postponing marriage there is a risk their children will not find someone to get married to due to age. Gist (1954) suggests traditionally in India when a son or daughter reaches the marriageable age, kinship coordinate a spouse and the whole ceremony. Danesh said:

Children who were born in this country, you know they have got educated, they have gone to university. You know by the time you have gone through that education system you are 24/25 then naturally you go into your chosen career that takes 2 or 3 years to settle down and by that time you are 28/29. Naturally every parents' dream and wish would be that their daughter or son to get married between the age of anything from 18 to 22. You know and I personally believe that is the right age in a way to get married, the reason is that when you are of that age, naturally 2 individual people have 2 different ideals and sense of humour and when you are of that age, as you grow on you tend to adapt to different types of ideals and values and grow into a very happy couple. But when you are in your 30's, you have set ideas and set values and set habits and when the two people connect together, sometimes to adjust to that would be very difficult you know and that could cause tension.

(Male, aged 55, first-generation migrant)

Although Danesh believes that it is better to get married at an earlier age because individuals are likely to adapt to different types of ideas and values; second generation migrants had other opinions on this matter. Anish said that people should be financially stable because they are in the right frame of mind to settle down. Nisha, a second-generation migrant put forward that there is an expectation in Gujarati culture to be married by a certain age and said: *'there's definitely a conception to say that when a Hindu man or woman is born there's definitely a date printed on their backside, a married by date that I call it'*. Studies have found that the young Asian generation are taking a more active role in the selection of their future spouse (Parry, 2001; Raj, 2003; Fuller and Narasimhan, 2008) and prioritise other factors such as love, affection and compatibility. Therefore, as Anish suggests the second generation *'have to be in the right frame of mind to be able to settle down'*.

Additionally, the other aspect of marrying later was that individuals tend to be more financially stable, because they have been working for longer.

Traditionally in Gujarati culture, marriage was less about being in love and declaring love but more about setting up the right foundation to have a family. Historically women tended to stay at home and be housewives and child bearers whereas men were the sole breadwinners. This meant that for women marriage was necessary because they would need financial support and were thus dependent on men. On the contrary men needed nurturing in terms of emotional, social and other day to day support. However, by having a career this framework that first-generation Gujarati migrants 'naturalise' is no longer necessary which means the dynamics of marriage has changed in the UK. This is causing parents discomfort because new attitudes are in their opinion increasing divorce rates and their children are not settling down. This has given women an opportunity to be 'pickier' and have more involvement in marriage and thus the patriarchal context is disappearing. Ramila explores these issues to some depth and says:

Men and women, they both earn quite good money because they both have got career, so they both are independent and if a girl is independent and she's earning money she can she's not going to tolerate no nonsense from a guy. So, she can just tell the guy well I can live my own life, I can buy my own house, I can buy my own car I can do this and that's why the divorce rates are so high because there's no compromise.

(Female, aged 58, first-generation migrant)

Nevertheless, first-generation migrants did not want to revert back the 'old-fashioned' way of doing things and suggested that it is really important in a western setting that both males and female are educated and career driven. They acknowledge that living in the UK is expensive and requires a high income to live a comfortable life. However, the issue is the attitudes towards marriage and first-generation migrants put forward that although it is positive that their children are becoming more independent, it means to some extent they are becoming more selfish. By becoming more independent, they are no longer able to compromise because they feel like they do not have to. Therefore, other

issues arise and one of these is that divorce rates in the communities are increasing and people have heard more about divorces. Whereas, historically or even a decade or so ago hearing about divorces in the communities was rare. Parents do not want their children to go through a divorce because their future is affected. Several factors that were raised were, they will have a lonely life because no one will want to marry someone who has been divorced, it is stigmatised in the communities and thus honour and representation of the family is affected. However, second-generation migrants put forward that they prioritised careers due to seeing their parents' struggle making a living in western society. For instance, Vikram said:

I feel that people have seen their parents grow up, struggle to make a living in this country you know [...] I think that kind of has an influence on their drive they don't want to be in the same situation financially, possibly that their parents found them in and of course when you are career focused you've got a good career, you have personality traits that come along with it and yeah I feel that being picky for a better word is certainly something that people are these days. They don't feel that they want to settle they don't want to be in a relationship if they don't see that that person doesn't tick every single box they have an idea of what their ideal person should be like and because they have got where they are in their career through hard work and dedication that they can apply that same mentality when it comes to a partner.

(Male, aged 28, second-generation migrant)

Maturity in western societies is understood in terms of increased autonomy (Wyn and Woodman, 2006). In this case, Vikram is illustrating that being career-orientated provides financial autonomy which can 'justify' people choosing to be 'picky'. Although the second-generation migrants are more individualistic, they are still considering their home life with their decisions, such as not wanting to 'struggle'. Thus, the 'acculturation-gap' that exists represents a

miscommunication between the two generations. First-generation migrants view their children as becoming increasingly selfish and prioritising other factors that delay marriage whereas second-generation migrants are responding to what they have seen at home and trying to avoid those things, in particular financial struggles. These intergeneration discrepancies will be discussed below.

Intergenerational discrepancies as a risk factor for 'mental health' problems

Above, I have used several different facets of culture to demonstrate an acculturation-gap between first and second-generation Gujarati migrants. Throughout these discussions, first-generation expressed them apprehensively because there was a risk of their culture changing; in a way which can be difficult to deal with. However, critically this has not resulted to a 'cultural clash' which many previous studies assume when looking at acculturation and south Asian communities (Anwar, 1998; Farver et al., 2002; Sekhon and Szmigin, 2005). Additionally, 'cultural clashes' or living 'between two cultures' has been of interest because of the conflict it can cause and in particular in terms of this context, the implications this can have for wellbeing and psychological distress. However, Brah (1996) criticises the 'culture clash' model and puts forward that there is no evidence to suggest that is the case with second-generation Asians and previous studies do not explore experiences. This is crucial because the findings of this study advocate that it is these experiences which are very telling, and rather than assuming that certain types of acculturation strategies will result in psychological distress causing ecological fallacy, complexities of social life are simplified. Furthermore, few studies have compared the two generations and the ones that have such as Raj (2003) have found instances of both conflict and negotiation.

Furthermore, throughout my discussions in this chapter, second-generation Gujarati migrants did not express being lost between two cultures; rather they were using the mode of an integration strategy of acculturation (Berry, 1990). They demonstrated that they retain many cultural values of their ethnic culture

whilst adapting to parts of the dominant indigenous culture. For example, when it came to taking care of elders, many second-generation Gujarati's expressed that they would still take care of their parents but have adapted the ways in which this will happen. For example, Veena said:

The son is still expected to look after the parents of that generation they are expected to do so but it doesn't have to be living in the same house so even though they are say for example my grandma and granddad live alone we live in a completely separate house so my dad still has to take care of them and he still sees them quite regularly but we don't live together.

(Female, aged 22, second-generation migrant)

Furthermore, marriage and job opportunities mean that this care will be approached from a distance rather than living in the same household. Similarly, Bacon (1999) found that in constructing ethnic identities, second-generation Asian Indians appropriates and reinterprets the rhetoric of the first-generation.

Although, second-generation have been appropriating and reinterpreting Gujarati culture, I would like to focus more on the attitudes of the first-generation toward these changes and how they are dealt with because this is neglected in current literature. The focus on acculturation work has moved away from first-generation Gujarati migrants' due to migrating in large kinship groups (Bachu, 1985), benefitting from upward social mobility (Patel and Shaw, 2008) and thus continuing home culture and using 'separation' acculturation strategies (Berry, 1990). However, my study illustrates that it is not as simple as this, and using Bourdieu's (1986) forms of capital, there will be an illustration of the complex ways in which first-generation Gujarati migrants respond and manage the 'acculturation-gap' between second-generation migrants and themselves.

As explored in chapter four, the communities used social capital to come together to set up organisations which allowed for their habitus to remain.

Thus, the Gujarati communities place a strong emphasis on maintaining these networks as well as cultural practices. Therefore, they feel they have a 'social obligation' (Bourdieu, 1986) to behave in certain ways that upholds their cultural and social capital and this could have negative consequences. In terms of responding to an acculturation-gap, first-generation Gujarat migrants adapt to changes by 'silencing' their true opinions because voicing them will risk causing fragmentation among their families. Although (Raj, 2003) found that negotiation occurs between parents and their children, in terms of adapting to various rates of acculturation and dealing with differences, my data illustrates that first-generation Gujarati's may be doing the negotiating. Furthermore, the first-generation migrants recognise that they are the ones that are predominantly doing the compromising but this is due to fear. If they do not compromise and adapt the changes that are occurring, then they will lose their children and as Pratik said, *'they are not willing to lose their children or disown them'*. However, by silencing opinions second-generation participants have expressed that on the whole their parents are more liberal and accepting of the changes that have occurred post migration. Nisha said:

I think when they realise that umm it's quite difficult finding someone who is Hindu let alone in your caste umm I think parents are a little bit more liberal nowadays in letting them choose their marriage partners.

(Female, aged 30, second-generation migrant)

However, for first-generation migrants these changes may be causing them to experience unhappiness as they compromise and adapt as methods of necessity, for the sake of their children. For example, Ketan said:

There is always a culture difference so there has to be a balance between the two, I'm not saying you have to be totally Gujarati style all the way, but you can't go extreme, you have to try and be balanced. Parents are accepting that things are different now our time I can't remember staying out till 2 or 3 o'clock but our children

do, you can't do anything about it, even if you say no they are going to go so you have to compromise with this and not start fighting it's not like you can say don't go you have to be like at least when you are out give us a ring, don't switch off your mobile phone and compromise with them.

Ketan also went on to say:

I think just like parents might think why am I putting pressure on my children and if I tell them that I am suffering with this then they might get a load on their mind and they can be affected. I can give my example of my own mum and when she's not really well and I say mum how are you, she just says yeah, I'm alright, she won't want to worry me and won't want me affected by her illness. So, these are the things they don't want their family to suffer as well.

(Male, aged 62, first-generation migrant)

This element reflects the notion that Gujarati communities are collectivist. Ketan explained that rather than discussing their feelings with their children, they choose not to say anything to restrict the component of their children feeling unhappy too. This relates to the attitude that Indians tend to be allocentric, where the self and the family are integral rather than separate concepts (Segal, 1991). However, previous studies have put forward that Asian Indians of all ages are expected to make sacrifices on behalf of the group, and the integrity of the family always supersedes individual identity (Das and Kemp 1997; Segal, 1991; Ibrahim et al., 1997). However, the data presented illustrates that first-generation Gujarati migrants have this attitude rather than their children. This is because they are under the impression that their parents are more liberal and accepting of the cultural changes that are occurring. Another component to these changes in culture is holding yourself accountable. Many first-generation migrants discussed their decision to move to the UK was based on having a better life financially and a better future for their children. For this to occur and for them to maintain happy in a new setting they suggest they

must change their attitude. For example, when discussed in chapter five many participants would overcome unhappy periods by looking for ways to change their attitude, it was suggested that they viewed 'mental health' as a private issue. This relates to Hannay's (1979) 'symptom iceberg' or 'clinical iceberg' where the majority of medical symptoms experienced by people are not presented to healthcare professions but rather ignored, tolerated or self-treated.

First-generation migrants' attitudes towards cultural changes can cause unhappiness lies with relying on themselves to change. Bharat explores this further:

You have got to make your life happier and by changing yourself, so if I didn't change myself, if I was still orthodox like my parents, I wouldn't be living a happy life now. My time was different, their time is different, but if there is no understanding then it's going to be a very difficult for Gujarati families.

(Male, aged 69, first-generation migrant)

In addition to times changing, there is a tendency in the Gujarati communities to uphold a certain image which gains people honour and respect (Segal, 1991). In a collectivist culture, individuals will care about what others think and one reason why first-generation migrants may be accepting the change and feel restricted in terms of talking about it, is to maintain a positive image and their honour. For example, Ramila discusses how people stay quiet because they do not want there to be any conflict with children and '*they don't want to ruin their family name*'. This is because in Indian culture the integrity of the family always supersedes individual identity (Das and Kemp, 1997). Thus, at the heart of the ways in which first-generation migrants respond to cultural change is because of the importance they place on cultural and social capital.

Furthermore, the silencing of 'real opinions' and adapting to cultural change because first-generation feel like they have a 'social obligation' or because their

attitudes are more allocentric, has potentially given the second-generation the perception that their parents are more 'liberal', 'accepting' and 'understanding'. The following snippets of discussions, demonstrate an overview of the attitudes that were presented by second-generation Gujarati's.

Anish

I think they are forgetting about the way the older generation used to be and the way that they are now um but looking at the way they are now I think they just carry on with what they have to do.

(Male, aged 20, second-generation migrant)

Rahul

Well I tell them that I am going to do what I want to do, they don't really say anything, they don't mind, I don't think. They probably do mind but I am just going to do my thing (laughs) (Talking about marriage).

(Male, aged 22, second-generation migrant)

Nisha

It just depends on where your parents are from; I mean if they are quite liberal they know that their son probably won't live with them, there won't be anxiety. this is the thing, in Leicester you have got quite a lot of Asian parents that are liberal and they have a social life and they go and do things. There's also a bunch of Asian people in terms of mid 50's age who all they've done is worked so they don't have that social life, the whole of their life revolves around their children and work etc. and so that's where the anxiety will wire I think, in those parents that their life is just comprised of their children and their work life and there's not much social going on.

(Female, aged 30, second-generation migrant)

These extracts show that second-generation Gujarati migrants feel like their parents are understanding of the change in culture. There is a clear acculturation-gap, and the way the first-generation respond allows for conflict not to surface in families. As Anish said, *'they just carry on with what they have to do'* and it could result in the attitude that Rahul depicts of complete autonomy. He will do what he wants, because he knows his parents will not say anything. Although, this allows for the Gujarati communities to be successful, without conflict per se, 'acculturative stress' can still be experienced silently with first-generation Gujarati migrants. Williams and Berry (1991) argue that acculturative stress can be a risk factor for 'mental health' problems. In immigrant families, a type of dyadic acculturative stress can occur, which is when parents and children acculturate at different rates (Szapocznik and Truss, 1978). In acculturation literature, it has been argued that different trajectories of acculturation can cause intergenerational conflict and thus pose a risk factor to 'mental health' problems (e.g. Sluzki, 1979; Kwak, 2003). However, my findings have illustrated that although an acculturation-gap exists with the Gujarati communities, conflict is not created but silenced due to 'social obligations' and being 'allocentric'. Thus, acculturative stress can be experienced silently, and can be a risk for 'mental health' problems with the first-generation migrants. However, with the second-generation migrants, this attitude depicts a view that their parents may be more 'understanding' and 'liberal' and thus they do not experience acculturative stress or feel like they are 'between cultures'. Therefore, as Brah (1996) suggested, it is more useful to explore intergenerational differences rather than intergenerational conflict, and indeed intergenerational discrepancies can be a risk to 'mental health' problems.

Therefore, rather than focusing on the interplay between risk factors of mental illnesses and how they compare with communities, there needs to be a much more in-depth focus on communities themselves. For instance, although migration, racism etc. can influence the risks of mental illness, the interplay of how people respond to these experiences are based on cultural capital and thus

it is these decisions that could cause risks of 'mental health' problems. Furthermore, an example is work ethic which was explored in the literature review and studies such as Wildman (2003) have found and argue that employment increases financial gains and thus the availability of housing, education and other amenities which can minimise relative deprivation and increase mental well-being. If this was explored as a comparison to the Gujarati communities, there would be an assumption that they experience good 'mental health' due their upward social mobility and being career driven. However, the cultural decisions that were explored by Vikram who suggested they are career driven because of seeing their parents struggle, suggests that attitudes are deeply rooted in culture. The interplay of these attitudes among two generations is significant and rather than merely exploring ethnic communities and risk factors, this study has shown that the area requires an exploration of how and why certain risk factors exist in communities, the ways in which they are responded to and managed with a closer focus on their cultures can be crucial and developmental in this area.

Summary of chapter

This chapter has covered the ways in which cultural values influences experiences of 'mental health' problems within the Gujarati communities. There has been an exploration that cultural norms and 'social obligations' can be a risk factor for emotional distress. This lays on the foundation of the importance the first-generation Gujarati's hold of their social and cultural capital. This results in behaviour and actions towards cultural change being predominantly due to 'social obligations' and thus to avoid conflict first-generation migrants are silencing their true opinions. First-generation Gujarati migrants express that they are not happy with the changes but prioritise izzat, reputation and social cohesion whilst the consequences may result in emotional distress. Thus, if 'mental health' problems exist, the next chapter will look at various ways in which the Gujarati communities have practices that manage 'mental health' and its' limitations.

Chapter Seven: Approaches and practices to ‘mental health’ management

Introduction

The first analytical chapter analysed understandings and conceptualisations of ‘mental health’; exploring the first research question, whilst the previous chapter explored the ways in which culture influences experiences of ‘mental health’ problems. Accordingly, this chapter will tackle the last two research questions addressing response and management of ‘mental health’ problems. The first part will provide an analysis of the ways in which the communities have practices and beliefs that help maintain ‘mental health’ management but also their limitations. The second part, will explore how cultural beliefs and attitudes impact help-seeking behaviours. Due to the complexity of these interactions, I will draw on Pierre Bourdieu’s (1984; 1986) work to provide context in understanding these relationships. In particular, Bourdieu’s (1986) classifications of social, cultural and economic capital which will demonstrate aspects of the communities that promote ‘mental health’ management but, also the same forms of capital can have a negative influence on help-seeking behaviours. In relation to ‘mental health’, forms of capital are at the core of help-seeking behaviours and can influence access to ‘mental health’ care. I will demonstrate significant community practices which form part of the communities’ habitus (resources gained from forms of capital, Bourdieu, 1986) that can aid ‘mental health’ management. Part two will explore various facets participants put forward that make up their habitus that are influential on help-seeking behaviours.

Part one: Community practices

This section will focus on the ways in which various community practices aid ‘mental health’ management. The areas that were prominent and will be discussed are; religion in terms of community organisations, going to visit

religious figures and ways of thinking and attitudes, agency, ayurveda and community help and services.

Religion

One of the most fundamental areas that were discussed was religion, which is at the heart of the communities remaining close-knit post-migration and thus, it is a pertinent starting point. This section will explore the ways in which religion helps to manage 'mental health', by using empirical data and drawing on Bourdieu's work on social and cultural capital. This will be examined under three categories: community organisations, going to religious figures and ways of thinking. All participants involved in this study identified themselves as a Gujarati Hindu and their 'religiosity' was not mapped in any way but rather focused on the ways in which beliefs and practices in Hinduism played a substantial role towards 'mental health' management.

Community organisations

Leicester has the second largest Hindu community in the UK with 41,248 people identifying as Hindu at the last census and religion plays a fundamental role in their lives (Raj, 2010). Additionally, this was also demonstrated in my empirical data and religion was discussed in many of the interviews. It can be argued that religion has been allowed to remain prominent in the UK due to living in large cohesive communities (Bachu, 1985). For instance, although Leicester is a large city, the Gujarati communities tend to live in clusters in confined proximities. For example, the area around Belgrave road which is colloquially known as the Golden mile, houses large numbers of Gujarati families. In doing so, this has enhanced their social capital in terms of networks and the Gujarati population have been able to maintain religiosity because collectively they have formed places of worship and through practicing have enhanced their cultural capital (Gale et al., 2003). The process of this was outlined in chapter four. However, here I will draw on theory in particular Bourdieu (1986) to contextualise how community organisations have played a role in managing 'mental health' problems.

Firstly, in his book *Distinction* (1984) Bourdieu draws on cultural capital as cultural knowledge that would signify identity to groups; namely class distinctions. However, in this case, Hinduism has been used with the Gujarati communities to come together as a large community that share common cultural practices, beliefs and identity. To remind the reader, Bourdieu (1985) defined social capital as 'the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual; acquaintance or recognition' (Bourdieu, 1985, p.248). As illustrated in chapter four, the importance of religion has allowed for organisations to be created and hence social and religious gatherings are organised for the communities. By doing so, religion has contributed to social cohesion and this upholds good 'mental health' due to a lack of loneliness (Krause, 1998; Matthews et al., 1998). Similarly, the story Mahesh told us of how these organisations were built (chapter four) exemplify that social capital was used (gathering members together) to gain access to economic resources. Additionally, due to creating a large umbrella body (The Hindu association); the Gujarati communities found it easier to apply for funding grants from the council. Thus, they used their social capital to increase their economic capital and subsequently further increased their cultural capital, because they were in a position to build temples and halls where they had the freedom to continue performing religious practices. Both embodied cultural capital and institutionalised cultural capital are at play here as it draws people together in an Institutional setting.

As a result of using religion as a common denominator across the Gujarati communities, most of the participants express not only gratitude towards this occurring but suggest it allows for social cohesion which promotes good 'mental health'. This also relates to Bourdieu's (1977) theory of doxa, and due to migration being a phase of crisis, doxa is no longer something that is taken for granted but their habitus and doxa is reinforced to overcome periods of crisis and in this case, that is relocation. Thus, the Gujarati communities reinforced their habitus by using the different types of capital to come together and are

still able to practice their own cultural, religious and social practices, albeit in a new environment to India or East Africa. This occurrence supports Allen's (1994) arguments of awareness of ethnicity signifying in contexts such as migration and discrimination which can undermine it. Overall, through utilising cultural and social capital the strength of their ethnicity has increased and been used as a strategy of adaptation in a new setting. Furthermore, there is a large body of research that advocates migration can increase risk of 'mental health' problems (Cochrane et al., 1977; Cochrane, 1983; Kuo et al., 1986; Beiser et al., 1993; Nevo et al., 2006). This is because migration can involve stress, isolation, change in terms of break-up of family ties and adapting to new surroundings and cultures. However, the data illustrates, the Gujarati communities have responded by reinforcing their own identity through remaining close knit, building places of worship, celebrating festivals and remaining religious (Bachu, 1985). Additionally, through these organisations based upon religion they benefit from social integration and support which can be positive for managing 'mental health' problems (Stansfield and Sproston, 2002).

Going to visit Religious figures

Additionally, through forms of social capital the communities have benefitted from economic capital and built temples around Leicester (explored earlier in Mahesh's story in chapter four). These hold a lot of value in terms of generating social capital as these are common places members come together, but also through cultural capital, as they are highly sacred as the 'home of God' brings you closer to God. For instance, Miland (explored in more depth later) suggested that the mandir (see glossary) is *'like my second home if not first, it is important we respect it'*. Evidently, it can be highlighted that religion is extremely valued in the Gujarati communities and holds a crucial place, not only for the communities' practices in day to day life but the very way they behave and think which will be explored in further detail below. Additionally, in the UK, there are over 170 mandirs and more than 20 of these are in Leicester which in relative terms is a considerable proportion, illustrating the sheer importance of mandirs to the Hindu population in Leicester.

Many interviews were conducted in participants' homes and although they had their own altar (a place for personal worship), they explained that the mandir was a special place where they can be close to God and share the experience with other devotees. Mandirs then, are prime examples of places of worship that aid social capital and allow for peoples' habitus to remain at a state that provides people with comfort and a sense of normality in their lives. In terms of 'mental health' and the relationship mandirs have, there were two distinct components that participants expressed. Firstly, going to the mandir allows you to interact with other devotees, take part in religious rituals which can be progressive for your 'mental health' because you are surrounded by people eliminating loneliness; a factor the communities put forward that causes mental illness. Additionally, there is also a positive aura perceived in mandirs which allows people to have a positive mind and be at peace. Secondly, in terms of managing 'mental health', mandirs provide another point of contact where people can speak to priests. Again, this would not be possible if the communities did not benefit from strong social capital and speaking to priests provides social support and guidance to overcome issues they may be facing.

Jayesh, who is 63, came to the UK when he was thirteen and after staying in Bristol for three months he permanently settled in Leicester. He told stories describing how people actively go to temples to seek help for their illness because they feel helpless. By doing so, priests at the temple can help them by having conversations about their illness. Religion is such an integral part of Jayesh's life and he believes that having a faith has a positive impact when people are suffering. Jayesh said:

When you have got a big problem with your health you can't cure you, where are you going to stop, what they do is go the mandir and pray say Bhagvan (God) will help me out and the guy will sit in there and say this guy is coming here quite often so he'll ask the question and they will go on from there and they will talk about it and they do help, they do help, certain preachers will help.

(Male, aged 63, first-generation migrant)

It needs to be made clear, that not all participants expressed this and is generally associated with the elderly who are retired. Many elderly people did not associate emotional distress as a medical problem, and when they were going through periods of sadness they would choose to go to the mandir and spend time there and converse with the priest due to having established a good rapport with him. There are two factors that provide support in this context. Firstly, going to the mandir allows people to experience comfort through embodied cultural capital (Bourdieu, 1986) and this improves their attitude and thus are able to overcome periods of sadness and secondly, as Jayesh suggests there is a support network available at temples. Arguably, participants put forward that this way of managing 'mental health' problems are diminishing and is common among the elderly. This could be because religion and mandirs hold a different role in their lives which makes up their habitus. For instance, participants discuss times in India when they would go to mandirs in the local village and have also grown up in households where their own altar plays an important part in their day to day lives. This illustrates that when the Gujarati communities undergo periods of crisis, and this may well be emotional distress or sadness, they may revert back to their habitus because it provides a sense of 'comfort' and 'normality' that will help them overcome their crisis (any emotions they are feeling).

Ways of thinking and attitude

Religion has helped the communities come together, build organisations, places of worship and continue religious practices. Another impact religion has on the communities is that it provides a distinctive way of thinking and attitude towards life, and broader issues confronted in life. Drawing on cultural capital, religion has given participants resources to a certain path in life. As religion is a form of developmental teaching, people are raised to have a Hindu faith from birth; it forms part of an embodied cultural capital (Bourdieu, 1986). Due to the investment over time, practices of Hinduism are converted into an integral part of the person which makes up their habitus. It is much more than merely an

individuals' identity but provides guidance for the very way a person approaches life itself.

In this study, participants suggested that these resources are good for people's 'mental health' as it encourages positive thinking and behaviour. Being religious means that you know the 'right' way to live and you will not cause harm to anyone and thus, harm is less likely to affect you. This follows the teaching in Hinduism of Karma which in its simplest form is a belief that stands on the premise of 'the past determines the present which combined with the past determines the future' (Sharma, 1973, p.349). For example, Urmila who lights a candle and incense every morning believes this is the right way to start the day which aids a peaceful mood and by doing so God will protect her. She takes real pride in being religious and a Gujarati. She wears a sari (traditional clothing) every day and explicated that it illustrates her identity. Urmila expressed:

Religion is not like you doing what it's called karma kanda world virtues it's not only that thing you know, religion means you know how to behave how to think how you take the decision [...] So Gujarati people are very very honest and um they have very good thinking and that's why they haven't got any problems because this is the thing if you give problem to other people then problem comes to you yeah.

(Female, aged 52, first-generation migrant)

Urmila explains, how believing in Hinduism as a faith is positive because you follow a lifestyle which is 'honest' and in return good for your health. She suggests that it is within you and being a Hindu not only impacts how you think and behave but assists on making correct decisions throughout life. There is a real connection with embodied cultural capital here and that being a Hindu grants you a certain way of thinking and behaving which diminishes the possibilities of 'problems' in your life. In relation to Karma, Rashmi said:

I think some people still believe in that and also, they get consolation from it. The Gita it says whatever happens in your life, it's because

of your past Karma's either in this life or in your previous life. The people who do strongly believe in it or want some sort of a consolation from it, from what's happening in their life and to overcome or cope with the situation they will say this is not going to stay with me forever. And I might have done some bad bits in the past so I'm suffering the consequences of that, so there is some sort of compromise and acceptance of the situation and I think that, that helps to get on with life.

(Female, aged 53, first-generation migrant)

Although this relates to a potential reason for not seeking help which will be explored further below, Rashmi views Karma positively because it allows people to 'get on with life'. This could be beneficial for some members of the communities who need to overcome emotional distress but can be problematic if 'mental health' problems are left unaddressed. Kunal, an engineer migrated in 2005 on a highly skilled migration visa for job opportunities with his wife and two daughters. Despite working in Loughborough, Kunal lives in Leicester because he wanted to be close to the Gujarati communities. Kunal expressed times when he felt 'down' due to migration; but religion helped him to work through the difficulties. He generally, is very optimistic and focuses on the positive aspects of life and believes strongly in always having a positive attitude towards any situation, even if it could be initially perceived as negative. Kunal states:

If someone asked me personally because I am very much involved in these kind of things by God's grace I studied so many things I am always trying to co-relate the faith the religion, along with the human things how our dharma, how our religion can be used in order to cultivate positive things in human beings.

(Male, aged 49, first-generation migrant)

Kunal's view suggests that religion is viewed as an aid that helps people to think positively and thus promotes good 'mental health'. It is well documented that religious beliefs can have a protective influence by moderating the impact of negative interpersonal life events (Krause, 1989; Matthews et al., 1998) such as misfortune, migration and racism (James, 1975) which influence 'mental health'. Both Kunal and Urmila put forward in their accounts that being religious is important for living positively and having the right attitude towards unfortunate circumstances. Similarly, Moreira-Almeida et al (2006) argue that one of the many ways in which religion can influence 'mental health' is 'healthy behaviours and lifestyle' which has also been expressed by the participants as being a Hindu allows them to have a distinctive attitude that helps with situations they are confronted with.

Correspondingly, another similar element but distinctive was the way in which religion was facilitated as a 'coping method'. The above suggested, being religious provided a distinctive attitude to life where you always see situations through a positive outlook that enable you to live the 'right' way. Additionally, it was expressed that religion can also be used as a coping strategy when people get ill. Miland, aged 78 is retired and lives alone. His wife passed away 30 years ago from cancer and Miland currently has a tumour. He has faced some problems with his son and daughter in law hence why he lives alone. Whilst discussing 'mental health' problems which he refers to as 'worry', Miland says:

I have heard of it though, it's when you worry a lot, I don't worry I just listen to religious songs all day, every day and it makes things better.

(Male, aged 78, first-generation migrant)

The conceptualisation of 'mental health' problems as 'worry' is significant and was discussed in chapter five. Nonetheless, in terms of management, Miland explains how religion is used as a coping mechanism which can result in a loss of worry and coming to terms with health issues. Miland elucidates how depression is a result of people worrying and he does not worry about things

but listens to religious songs. Miland went on to say, that listening to religious songs meant that he was in a better mood and he felt that God was overlooking him which would result in positive well-being. Similarly, Koole (2010) advocated that religion promotes better health because religious believers manage to control their behaviour when responding to life threatening events, and Pargament et al. (2005) found that religious and spiritual coping influenced psychological distress and promoted good health. In Bourdieu's terms: religion forms part of one's habitus, and when crisis occurs in one's life and this may be ill health, the habitus serves a purpose of normality. In this case people may revert to religion as a coping mechanism because it can be comforting. Having formed part of their embodied cultural capital it is an integral part of people's daily lives.

Contrary to the above analysis and what Urmila explored; where Hinduism allows people to live the 'right' way and think positively. This has also been viewed negatively or at least with caution. Suresh migrated in 1976 from India and went to Birmingham after marrying his wife. He started working after just 4 days of moving to the UK and he moved to Leicester around 9 months later as his wife could not find a job in Birmingham. Suresh describes himself as a 'workaholic' and a Hindu. When talking about Hinduism he said:

Our Hindus are very polite they don't speak out they keep it with them and they try everything but if they want to put their foot down then they can achieve something but I don't think so, I don't think so. They just stay quiet and then more problems can be created so they worry and their health goes bad.

(Male, aged 57, first-generation migrant)

Suresh suggests that a distinctive personality trait of being a Hindu is being polite and this is not always a good thing. It means in some situations; Hindu's suppress their real feelings which can have an adverse effect on their health. Kendler et al. (2003) and Pargament et al. (2005) found that religious beliefs and practices are not always positive for health. They found that a poor quality

'relationship' with God and religious conflicts are associated with poorer health. Although, the communities do not have a bad relationship with God per se there may be conflicts or dilemmas with how their religious beliefs affect how they deal with situations they face in day to day life. As Suresh explicates, many members of the community will be polite due to their faith even though there may be a conflict in beliefs and thus negative for their health. In relation to cultural capital, religious affiliation teaches the communities cultural codes of ways to behave in situations and certain settings. Suresh suggests that the teachings of Hinduism denote that people may be polite in social settings but consequently their true feelings may be suppressed which could lead to 'mental health' problems due to 'worrying'. Therefore, knowing the appropriate cultural codes may provide a positive way of thinking that helps to manage 'mental health' but some participants did view it can also be problematic.

Agency

Similar to participants expressing that religion provides a certain way of thinking and the right attitude to manage 'mental health'; this was stretched out to the 'Gujarati culture' more generally. Participants acknowledged that there is something distinctive about Gujarati culture which aids people to have the right mind-set to overcome emotional difficulties they may experience through life. As a result, many participants did not view more common 'mental health' problems that required help from their GP's but they felt that this was certainly a private matter that should be dealt with individually or privately. Kunal explains:

Most of the people will try on their own without revealing or describing the things. Like you know you take my example I was feeling very home sickness when I came over here okay. my family my wife and my two kids they know daddy was a bit upset because we left everything in our home our 3-storey house we left everything down there a very good job everything and we left everything over there and came over here, just for a good quality of life and for the education for my kids. so initially I thought it was home sickness but

I was able to recognise that particular thing but I was not admitting openly even in my family I admitted only in front of my wife and my kids because they should know what's going on in my body or in my thinking. So, you know they might help but at the same time I started sort of self-help. I search everything a few things on the internet, I contacted a few gurus in India from here I read some books and started practicing some of the things from that particular thing.

(Male, aged 49, first-generation migrant)

Kunal's personal experience illustrates that he went through a period of difficulty but overcame it by himself. From the communities' perspective, this is not viewed as problematic but an appropriate way to manage emotions. Often, in literature these kinds of attitudes are grouped as denial or reluctance to openly speak about 'mental health' problems which are viewed negatively or as barriers to seek help (Dogra et al., 2005). Indeed, these attitudes can be present but many participants viewed this as strength of the Gujarati communities. From a Bourdieusian perspective, the Gujarati communities are suggesting that their forms of cultural capital that make up their habitus are empirically utilised through periods of hardships to deal with these types of issues. A contributing factor to people having this attitude towards 'mental health' problems is also their strong forms of social capital and the nature of 'collectivist' communities. Many participants put forward that revealing personal issues will trouble other families and they do not want this to occur so they initially approach it by dealing with it themselves. Or alternatively it could be hidden due to stigma (Lee et al., 2009; Masuda et al., 2009) which can be an issue, if these problems are hidden and remain unresolved. Furthermore, participants outlined that the families are resourceful and will find a way to manage these issues without involving wider communities or doctors. Poonam, who is a GP and has many Gujarati patients, tells an anecdote of a family she knows.

I think on the whole the Gujarati community is very resourceful I had a family where there was a problem with the father being an alcoholic um but his wife couldn't do anything with him but they also had a liquor store you know off license so you can't stop him drinking his own stuff um so he was very ill physically because of the conditions associated with chronic alcoholism, it was a very difficult situation and yet she was helpless she really wanted to help him but she was also working in the same shop and the two boys the two sons were also working and their other family were in different parts of the UK. But then his family in India were very concerned and they sent him to India for three or four months and he was absolutely fine you know he couldn't get much liquor there he didn't need to because a lot of people had a lot of time for him, he didn't need to work in his shop he got a real break and he back and looked so much better and so much healthier but within a few months of coming back he was doing the same thing again. But the family in India are very resourceful they really love him and really care for him and not put off by the fact that he was an alcoholic because once he goes there he doesn't need to do it and so they have come to a situation where every winter September, October he goes to India to Gujarat and he comes back in March, April because the winter used to drag him down as well.

(Female, first-generation migrant)

Poonam describes characteristics of the Gujarati culture which are inherently positive in terms of managing distress. Families will find solutions that will help to mediate the situation and carry on with daily life. However, this can be problematic if individuals feel that they are doing something for their family and in turn suppress their own feelings. As Han and Pong (2015) argue in Asian cultures mental illness is often illustrated as a reflection on the family and thus individuals may choose to keep it hidden. Although, Poonam and Kunal argue that individuals will manage distress and families will be resourceful, the

underlying reasons could be engrained in their cultural capital. For example, these types of emotions should be hidden because they reflect badly on their families. This could form part of the 'clinical iceberg' or 'symptom iceberg', which refers to the notion that many symptoms are not presented to health professions but are ignored, denied or tolerated and in this case, could be due to social norms of collectivist cultures. Additionally, in Poonam's description, individuals may listen to their family due to the immediate social capital they obtain but simultaneously feel isolated as they may not talk to others outside this network due to the negative attitudes attached to 'mental health' problems (Nguyen and Anderson, 2005; Lee et al., 2009; Masuda et al., 2009; Han and Pong, 2015). Therefore, it may seem that emotional distress is being managed but it could mean that they are hidden to protect the reputation of families.

Ayurveda

Ayurveda is another facet that makes up the communities' habitus. Ayurvedic and more generally traditional Indian remedies have a longstanding position in Indian culture, which forms a health system that many participants have been raised around and have had access to throughout their lives. It is not surprising then that similar to using social capital to ensure religion has a home in Leicester, ayurveda has gone through a parallel journey. Likewise, the use of complementary and alternative medicine such as ayurveda has been increasing in the west (Bodeker, 2001; Satow et al., 2008) and the use of ayurveda was explored during interview discussions. Krause (1998) argues that this is an important conceptual framework to explore because the traditional Indian medicinal system can provide an insight into Indian ideas about ill health and treatment. The principles of ayurveda have been discussed in the literature review chapter, but it is broadly 'based in a comprehensive theoretical, diagnostic and clinical framework and has the prevention of disease as its primary emphasis' (Sharma and Clarke, 1998 cited in Bodeker, 2001, p.389). overall, participants acknowledge that many members of the Gujarati communities choose to use ayurvedic products at some point in their lives.

There were two main reasons suggested for opting to use ayurvedic treatments. Firstly, ayurvedic medicines are made from natural products and there tends to be no or very few side effects (Das, 2012). Secondly, people have tried other forms of medication, such as western practices and have either not liked the medication due to side effects or it has not worked; in which case, they seek help from ayurvedic clinics.

I was fortunate to have had the opportunity to speak to Urmila, who owns her own ayurvedic clinic in Leicester. Urmila is a very religious lady, who had a little temple in her clinic; where she lights a candle, and incense every day. She has a strong fear that in the near future, changes in law in the UK will remove non-allopathic products and this will be negative for the communities. She suggested:

They use ayurvedic products, which in there is no chemicals, there are no side effects and they are working very nicely. Takes a little bit longer but all the ayurvedic food supplements are made from the roots and branches and dried fruits and that kind of thing you know.

(Female, aged 52, first-generation migrant)

Similarly, Ramesh, who works closely with the Gujarati communities in an organisation, put forward that:

Yeah, many people do use it, around 10% of the community do. With Indian herbal it has increased now because of television adverts and in Leicester there was only one or two ayurvedic clinics but now there are so many. Sometimes it could be because the medicine you get here, with all the chemicals and all that; it has many side effects. Even with those chemicals and side effects people can get depression and all those problems.

(Male, aged 66, first-generation migrant)

As Ramesh and Urmila suggest Gujarati communities use ayurvedic due to its natural ingredients and there is a strong belief that these do not have side effects. Furthermore, this could reflect gaps in conventional western medical care and illustrates a need to understand what is meant by 'side effects' and 'chemicals' - in this case to improve therapeutic efficiency (Satow et al., 2008). Additionally, 'long-term' use was common among participants and they acknowledge that the use of ayurveda is long-standing; in some cases, a lifestyle that you adopt. This perhaps relates to the traditional premise that ayurveda was 'meant essentially to promote health, however, rather than fight disease' (Chopra and Doiphode, 2002, p.76). Interestingly, the long-term component of ayurveda did not act as a deterrent from choosing to use it and people are generally open minded when opting to use ayurveda. This is because participants expressed that ayurveda was generally not the first point of call when illnesses occurred but rather when conventional western medicine did not work or do anything to tackle the issue. For example, Bharat who is 69 and was born in Mombasa spoke about medicines and healthcare as he is the carer of his wife who has some 'mental health' issues. Bharat said:

Many people try and use ayurvedic medicines and treatments because they get fed up with trying to make appointments with their GP and then they don't give good medicines [...] It is also something we are used to, when people used to get sick you would give them turmeric and milk and they will be fine so these things we have been doing for a long time.

(Male, aged 69, first-generation migrant)

Thus, as Fenton et al (1996) argues dealing with illnesses in the Indian culture can be pluralistic and indeed my participants' experiences reflect this notion. Also, as Bharat states it is something the Gujarati communities 'have been doing for a long time'. Drawing on Bourdieu's (1986) embodied cultural capital, ayurvedic treatment is something that has been engrained in the communities' practices as they have grown up surrounded by it. Through repetitive behaviour

from childhood, ayurveda has become normalised and thus is used in day to day practices. Bourdieu (1986) argued that embodied cultural capital is formed by long-lasting interactions and are things that become part of our cultural capital through time and socialisation. Evidently, this has been the case with ayurveda and due to it being part of the Gujarati communities' embodied cultural capital; they are likely to revert to using it to manage health and illness.

Also, as Ramesh notes earlier, one of the reasons for the use of ayurveda growing in Leicester is due to the increase in it being advertised and also the increase in availability. Others suggested that people are increasingly using ayurveda through positive word of mouth. However, Ramesh puts forward that many people use it, but then 10% is the figure he states. However, all participants were aware of ayurveda and although some had not used it themselves, the majority of them knew someone who had. Therefore, as Littlewood and Lipsedge (1987) argue, despite the global hegemony of western medicine, replacing religion and legitimising itself as the mainstream route to healthcare, traditional healing practices still play a crucial role in many parts of the world. It is clear here that although Ramesh suggested 10% of Gujarati's use it, the increase in ayurvedic clinics and shops selling ayurvedic products has increased in the last decade in Leicester, illustrating its' popularity.

On the contrary, members do not specifically approach ayurvedic clinics for 'mental health' problems but are likely to speak to a homeopathic specialist if mainstream services are not suitable for their needs. Often this entails a feeling that mainstream tablets are '*heavy*' for the body or results in side effects. Interestingly, it was suggested that people tend to go to ayurvedic clinics for physical issues such as insomnia or hair loss. A symptom of depression that was explored was a lack of sleep, and that people would go to ayurvedic clinics to gain medication for insomnia. This could mean that ayurveda is used in the communities to tackle the physical symptoms caused by 'mental health' problems, but if someone has 'mental health' problems then this could go undiagnosed and untreated, if they do not approach western medical care, ayurveda clinics or address in other ways. Nevertheless, it was expressed by

many participants that by treating physical symptoms you are likely to be happier; contributing to less emotional distress. Understandably, this may be the case with acute 'mental health' problems, but if people are experiencing depression or other emotional distress that does not have physical symptoms, they risk not being treated. This could be problematic, and is an area unexplored in research; little work has been done in examining the use of traditional healing in relation to 'mental health' care (Bhui and Strathdee, 1993, Dein and Sembhi, 2001).

Yoga

An aspect linked to natural remedies and ayurveda was partaking in Yoga. overall, yoga was indeed popular with the older participants who were retired and had time, whereas working members outlined time constraints that restricted them to do yoga on a daily basis. However, there was a strong belief that yoga is very good for both your physical and 'mental health'. Many participants acknowledged that yoga is not simply a form of exercise but it cures illnesses and is beneficial to relieve you from daily stresses by clearing your mind. Jayesh came to the UK when he was only 13 and after struggling to settle down in Bristol, he moved to Leicester after three months of being in the country and has lived in Leicester since 1965. Jayesh has been doing yoga for years and discusses his opinions about yoga in relation to the Gujarati communities:

Yoga has been popular from day one, in our own generation because it is curing people, because of the exercise that you do breathing and all that. It does help and it did help me, I have been doing it and it does help you. I think it is all to do with your mind, if your minds there and it is clear, you won't have any problem but if you carry stuff on mind that this is happening to you then it will stay there, it won't go away but if you sit there and relax, you'll see it within ten or fifteen minutes you are relaxed and you will be free. I never used to believe all of this but I started to and it does help you

especially when you are going through depression, just think about something good and not bad.

(Male, aged 63, first-generation migrant)

Jayesh explores the positive benefits of doing yoga and how it helps to clear the mind. This also suggests that 'mental health' problems are viewed as issues and stresses carried by the mind that can be alleviated by '*relaxing*' and '*clearing out the mind*'. These understandings of 'mental health' have been discussed in chapter five. Largely, participants expressed a positive attitude towards yoga and it is significant for a healthy lifestyle, both physically and mentally.

Additionally, another positive aspect of yoga was that it enables people to socialise with others as there are many yoga clubs and events in Leicester. Bourdieu (1986) offered a rich conceptual framework regarding social capital and power which is significant here. Yoga was also another way in which the communities could increase and thus benefit from strong forms of social capital. This is because yoga provides a space for people to come together, socialise and integrate through a common activity. This reduces triggers that cause 'mental health' problems: loneliness and segregation to name a couple, which the communities outline. During my visits to temples and community halls, I saw many posters and leaflets regarding yoga events. Although, the uptake of these events is questionable and some are more popular than others it is widely available to the communities. Again, they expressed busy lifestyles and work as reasons for not having the time to go to these classes. However, the elderly who have retired showed more interest in yoga and consequently, yoga is perceived positively and a way to help and manage 'mental health' issues. Although these classes were not always the route people chose to partake in yoga; it was indeed a popular activity in established community services that are provided around Leicester and this will be explored below.

Community help and services

In the last decade, Leicester has seen an increase in different services available for the communities. These include lunch clubs for the elderly, Savera,

Crossroads care, Adhar project, and Relate Leicestershire. overall, these services are viewed positively by community members and they emphasised that they are beneficial for health. Some of these services have been created by community members for the communities. Many people have used sources of social capital to gain funding from the government to increase their economic means for these services to be made available (explored in chapter four).

However, there were issues around knowledge, access (as in many cases you have to be referred), cost and stigma associated to care centres and homes. Mahendra is a manager at a day care centre in Leicester and works closely with many members of the Gujarati communities. Although the centre is not specifically catered for the Gujarati community, more than 80% of its users are Gujarati. The centre is vibrant, full of Indian culture such as having a temple, serving Indian food and also all the care staff are of Indian origin. This was interesting to witness because the centre deems that its' success is due to maintaining Indian culture and this contributes to a 'community feel'. Once again, Bourdieu's (1985) social and cultural capitals are apparent in reinforcing social cohesion which reduces loneliness and thus emotional distress. Mahendra explores these elements in conversation:

In Leicester, you see day centres but our people didn't want to leave the house and they didn't know about it. There are still people who don't know what day centres are they have no awareness and they are scared to leave the house but if they come here and speak to other people and socialise it would make such a big difference. Loads have people have benefitted from coming here; if you have activities and things then it keeps you busy [...] If we talk about India, in the evenings when they used to sit outside as everything is open it would make people feel happy and they would feel satisfied. They could share things with other people and talk to people and it would help.

(Male, aged 60, first-generation migrant)

Ketan who also works at a different centre said:

I have noticed one thing that people who come to these centres they feel very happy for staying here and somehow you feel like they are regaining their confidence, they talk to various people and the staff try and make them really happy by cracking jokes, talk about past things like when we were in India these kind of things because they probably enjoy it listening to it and if you notice around 12 o'clock there is an exercise session down here and this is followed by some sort of bingo games and other activities which keeps their mind occupied and during this period they probably won't think anything negative of their own problems.

(Male, aged 62, first-generation migrant)

Although participants express positivity about care centres and how they are beneficial for the communities in terms of reducing loneliness and maintaining happiness; there seems to be issues with awareness and the uptake of these services. Mahendra emphasises that people have no awareness of care centres but even when they do, people are scared to leave the house. This could suggest that while services are being provided for the communities that would help their 'mental health', people are choosing not to use them. This could relate to stigma being attached to receiving care in this manner. Moreover, both Mahendra and Ketan discuss the importance of India and how this would bring happiness to the communities. This suggests that there is an attachment to India and the communities do not want to lose that. Traditionally in Indian villages, home doors were kept open and people sat outside and socialised with their neighbours and village communities. Participants reflect that they preferred the 'openness' of living in India and these centres to some extent allow for that type of communication to take place, reinforcing their habitus. Thus, to mitigate changes faced in the UK, these centres recreate the community spirit which serves as a way to restore normality. Indeed, the people who use these services expressed gratitude for them and in particular retired people; it allows them to socialise, remain integrated in the

communities and keep occupied. Participants outlined that these features are crucial for maintaining good 'mental health' because it reduces loneliness and disintegration— two factors that participants put forward that contribute to poor 'mental health' which has been supported by findings from Dogra et al. (2005).

Additionally, in terms of the community organisations contributing to the management of 'mental health' is questionable. Earlier, it was outlined that Leicester houses many Gujarati organisations which offer spaces such as community halls, for religious and other events to occur and provide for the communities in different ways. As this was one of the routes I used to gain access to participants for this study, I was able to interview a number of committee members from different organisations. Many of these participants put forward that the community organisations itself provide and support 'mental health' management through organising health seminars. This is usually an open event where anyone can come and get advice on health issues from community doctors and ayurvedic clinicians. However, during my visits to these community centres and temples, I found that indeed there were many leaflets and posters addressing health issues such as diabetes and obesity but nothing on 'mental health'. I thought it would be interesting to go and observe one of the health seminars that took place. There were many discussions on diet and yoga but nothing on 'mental health'.

Bourdieu (1985) acknowledged how in some ways social capital can be negative because some people may feel like they have a 'social obligation' to act a certain way, which appropriates the doxa for that community. Due to these, participants that were actively representing their organisations and thus were fulfilling their 'social obligations'. It may have well been the case that they wanted to portray a certain positive image of their organisation in my presence. This is problematic because on the surface it will appear as though 'mental health' is being managed in the communities, but this may not be the case and there could be real problems for people in the communities. Additionally, it is well documented in literature that the Gujarati communities that reside in

Leicester are close-knit and well-integrated (Bachu, 1985; Patel and Shaw, 2008). It may be the case that in terms of location, the Gujarati communities do cluster in certain areas in Leicester, but the upkeep of this positive portrayal may be hindering the management of issues in the communities such as 'mental health' because they will not want to jeopardize their 'image'. As a result, it may be the case that the committee members of these organisations and others will speak highly of their organisations due to a 'social obligation'. Therefore, as explored above, the communities have used forms of economic, social and cultural capital to settle and reside in Leicester, which has allowed for their habitus to continue in a new environment. Arguably, the communities may have been able to manage 'mental health' issues. However, the same strengths identified may cause barriers in terms of 'social obligations' to seek help and thus, 'mental health' problems may be a hidden issue. These factors will be considered below.

Part Two: Factors that influence access to 'mental health' care/ Barriers to help-seeking

Help-seeking behaviours among ethnic communities are not a new phenomenon when observing 'mental health' and ethnicity (e.g. Hussain and Cochrane, 2004; Han et al., 2015). 'Mental health' is commonly overlooked in Asian communities and cultural barriers have been highlighted as the most domineering contributing factor (Lee et al., 2009; Han et al., 2015). However, to aid policy intervention these must be untangled and understood to avoid making cultural stereotypes. Although it is well documented that cultural barriers have been utilised to explain the current low reported rates of mental illness among the Asian communities, this area is much more complex. This study found that in some cases the communities' cultural capital influenced access to healthcare but on the other hand some aspects only influenced 'openness' in terms of keeping it hidden from wider community members. Furthermore, the communities recognise that 'mental health' services are confidential and would go and seek help (if they felt it needed medical attention) but the concern was to keep this hidden from the communities.

Therefore, help-seeking patterns are multifaceted and influenced by the range of factors and these will be explored below. There were four main categories that affected access to 'mental health' care and thus this part will be split into four sections: Religion, GP interaction, communities' reactions and cultural norms.

Religion

Karma and help-seeking

Although many positive aspects of religion in relation to 'mental health' were revealed during the interviews, this was also full of contradictions. Many participants did view being religious and being involved in religious practices as a positive thing but there were many areas that were to some extent negative or perhaps misunderstood. Earlier I explored how the belief in 'karma' was viewed in a way which enhanced health because as Urmila described, it allowed people to live in a way which was '*honest*' and in return they would experience good health. Rashmi also shared how believing in 'Karma' allows for people to get on with their life when they are suffering. However, the other aspect of 'Karma' is that its' premise could be used to justify illness and thus lack help-seeking. For instance, Juthani (2001) argues that the interrelationship between the laws of karma, destiny and God's will is often held accountable for ill health by Hindu Indians. However, there is a consensus among my participants the thought that God had destined people to go through certain struggles, pain and worries is old fashioned and it is a diminishing view, whereas Anand et al. (2005) found that this opinion was common among South Asian women. Furthermore, Riya puts forward that only a few people believe in this and it was more common with the older members of the community.

Overall, this explanation of illness is viewed negatively because participants suggested that it could mean that people do not get help and their health will continue to deteriorate. For example, older members of the communities such as Miland, who have several illnesses, believe that they are coming to the end of their life, and thus have a view that it is not beneficial to seek medical

assistance and praying as an alternative is more comforting. Participants also made clear the regular devotees are more likely to believe in God's will. Although it is viewed as a coping strategy for the individual and it can be helpful, others such as family members and friends may find this attitude difficult to deal with. Additionally, Marshall and Yazdani (2000) found that amongst South Asian women self-harm was a coping strategy for managing emotional distress. Although this is very different to praying as a coping strategy, it needs to be noted that although these avenues are used as coping strategies it does not mean that 'mental health' problems are not managed. In literature, it is assumed or perceived that help-seeking barriers are negative and may mean issues remain unresolved. Although the Gujarati communities may potentially hold this attitude and not seek help through western services, they may go to the mandir as previously discussed and be helped through this route or view it as a personal problem as explored above. The multifaceted nature of factors that influence conceptualisations and attitudes to help-seeking behaviours dictates the complexity of indicatively knowing if 'mental health' is managed within the communities and it is only problematic if 'mental health' issues are left unaddressed. This finding of pluralistic nature of help-seeking behaviour among Asian communities is not a new finding and has been well documented (Dalal, 2000; Greenwood et al., 2000; Hilton et al., 2001; Hussain and Cochrane, 2004).

Supernatural explanations

In addition to using religion to explain causes of 'mental health' problems, supernatural explanations are used and very closely interlinked. It was argued in chapter five, that an understanding of 'mental health' in the Gujarati communities is because of supernatural causes. Bhugra and Bhal (1999) argue another explanation that can be given to 'mental health' is supernatural. Nguyen and Anderson (2005) found that Asians believe in supernatural explanations of 'mental health' in that a person affected is possessed by a demon or a spirit. This can contribute to the stigmatized nature Asian cultures

associate with 'mental health' (Ngyuen et al., 2005; Lee et al., 2009; Masuda et al., 2009;). This affects the nature of help-seeking behaviours.

There was consensus that the opinion of 'supernatural causes' or God has destined people to experience certain struggles is deteriorating with the communities and this may only be a barrier with the elder communities. The interesting component of this is to explore why help-seeking is pluralistic rather than barriers to western health services. This is where previous literature has been limiting and has suggested that because Asian communities tend to believe in supernatural causes; it correlates to a barrier in help-seeking from western services; of course, in some cases it does. However, my data shows us that this is naïve and an area that needs further exploration. Evidently, these generalisations and cultural stereotypes have previously been identified, but the data suggests that the relationship between help-seeking and supernatural explanations is much more complex than this. By no means am I dismissing previous studies that have found this as a help-seeking barrier, but highlighting the contradictory influential factors in help-seeking exemplifies an area that needs much more in depth focus in research.

Undeniably, some members of the Gujarati communities do have these attitudes and they are likely to visit traditional healers rather than western services for two proposed reasons. Firstly, they don't perceive the cause to be medical and secondly, traditional healers are viewed as part of the communities, and the similarity in cultural belonging aids comfort in discussing such issues; also found by Malik (1998). Indian health beliefs accommodate for their cultural needs as they have been described to be holistic, incorporating physical, psychological and social factors and the supernatural (Dalal, 2000) which include spiritual healing, discussions with religious leaders and ayurvedic treatment. From a Bourdieusian perspective, this can be explained in terms of cultural capital and their habitus. These beliefs of supernatural causes are culturally located and passed on through generations. Therefore, their cultural capital is shaping the way some people think and thus the likelihood of visiting traditional healers is due to their habitus. If this type of healthcare is one that

people have been exposed to from birth, it becomes 'normal' and 'natural' as explored earlier to seek help through these systems when health issues arise.

However, as mentioned above, participants suggest that in some cases religion and supernatural causes can be used as a temporary coping strategy. People tend to question 'Kismet' and 'God's wishes' to get them through the initial feelings they are experiencing, and thus help-seeking to western services is only impacted momentarily. Thus, this will affect help-seeking statistics but the nature of believing in supernatural causes is multifaceted. Therefore, there are many reasons contributing to the low representation in statistics, which are interrelated. Although, there may be issues with somatic expression on behalf of the communities, limitations to seek help from western services was more to do with their opinions of the service rather than 'cultural barriers' such as difficulties in getting GP appointments, an assumption that doctors will only give you paracetamol and negative opinions associated with antidepressants. These factors will be explored below. Cultural barriers such as stigma and gossip was much more connected to communities' reactions and thus 'mental health' problems were less likely to be discussed with extended family, community organisations and wider communities. In fact, there was a belief that going to the GP would not have an impact on this or interfere with the communities knowing as these services are confidential and the communities are aware of this. Of course, for some people due to 'fear' or reluctance to discuss 'mental health' in the communities; they would not openly talk about their problems or discuss 'mental health' and thus would not seek help altogether. Conversely, these issues have traditionally been integrated and discussed as contributing to help-seeking behaviours but data suggesting it is relational or correlational can misrepresent the multidimensional impact culture and traditions have in shaping attitudes towards 'mental health' and thus, help-seeking behaviour.

GP

This next section will explore the communities' attitudes towards GP practices, experiences of their interaction with GP's and opinions of western medication. This was closely linked to their attitudes towards seeking help, and this will be

explored in relation to whether 'mental health' is being managed in the communities. Wilson and McCarthy (1994) argue that a plausible explanation for the low reported rates of mental illness amongst the Gujarati communities could be that members are not visiting GP's, or GP's could be failing to detect mental illness. This study found that the first trend to be significant and overall, the majority of participants had negative opinions towards GP services.

Language, somatic expression and interaction with GP's

Literature suggests two points regarding interaction with GP's, one where members of the South Asian community use somatic expression and thus, GP's may not be able to recognise mental illnesses and the second is language barriers when patients interact with doctors (Kleinman, 1986). An aspect explored during the interviews was whether there were any language barriers present among the communities which deterred people visiting GP practices, possibilities of GP's failing to detect mental illness and whether language was viewed as being a problem. Participants suggested that language was important and they preferred having an Asian doctor as they could speak a variety of languages which came more naturally to them than English such as Hindi, Punjabi or Gujarati. For instance, Ramesh who spoke to me in Gujarati said:

Everyone has language problems and people don't know about all these health problems and names of diseases as they require large amount of knowledge and education so it is easier to speak in our language to express what is wrong with us. So, either they speak Gujarati or Hindi or Punjabi or Urdu.

(Male, aged 66, first-generation migrant)

Interestingly, Ramesh explains that although there are language preferences it is in fact linked to not having the knowledge about 'health problems and names of diseases' and thus they prefer to explain their symptoms in another language that comes much more naturally to them. Not being aware of diseases is linked to understanding and attitudes of 'mental health' which has been explored in chapter five. However, it is useful to reiterate there is not a binary relationship

between the two factors: language and help-seeking barriers. Although, the communities' express preferences in discussing their illnesses in a language that came naturally to them; services allowed them to do so. Most of the participants who had a preference in language or could speak no English at all, had Asian GP's and this was not a deterrent to seek help. However, complexity arises in interaction as the communities suggest that their awareness of terminology around 'mental health' or knowing names of mental illnesses is limited. This could be contributing factor as to why it has been continuously argued that the South Asian community express illnesses somatically (Hussain and Cochrane, 2004).

I also interviewed a few Gujarati doctors and gained information regarding their experiences with working and providing for the Gujarati communities. Pratik, who migrated to Leicester in 1974, opened his practice instantly and served the population all his working life stated that there are still a few medical problems that the communities face with 'mental health'. He suggested:

'Mental health' is one where the taboo is there from a long time umm and I think one thing you find is that when depression or anxiety occurs in an Asian family they don't come to the general medical practitioner and say I feel depressed. They come with 100 other problems which have got bearing on physical illness and then you find out after a lot of enquiry that that person is depressed or otherwise. And I think because of the stigma attached to even today someone says so and so is depressed they don't accept it.

He also said:

Yes, because as you see if a white patient is depressed they will sit down and say doctor I am feeling depressed. You hardly find a Gujarati patient coming to the GP and sits down and says doctor I am feeling depressed. He will come with so many somatic symptoms that the GP also feels dizzy (laughs). By the time you have heard all that you know, so umm a doctor or a psychiatrist qualified within

this sort of situation might not be able to understand our culture as to how we come out with depression You know our symptoms are completely different umm an English girl would probably come and say you know I'm not having no sexual joy yeah with my partner you will hardly find a Gujarati even a married girl, a married woman coming and saying that you know I feel low because of this yeah. It is until you probe and probe.

(Male, first-generation migrant)

Pratik discusses issues regarding somatic expression and stigma attached to mental illness in the communities. Therefore, Furnham and Malik's (1994) argument that perceptions about mental illness and perceptions of how to respond to it are related to culture is seemingly apparent in this study. The cultural and communities' attitudes towards mental illness are shaping the beliefs around the phenomenon and consequently how it is dealt with. This illustrates complexity in language, translation and how meanings can be misinterpreted; which is complex.

GP appointments

A barrier to help-seeking which is not rooted from cultural practices and beliefs is the general negative perception surrounding GP appointments. Participants expressed that a reason why they are unlikely to go to see their GP is because of the difficulty in getting an appointment. Many conveyed an attitude that they would only approach a doctor if it was necessary and this also contributed to the usage of alternative medication; be it ayurveda, home remedies or going to India to get treatment.

Mahesh said:

The GPs, the surgeries, it's better not to go there because the receptionist itself is better than a doctor says no no that's alright you don't need an appointment just take paracetamol this that and chucks you out from there. even myself when I go to see the GP I have to tell him many times, say I can reach God better than reach

you, it's that difficult to come and see you, I can't come and get an appointment to come and see you.

(Male, aged 67, first-generation migrant)

Therefore, a potential barrier to help-seeking may be the institution itself and the current appointment system that is in place is not favoured by the Gujarati communities. It may be the case then that people who are suffering from 'mental health' problems may not be seeking help because of the sheer difficulties in trying to get an appointment.

Western tablets are 'heavy' – side effects, negative opinion towards depression

Furthermore, as explored earlier, people were likely to use ayurvedic treatment because the medicine given was made from natural ingredients.

Rashmi said:

They don't know how it's going to be treated because sometimes the doctors will just prescribe some sort of medicine which they will not be able to come out or they get the habit of having it they will not be able to stop taking it as it is heavy and addictive some people are afraid to take any medication for that reason so they will not go to the doctors because all they say is that if you go to the doctors he's just going to write down a prescription and let you get on with it because doctors don't have a lot of time to spend with the patient.

(Female, aged 53, first-generation migrant)

There was a strong view that although you had to use these long-term, there were few or no side effects caused by using them. The first-generation migrants had a perception that people are unlikely to go to the GP because all they will do is put you on medication and give you tablets that are 'heavy'. In this circumstance, participants suggest that heavy connotes several things: interrupts with digestion, feels heavy on the stomach, increased side effects

such as nausea, headaches etc. and an increase risk of other problems occurring. Also, there is an attitude that western medication is addictive, so they solve the symptoms and problems whilst you are taking the tablets but when you decide to stop taking them, the problems will appear again and they don't want to be restricted to taking tablets for long periods of time. However, people use ayurveda as there is a belief that it aids a 'healthy lifestyle' rather than simply eradicating symptoms of illnesses.

Communities' reactions

The above section discussed institutional barriers to help-seeking which the communities expressed as being significant in terms of going to see their GP's. This section will discuss often what is termed in literature as 'cultural barriers' to help-seeking. Furthermore, this entails cultural dispositions which restrict people from discussing and seeking help. These include religious explanations, stigma and cultural norms. Having already discussed religion, which arguably can deter and shape help-seeking patterns, I will focus on communities' reactions which are shaped or driven by cultural expectations.

Overall, there are cultural barriers that limit the communities from discussing 'mental health' because of communities' reactions such as stigma, gossip, out of the cultural norms and family reputation. It is important to highlight that previous literature views these as possibilities for barriers to help-seeking from western services and in some cases, this may occur. However, participants clearly identified that they are aware that GP services are confidential and they can use these services without the communities finding out. The barrier that was more predominant among the communities was in fact keeping 'mental health' issues from the wider communities because of their reactions to disclosure. Although there are barriers to help-seeking these were more in relation to attitudes towards GP services (previously explored above) and that in Gujarati culture, these issues should be hidden, people do not talk about them. Yet, in many cases this does not hinder individuals to go and seek help, because they know western services are confidential but it does contribute to

people not admitting their 'mental health' problems. Therefore, in some respects it can deter help-seeking but again, it highlights that this domain is multifaceted.

Furthermore, this cultural trait of emotions not being discussed means that an attitude is created where emotional distress is denied. The key barrier is that this kind of cultural up keeping may be prioritised in individuals' life which results in people not being able to recognise that the emotional distress which they may be experiencing can be treated. Here, in terms of cultural and social capital, participants suggested that in some cases people would act a certain way because they felt they had a 'social obligation' or a 'cultural duty' to do so and this is the power that social and cultural capital has on an individual. This view is contradictory among the community members. Some people see this as a positive aspect because it means individuals have resilience and can deal and cope with 'mental health' issues themselves because Gujarati's have always done it that way, and it means the harmonious display of the communities continues. Participants revealed how 'mental health' is also detrimental to people's wellbeing. If the communities have used social and cultural capital to remain together then these networks should be able to help in times of need. However, the hierarchy of prioritised aspects of culture means that rather than showing or disrupting the perceived happy community culture and structure, people feel like they are forced to keep it hidden because no one wants to know about their personal life, and the communities' reactions add to this.

Additionally, this can be explored by using a Bourdieusian perspective. The Gujarati communities have distinctive cultural traits and 'doxa' which are unspoken rules of ways to behave in various situations. Some clear traits that were explored during interviews were people don't tend to talk about emotions, they are proud of presenting the communities as harmonious and integrated, and emotions are viewed as a personal issue which should not be discussed in a community environment. These 'unspoken rules' or ways of being make up people's habitus and the Gujarati communities tend to follow these without thinking about it as it becomes normality. Not only does one's

habitus add to this but in the case of the Gujarati communities the perceived 'togetherness' through strong forms of social capital signify the needs to behave in a certain way. This section will discuss some of the negatives of having strong forms of social capital in the sense of communities' reactions. These reactions are also rooted in culture which will be explored below and I will argue that there is a strong relationship between one's habitus and forms of capital. However, strong forms of social capital which can signify one's cultural capital and thus their habitus can have detrimental influences. This is due to feeling like one has a social obligation to behave a certain way. In terms of 'mental health', these may not always be helpful for management and these will be explored below.

Gossip

An issue that was revealed during interviews was gossip. Participants put forward that a trait of Gujarati culture was a tendency to talk about things that people have found out about other people. This perhaps could be rooted to the history of India, where villages had no other means of entertainment such as technology nowadays – television, internet etc. Thus, the open nature of villages resulted to people talking to each other and in many occasions, discussions would revolve around occurrences in the villages and people. However, many participants have suggested that due to strong forms of social capital, this trait has been able to continue due to the large cohesive communities. Therefore, a known trait that continues in the Gujarati communities is if people find out what is going on in certain families, news will spread and people will talk. This notion of gossip acts as a deterrent to let people know about 'mental health' problems because the matter will spread which will make the situation worse.

For instance, kamlesh stated:

Its gossip like this has happened to this person let me go and tell this person what is happening, and messages keep getting passed

around so instead of getting better the whole situation gets worse, then the village people will all start talking.

(Male, aged 66, first-generation migrant)

Ramila said:

In our community that's another issue that if I tell you something and if it's not confidential you will go and tell that third person and then that third person will go and tell the fourth person and then it goes around and that's another issue why people don't why people keep it to themselves, they don't talk because they know that if I tell somebody they'll go and tell somebody else and somebody else somebody else and it will go around to ten people with different stories not the same story so that's a big issue really in our community.

(Female, aged 58, first-generation migrant)

As Kamlesh and Ramila both illustrate that people may not speak to the communities about 'mental health' problems due to people gossiping and instead of helping, people are worried that issues will get passed on from one to another with wrong information. A component that is linked to this is that people are worried about what others will think of them. This is because it reflects negatively on the family as found by Han and Pong (2015) and there is stigma associated with 'mental health' problems (Nguyen and Anderson, 2005; Masuda et al., 2009; Lee et al., 2015).

Stigma

Although it is documented that the Gujarati communities are affluent, well-educated and prosperous, there is stigma associated to 'mental health' in terms of negative connotations. This is not a new phenomenon and it is widely known that 'mental health' is stigmatised in Asian cultures (Nguyen and Anderson, 2005; Lee et al., 2009; Masuda et al., 2009). Prior to 'mental health' being medicalised, it used to be perceived as a cultural phenomenon and labelled as

"mad" or "crazy". Participants have suggested that in many cases these associations are still lived realities in the Gujarati communities.

For instance, Mahendra epitomizes this reflection:

Particularly our Asian people thought that people were crazy but after I came here I have attended different courses on mental illness so I know what 'mental health' is but our community's awareness of what 'mental health' is, so people just think they crazy, but in 'mental health' there are various different things and our community don't know about them. Because of this they are not able to get treatment quickly.

(Male, aged 60, first-generation migrant)

Mahendra demonstrates that a reason for having this reaction is due to the lack of knowledge or awareness. These attitudes and understandings underpin the nature of stigma associated with 'mental health' and thus social capital is not utilised positively. Rather, the strong nature of social capital and the collective attitude of stigma hinders the possibility of 'mental health' being addressed in the communities. Alka draws on a strong feeling people may experience who are undergoing periods of emotional distress. She said:

Because they're scared, they're scared of people saying you are pagal (mad) that's how they are; if you share things they will say things like that to you.

(Female, aged 43, first-generation migrant)

It has been made apparent the Gujarati communities have utilised their networks to develop institutions and remain close-knit, with a strong focus on religion. However, the same collectiveness may be contributing to people not wanting to discuss 'mental health' with other community members. For instance, due to holding on to stigmatised opinions, the communities do not share 'mental health' problems with other members and as Alka put forward

they remain 'scared'. Overall, this could influence help-seeking as it could cause fear about discussing issues and thus may be kept quiet and hidden.

Cultural norms

Gujarati culture has its own doxas and these expectations influence the way in which individuals deal and respond to certain issues.

Hidden issues

Many participants suggested that 'mental health' was an area that was just kept hidden and people don't often discuss these. This is because of stigma and gossip which were discussed above but also because it is known that these are private troubles rather than public issues. For instance, Ramila said:

Often in our Gujarati community people don't often talk about things like this even if they have got a drug addict in the house or if people are drinking alcohol or if there's domestic violence or if there's abuse anything our Gujarati community never come out with it and that's everybody, everybody knows that.

(Female, aged 58, first-generation migrant)

Stigma and gossip aside, Ramila illustrates that a trait of Gujarati culture is that traditionally certain issues were not discussed in a community setting. Although stigma, gossip and other attitudes contribute to this 'norm' being passed down generations it is has become engrained in their habitus and thus if this continues, these issues will not be discussed in future generations. This can be problematic because individuals are socialised with the attitude that issues such as drug addiction, alcohol abuse, domestic violence or other 'mental health' problems should be kept hidden and thus these issues can be left unaddressed.

Family reputation

Throughout this chapter it has been exemplified that the Gujarati communities thrive off close social networks and thus their culture is collectivist in nature.

As Han and Pong (2015) found 'in Asian cultures mental illness often is not considered as an individual problem. Rather mental illness potentially represents a negative reflection on the immediate family as well as their ancestors' (p.2). This was mirrored in this study and participants suggested they did not want the communities to know because of the negative attitude that they will have. Sarla reflected these negative opinions:

I think communities are not helping there either, if I have got a problem the community need to have somebody they can talk to and have nothing to worry about, these things are just a natural thing but communities not doing that they would say oh look at her look at that and gossiping, worried about people talking people gossiping, people giving bad names to family, so why would people tell others then? It's shameful; we do anything to protect our family, all Gujarati's, we all know that.

(Female, first-generation migrant)

Therefore, as Sarla suggests, a cultural norm in Gujarati culture is to protect the family's reputation. More commonly, literature has denoted this as 'family honour' and this is reflected among participants. It is an important part of 'Gujarati culture' and Sarla suggests that it is common knowledge, everyone will know how to behave: '*we all know that*', reflects the universality of the norm. This shows the habitus influences behaviour towards 'mental health', and cultural influences provide an understanding of 'mental health' management. In this case, many Gujarati's may opt to not discuss problems which they may face with regards to 'mental health' with their family or to other community members due to family reputation and thus it may continue to not be managed.

Summary of chapter

This chapter has highlighted that it is difficult to indicatively put forward if 'mental health' is being managed within the Gujarati communities' due to the range of factors that influence management and help-seeking. The first section highlighted that the communities indeed have various elements that aid

'mental health' management. As it was explored, these may not be applicable to everyone. For example, believing in God's will was only applied to the elderly, whom are the population likely to visit temples and see religious figures. However, it also demonstrates limitation in mental health management. For instance, religious views, may mean that help is not sought or may be managed through religion. The second part, explored a range of barriers of discussing 'mental health' within the communities which could act as a deterrent for some people seeking help. However, on the whole participants stated that they acknowledge GP services are confidential and inherently does not associate emotional distress as issues that require medical attention. Additionally, communities' reactions and cultural capital can inherently influence the ways in which people respond to emotional distress and whether it is managed or unmanaged.

Chapter Eight: Concluding the Research Journey

I have always found conclusions difficult – among other things, simply because even when you ‘open a new chapter’ in life, it does not mean that you forget what has happened leading up to that moment. This research project is no exception. The beginning of the end was marked by numerous hours of staring at a computer screen and thankfully, lots of tea breaks in between. I would like to recall one discussion with my fellow PhD colleague, and dearest friend Elena Genova. As both of our writing was well under way, we would often take breaks together. Although we promised not to talk about our theses, the conversation always made its’ way back there. Elena was experiencing some difficulties analysing her data, which she summarised in the following way: “I am living my PhD, I am so immersed in the topic I am researching, it’s almost like I am analysing myself”. We started untangling what this all meant – what it meant not only for the research but also for her emotions and how this contributed to data generation. My advice to Elena was simple: “it is important to capture because it is so telling, of not only the way you will analyse your data but the way in which it has influenced you hearing the stories of your participants”. Although the conversation was brief and swiftly moved on to other things such as holidays, cinema dates and of course when our next tea break was; the statement never left me. There was something fascinating about it and you know me by now – beyond inquisitive and, above all, curious. I thought about it for days, even weeks after and more importantly I still do. This is because every experience I go through influences not only ‘who I am’ but also the lens through which I view the world. With regards to my research, I was, too, ‘living my PhD’ and although I have always acknowledged my role in co-producing data with my participants, it does not just stop there. This has been a ‘journey’, an academic one but also a personal one and every experience over the last four years has contributed towards the way in which this thesis has been presented. Crucially, the experiences will continue and as Mitch Albom said in his novel ‘The

five people you meet in heaven': "All endings are also beginnings. We just don't know it at the time".

Throughout this thesis, I have discussed the 'complexity' in the understandings, attitudes, experiences, and management of 'mental health', which stems from how multifaceted social life and culture is. Therefore, this chapter is no different and I start from this premise because I am 'concluding a journey'; one that is multifaceted too. The conclusions I offer in this chapter are from the Gujarati communities that reside in Leicester, interviewed at a particular time with me co-producing the data. These conclusions are indeed subject to change as is life and imperative to this thesis, policy recommendations and future research. Thus, this chapter will provide 'conclusions of the research journey' and rather than offering definitive answers, which is an impossible task, it will illustrate the key findings by revisiting the research questions. Alongside summarising the key points found in this thesis, I will provide an overview of the ways in which this research makes an original contribution to knowledge, nuanced implications for future research and policy recommendations. Lastly, I will offer reflections upon the study journey by drawing on my experience as a cultural insider and as a researcher. To do so, I will focus on both the professional and personal implications of this journey.

Revisiting the research questions

'Concluding a journey' can only be given a degree of justice if a summary is provided of why it initially occurred. Therefore, it is imperative to reflect upon and discuss the research questions this thesis has addressed through a combination of empirical data, analysis, and theory.

The overarching purpose of this thesis was to explore the ways in which 'mental health' is understood, conceptualised and experienced within the Gujarati communities in Leicester. This was primarily for two reasons: firstly, to explore the role of culture in shaping 'mental health' experience and management. Secondly, mental illness prevalence has been reported to be low among these communities but literature would suggest that migration causes an increased

risk of 'mental health' problems (Cochrane et al., 1977; Cochrane, 1983; Kuo et al., 1986; Beiser et al., 1993; Nevo et al., 2006). To explore these areas, there were four key open-ended, questions this thesis focused on. These are reiterated below:

- 1) In what ways do Gujarati communities understand and conceptualise 'mental health'?
- 2) How has culture influenced perceived experiences of 'mental health' problems within the Gujarati communities?
- 3) In what ways do the Gujarati communities manage 'mental health' problems?
- 4) what role do help-seeking barriers (cultural, social, institutional and linguistic) and alternative coping strategies (traditional healing) have in managing 'mental health' problems?

Although, this is an over-simplification of the layout of this thesis, each analytical chapter addressed a particular question. Chapter 5 addressed the perceptions and conceptualisations of 'mental health'. Chapter 6 largely addressed how culture may influence the perceived experiences of 'mental health' problems, mainly focusing on acculturation, whilst chapter 7 addressed both question 3 and 4, and focused on barriers to seek help and coping strategies for 'mental health' management.

However, it should be noted that there was not a firm delineation between the three questions. The data has illustrated that the exploration of each question does not fit into rigid or firm categories. To help untangle these complexities of interrelatedness, another underlying question that has been explored to bring together the four questions, and was introduced in chapter four was:

- In what ways does social and cultural capital influence how 'mental health' is conceptualised, experienced and managed in the Gujarati communities?

All three analytical chapters overlapped, intertwined and most importantly – they were interdependent on one another to provide nuanced, thorough and meaningful considerations of the area. As mentioned in the Introduction of this thesis, it is largely due to the fact culture is and has been the central component to this project.

Culture serves as the web that structures human thought, emotion and interaction [...] within the multicultural mosaic; cultures shape the conceptions of and responses to mental illness (Guarnaccia and Rodriguez, 1996, p.437)

As Guarnaccia and Rodriguez (1996) argue, culture serves as the ‘web’ and in this thesis, it has done precisely that in relation to ‘mental health’. Additionally, through the data, it has been demonstrated that culture does considerably more than shape social practices and beliefs: in relation to ‘mental health’, it shapes the conceptions of and responses to ‘mental health’ problems. Furthermore, to remind the reader, this thesis utilised Hall’s (1997) definition of culture: ‘culture... is involved in all those practices... which carry meaning and value for us... the ways we classify and conceptualise them, the values we place on them’ (p.3). Critically, because the emphasis was to focus on the importance the Gujarati communities put on their values, beliefs, expectations, norms and cultural practices. In describing the complex nature of culture, in relation to ‘mental health’, including the way it is understood, experienced and managed, Bourdieu’s (1986) forms of capital were used as a theoretical framework to conceptualise the revelations of the discussions with the participants of this study. Correspondingly, I will now address each question in turn by providing a brief summary of the key findings. As an alternative of providing an in-depth analysis of the key points, the focus of this section is placed on the interrelatedness of the research questions and the topic as a whole.

Broadly, there were three definitive areas that underpinned the communities’ understanding of ‘mental health’. These were depression, usage of language and religion. Additionally, using these separate categories to formulate the

communities' understanding of 'mental health', they suggested themselves that they have a limited understanding to what it means. Overall, it was demonstrated that these understandings are intrinsically linked to the communities' social and cultural capital. This also plays a crucial role in attitudes towards 'mental health'. These attitudes included 'mental health' being a phenomenon that is not openly discussed, is perceived as a personal problem or denied and people who have a mental illness are 'othered'. The link between understandings of and attitudes towards 'mental health' is of particular interest. This is because, understandings and attitudes are reliant upon one another - understandings of a concept influence the attitudes towards the same concept whilst this also in return influences understandings at the same time; the relationship is undeniably, intertwined. For example, first-generation migrants acknowledged that they have a limited knowledge of mental illness and language was a key factor.

There is no word for depression in Gujarati, and many first-generation participants had heard about it post-migration. Limited words relating to 'mental health' in people's everyday language in Gujarati may not only affect knowledge but also influence using words such as 'mad', 'crazy' and 'slow'. The use of this type of language can result in 'mental health' being stigmatized, not being openly discussed in the communities, resulting in denial. Many studies have previously discussed the issue of stigma being attached to 'mental health' (Corrigan et al., 2001; Gilbert et al., 2004; Lauber et al., 2007). As Sussman (1997) highlighted, all societies have struggled with the impact of mental illness, and rejection of mentally disabled people are common. This research has found that these attitudes have been sustained in Leicester post-migration which could be due to strong forms of social capital, that has enhanced cultural values to remain significant. Using Bourdieu's (1986) forms of capital, it has been illustrated that these understandings form part of individuals' embodied cultural capital. Consequently, through long-lasting dispositions these understandings become 'normality' and are not easy to change as they make up individuals' habitus.

Additionally, if 'mental health' problems are conceptualised in such a way that causes them to be stigmatized, it will affect how they are managed. As a result, participants suggested that issues relating to 'mental health' are not openly discussed, but are denied. Other studies have also found denial to be a strong element of coping and responding to mental illnesses among Asian communities (Thara et al., 1998; Kumar et al., 2010). However, these decisions could also reflect the collectivist nature of Gujarati culture. Although further discussed in chapters 5 and 7, these routes of management can be chosen to protect an individuals' family honour. If values, such as maintaining one's family's honour by keeping 'mental health' problems hidden in Gujarati culture is part of one's embodied cultural capital, then these attitudes are indeed subconscious and are practiced because they form individuals' habitus. Therefore, understandings and attitudes of 'mental health' have a complex but critical relationship with both social and cultural capital where the relationship between the forms of capital and 'mental health' are indeed interdependent and interrelated and thus contributes to the way in which illnesses are managed.

Thus, the above example clearly demonstrates the complexity of this area. Therefore, the questions that address understandings and experiences of 'mental health', will result in multifaceted answers and explorations. Furthermore, I have argued that at the heart of this is culture, in particular, embodied culture that contributes to one's habitus. Maton (2008) explains Bourdieu's ideas arguing that habitus is associated with the structure of practices that people have, which 'focuses on our ways of acting, feeling, thinking and being' (Moore, 2008, p.52). Thus, it is these range of practices that form part of culture, which in turn influences understanding experiences and management of 'mental health'. However, culture itself is complex and thus it has been illustrated that there are no fixed categorisations to these research questions but rather bound to the multidimensional nature of culture. In saying so, I have not argued that mental illnesses are not bound to biological or

scientific approaches but that in the process of utilising these domains of thought, usually social processes are side-lined. This is highly problematic because social processes such as culture can shape the very concept of 'mental health', setting its boundaries (Busfield, 2000). Thus, universal constructions of illnesses do exist but cultural specificity influences their understanding, experience and management. It is this complexity of culture that requires further attention if ethnic inequalities in relation to 'mental health' are to be addressed.

Now, I will focus on chapter 6, which broadly addressed 'how has culture influenced perceived experiences of 'mental health' problems within the Gujarati communities?' This chapter was pivotal in using principles of a grounded theory approach, because it was not an area that was explored in the literature. This is because acculturation theorists are primarily interested in the ways in which new migrants adapt to a new setting or how second-generation migrants manage and negotiate being surrounded by two cultures. Although second-generation Gujarati migrants were interviewed, my focus lied with the first-generation migrants. This is because the attention on first-generation Gujarati migrants in acculturation work has recently been scarce. Such migrant groups have been largely documented as successful communities who migrated in large kinship groups (Bachu, 1985), benefit from upward social mobility (Patel and Shaw, 2008) and thus continue home culture as well as use 'separation' acculturation strategies to do so (Berry, 1990). However, my data has shown that it is not as simple as this, and even ten or twenty years after migration, acculturation strategies are still being negotiated. Additionally, interviewing second-generation migrants was crucial because it illustrated an acculturation-gap and the different attitudes towards 'mental health' from both generations. Through using Bourdieu's (1986) forms of capital, I illustrated that these attitudes and management strategies towards the existent acculturation-gap were rooted in culture.

Thus, chapter 6 covered various cultural practices and beliefs to demonstrate an acculturation-gap between first and second-generation Gujarati migrants. A

few of these changes in culture included marriage, language and taking care of elders. In terms of responding to an acculturation-gap, first-generation Gujarati's adapt to changes and in many cases 'silence' their true opinions because voicing them will risk causing fragmentation among their families. Although Raj (2003) found that negotiation occurs between parents and their children, in terms of adapting to various rates of acculturation and dealing with differences, my data illustrated that first-generation Gujarati's are indeed predominantly doing the negotiating. Furthermore, they recognise that they are the ones that are primarily doing the compromising but this is due to fear. Participant suggested, if they do not compromise and adapt to the changes that are occurring, then they will lose their children and *'they are not willing to lose their children or disown them'*. Therefore, although these changes may be causing first-generation Gujarati migrants to experience unhappiness, they compromise and adapt as methods of necessity for the sake of their children. Again, linking back to the earlier discussion, these decisions are shown to be embedded in the collectivist nature of Gujarati culture. These decisions and negotiations may be made because they want to uphold a certain image, which gains people honour and respect (Segal, 1991) or commonly known as 'izzat'. Therefore, because the first-generation Gujarati migrants place such a large importance on their cultural and social capital, they may be coerced into the negative component of strengthened social capital termed by Bourdieu (1986) as 'social obligations'. Thus, the silencing of 'real opinions' and adapting to cultural change is a response of 'social obligation' because attitudes have been shown to be more allocentric. This is also very similar to the ethnic density theory where Bhugra and Jones (2001) argued when cultures are sociocentrism, the positive affects of social support can diminish.

Although, this allows for the Gujarati communities to be viewed as harmonious without conflict per se, 'acculturative stress' can still be experienced silently by first-generation Gujarati migrants. Williams and Berry (1991) argue that acculturative stress can be a risk factor for 'mental health' problems. In immigrant families, a type of dyadic acculturative stress can occur, which is

when parents and children acculturate at different rates (Szapocznik and Truss, 1978). In acculturation literature, it has been argued that different trajectories of acculturation can cause intergenerational conflict and thus establish a risk factor to 'mental health' problems (e.g. Sluzki, 1979; Kwak, 2003). However, my data has illustrated that although an acculturation-gap exists within the Gujarati communities, conflict is not created but silenced due to 'social obligations' and 'allocentricity'. This does not necessarily mean that the risk of 'mental health' problems is reduced. In fact, I argue it may be heightened because there can be problems that are inherently kept hidden and left unaddressed as acculturative stress is experienced silently. However, by first-generation migrants silencing their true opinions, it is indeed beneficial for second-generation migrants because the conflict never surfaces and their attitudes depict a view that their parents are 'understanding' and 'liberal' and thus they do not experience acculturative stress or feel like they are 'in-between cultures'. Therefore, as Brah (1996) suggested, it is more useful to explore intergenerational differences rather than intergenerational conflicts, and indeed intergenerational discrepancies can be influence 'mental health' problems; more so if these are managed at the expense of cultural norms and not openly addressed.

Finally, I will discuss chapter 7 which focussed on the barriers the Gujarati communities face to seek help and also if they have alternative coping strategies that manage 'mental health' problems. Unsurprisingly, due to the complexities revealed in the previous two analytical chapters, it was difficult to indicatively put forward if 'mental health' is managed within the Gujarati communities. The first section highlighted that the communities indeed have various strategies that aid 'mental health' management. Although, these 'strategies' may not be applicable to all the communities. For example, participants suggest believing that illnesses are a reflection of 'God's will' was only believed by the elderly, who are the population likely to visit temples and seek help from religious figures. The second part of the chapter, explored a range of barriers of discussing 'mental health' within the communities, which

could act as a deterrent to seeking help for some people. However, on the whole, participants stated that they acknowledge GP services are confidential and as such do not associate emotional distress as an issue that requires medical attention. Thus, the problem is not solely help-seeking barriers which previous literature (see Hussain and Cochrane, 2004; Han et al., 2015) has found to be the case among South Asian communities; but, the data in this thesis has outlined that behaviours are intrinsically linked to culture.

Overall, the data presented in all three analytical chapters have begun to 'untangle and tangle' the area of how 'mental health' is understood, experienced and managed by Gujarati communities in Leicester. This is because, as demonstrated above and throughout this thesis, the underlying thread that shapes the communities' perceptions, experiences and the way in which they then begin to address 'mental health' is interlocked with various components and aspects of culture.

Original contribution to knowledge

Throughout this thesis, I have analysed and been critical of previous literature that covers ethnic inequalities and 'mental health' and have demonstrated the distinctiveness of this research through empirical data. However, here I will explicitly reflect on the ways in which this thesis is original, inventive and thus contributes and develops existing knowledge in the field of ethnic inequalities, culture and 'mental health'.

Firstly, in the introduction, I outlined the weaknesses of using 'South Asian' as a category in this area, predominantly due to two reasons: causing ecological fallacy and cultural stereotypes. The distinctiveness of this research lies within its focus on the Gujarati communities' perspective in exploring 'mental health', which the majority of previous studies have neglected. Consequently, this study has given a platform to the Gujarati communities to voice their perceptions. Although the approach of interviewing communities is not new to the field of 'mental health' and ethnic inequalities, this study has been distinctive by narrowing the larger and broader categories of ethnic groupings. Although

Dogra et al. (2005) did use interviews, their study did not mention flexibilities of adopting principles of grounded theory. Furthermore, using a qualitative interpretivist approach with elements of grounded theory has resulted in novel findings as discussed above.

Secondly, the theoretical framework utilised has been innovative in this field. Understandably, social capital and its relation to 'mental health' is not a new phenomenon. Social capital has largely been written about in terms of its benefits and negative consequences. For example, Portes (1998) argues there are three functions of social capital: a source of social control, family support and benefits through extra-familial networks. Additionally, Halpern (2005) argued that the academic interest in social capital focuses on the relationship between the quality of people's social networks and influences on a range of elements such as economic growth, educational performance to name a few (Halpern, 2005). Thus, the focus is predominantly on 'relationships' and what social capital can cause, be it benefits or negative consequences. This is indeed not a new phenomenon in sociology and dates to Durkheim's (1893) study on suicide who argued that an individual act such as suicide can be best explained by 'social forces external to the individual' (Halpern 2005, p.5). Durkheim illustrated that suicide was more common in societies that have loose social bonds and social dislocation, whereas in societies that had a higher level of solidarity, more social support and social cohesion, suicide rates were lower. However, this study has found that this may not be the case and after a certain level of social cohesion, social capital can have negative consequences as individuals may feel they have a social obligation to behave a certain way that conforms to the communities' social norms.

Thus, rather than focusing on the relationship social capital has on 'mental health' problems, this thesis has been distinctive in using it as a platform for understanding 'ways of acting, feeling, thinking and being' (Moore, 2008, p.52). Therefore, its originality is using Bourdieu (1986) and forms of capital to further our understanding in conceptualising, experiencing and managing 'mental health'. For example, the strength of social capital within the Gujarati

communities, does not always mean increased levels of social support and can result in 'social obligations'. This research has shown that increased levels of social capital heightens cultural capital and individuals may feel they should behave in certain ways to belong to communities. As a result, this can increase 'mental health' problems because of the pressures of upholding or abiding by what is viewed as 'appropriate norms' or indeed hidden. For example, mental illnesses are culturally viewed as 'mad' or 'crazy', and as a result could be hidden or denied ensuring they are not deprived of group membership or viewed as an 'outsider'.

Thirdly, the data generated is quite distinctive in understanding ethnic inequalities in 'mental health' area due to its philosophical, methodological and theoretical underpinnings. Although I will not go through all the individual findings here, I will concentrate on a few main areas that are original contributions to this field. Ethnic inequalities in 'mental health' is an area that has had large attention by many professionals and indeed, as such, it is not a new area of research in sociology. To ensure that healthcare services provided are effective, an understanding of why certain people are more likely to experience 'mental health' than others is required. In terms of ethnicity as a marker of 'mental health' inequalities, various risk factors have been explored: migration, employment, family type, housing, racism, social class, and family structure to name a few.

However, this research is significant because it recognises the limitations of using risk-factors of mental illnesses as definitive causal-effect relationships to 'mental health' problems. Primarily because social lives are very complex and combined risk factors can affect and contribute to 'mental health' problems in various ways. This thesis is novel also because it recognises that risk factors do more than explain why some groups of people are more likely to experience 'mental health' problems but also cultural and social factors can influence the conceptualisations and understandings of the concept itself. As Durkheim (1893) found, the stronger one's access to social capital, the less likely they are to commit suicide because they are integrated into a society where they have

access to social support. To some extent, the findings in this thesis disagree with this argument. Although the support gained from strong forms of social capital can be positive, they may also be negative. Additionally, if communities are very close-knit, the practices that are viewed as culturally appropriate will be much more significant. Thus, this importance, heightens cultural capital through the continuation of practices and therefore one may feel they have a 'social obligation' to behave in certain ways that adhere to the norms and values that are viewed as acceptable in these communities, i.e. silence true opinions and suffer in silence. If they do not conform to these culturally appropriate practices, it may result in losing the membership to the communities as the individual can be 'othered'. Therefore, strong forms of social can strengthen cultural capital. In relation to 'mental health', the cultural labels attached to 'mental health' problems such as 'madness' are very much lived realities for the Gujarati communities. Therefore, this argument illustrates that the positive relationship between strong forms of social capital and good 'mental health' is an over-simplification.

Secondly, another large area that the findings prove to be making original contributions to knowledge is in chapter 6 in relation to acculturation. Acculturation between two generations has been largely researched and the focus has been on 'intergenerational conflict' due to different strategies that have been adopted (Lau et al., 2005; Deepak, 2005). However, this thesis moves away from these predisposed assumptions. Additionally, it does not mean that if there is no intergenerational conflict, these communities adapt to new settings successfully. By using principles of grounded theory, this thesis is original in adopting an approach to acculturation theory that cross-references between two generations, but crucially focuses on first-generation migrants as their strategies may be in a state of flux instead of being rigid categories that are chosen immediately after migration. My data has shown that acculturation is an on-going process, which requires constant negotiation and renegotiation through the boundaries of culture. As such, it represents a journey, one that indeed could affect 'mental health', in a way in which cultural changes are

negotiated. Furthermore, culture is at the heart of negotiating ways of living in a new environment. Betancourt and Lopez (1993) argue that previous studies fail to define culture when their conclusions are based on cultural differences. However, this thesis has outlined the definition of culture in referring it to the values, beliefs, expectations, norms and cultural practices that my participants have outlined as important. These are practices that have been analysed in this thesis: marriage, language, taking care of elders etc.

Overall, culture is crucial. This thesis gives a prominent place to culture in the field of understanding 'mental health'. It moves away from assuming the medical model is universal and has provided an insight from the communities' perspective that has illustrated the significant role culture plays in this field. This has been distinctive because as Williams (1981) argues 'culture is the signifying system through which...a social order is communicated, reproduced, experienced and explored' (p.18). Therefore, through the meanings associated to values, expectations and practices that form culture, social order is transmitted. This is the very reason that culture continues in different environments because of the 'meaning' attached to values. Cultural practices and cultural production 'are not simply derived from an otherwise constituted social order but are themselves major elements in its constitution' (Williams, 1981, p.19). This is the very reason why strong forms of social capital have allowed for cultural capital to continue i.e. religious traditions and festivals. Thus, culture can then dictate a type of social order that also permits social control among communities, mirroring the same set up the medical model has in controlling and setting the boundaries of 'mental health' in the West. Ultimately, as Cochrane (1983) argues, culture itself can influence mental illness and the findings from this thesis are implicitly unique because rather than primarily focusing on causal relationships, it has sought to provide an in-depth overview of how culture influences conceptualisations, understandings, attitudes, experiences and management of 'mental health'.

Furthermore, the findings from this study have illustrated that causal arguments made in previous studies can be of limited use and social and

cultural factors play a complex role in 'mental health' problems and the Gujarati communities. Critical psychiatry assumes that ethnic minorities are oppressed and that this results in higher rates of mental illness. For example, racism among ethnic minorities has been argued to increase the risk of 'mental health' problems (Williams and Collins, 1995; Karlsen and Nazroo 2002; Williams et al., 2003). However, this study has shown that this is not always the case and ethnic minorities can utilise social capital and cultural capital to ensure discrimination is managed positively. Consequently, the next section will focus on how this research can be used to further policy development in this area.

Policy and future research recommendations

This thesis can indeed provide useful insights that inform policy but it is difficult from a niche area of research to conclude definitive policy advancements. In this section I will provide suggestions for policy based on the data generated, literature and theoretical frameworks used in this thesis to develop the area of 'mental health' and ethnic inequalities.

It was highlighted in the introduction that 'mental health' is an area that is increasingly being given prominent attention by the government because its' effects have significant implications for societies. This thesis has highlighted that the cultural context is crucial. Thus, culture should be taken much more seriously and research and at the centre of mental healthcare provision. Fernando (2010) argues:

The west prides itself on its scientific sophistication and an advanced system of medical treatment to combat ill health; but the question of 'mental health' is somewhat different, especially when considered cross-culturally (p. 2).

To advance 'mental health' care in relation to ethnic communities, culture must be at the forefront of research and approaches taken to develop policy. However, this should not be a 'blaming' activity of culture but rather one that seeks to 'understand' the complexities in culture and its' relationship with 'mental health' more broadly. Campaigns such as 'Time to change – let's end

'mental health' discrimination' have led on this area since 2007. However, its' prime focus is on 'improving public attitudes and behaviour towards people with 'mental health' problems'. Critically, this thesis demonstrates that it is not this simple and largely very difficult to change existing opinions that form part of individuals embodied cultural capital. Also, a range of factors contribute to the reasons why certain people have the opinions they do and behave in a certain manner. Thus, to advance policy in this area the following must be recognised:

- Culture needs to have a significant platform in research in this area, especially when policy is being developed. It is not as simple as 'blaming' culture as being the crucial component to causing 'mental health' problems to become a stigmatized and a taboo subject. Rather closer attention needs to be paid to complexities of culture and how from the communities' perspective these can be addressed.
- Additionally, I am not arguing that the sole focus should be on culture too, and that intercultural meanings of emotions, experiences and 'mental health' should be accepted and left unaddressed but rather that both the medical model and cultural variations in understandings of 'mental health' are complementary and must work together to provide a more appropriate and nuanced framework to support managing 'mental health'.
- If policy is to provide meaningful advancements, there needs to be a shift away from the 'South Asian' category which is too wide and misleading to be useful in health research (Nazroo et al., 2002). It causes ecological fallacy (Bryman, 2004) and risks making cultural stereotypes (Burr, 2002). Thus, large groupings can be of little use, and further attention needs to be given to specific ethnic communities. Additionally, as Nazroo (2003) there needs to be recognition of the different factors that make up ethnic identity such as cultural and historical factors and the ways in which this influences communities structurally.

- In relation to this previous point, policy development that is addressing 'mental health' care and ethnic communities cannot be progressive without involving communities themselves. Thus, future research in the area could explore the possibilities of engaging more actively community members in research agendas by utilising participatory and action research techniques. However, I recognise that in providing care, communities solely do not provide an understanding that fulfils every aspect of this area. There should also be a focus on healthcare professionals but rather than side-lining communities, future effective developments will require the involvement of communities. This is because; this area is not a new one and tackled by healthcare professionals. However, the on-going problem and my data illustrates that there is a gap between the assumptions healthcare professionals make and the opinions of communities.
- Following on from this point and relating back to 'concluding' a journey, this research has shown that 'cultural change' is essential in understanding 'mental health'. However, culture will change and has been changing, especially in the case of third and fourth generation migrants. For research to be of significance, continued work is required in this area. Moreover, as argued by Fernando (2002) cultures are not static, especially in environments where there are people from different cultures living side by side. Ultimately, this area requires a close informative relationship between communities, researchers, healthcare professionals and policy makers.

Reflections upon the study

This section will provide reflections of the study, in particular methodology and the journey of the researcher. From the outset, this study used principles of grounded theory. Vitality, this flexibility helped to understand respondents' perceptions and what they identify as important. To remind the reader, the underlying foundation of this study was exploratory and this is defined by Blumer (1969) below:

A flexible procedure in which the scholar shifts from one to another line of inquiry, adopts new points of observation as his study progresses, moves in new directions previously unthought of, and changes his recognition of what are relevant data as he acquires more information and better understanding (p. 40).

This approach was imperative and has been significant in this area of research. The exploratory nature revealed the complications in decisions that were made in relation to 'mental health' as well as its understandings and experiences. Furthermore, a positive component of this study was that rather than using the 'South Asian' category as whole, there was a particular focus on the Gujarati communities to distinguish the cultural exclusivities. Despite this, it does not mean that some of the findings in this thesis will not be applicable to the other communities who belong to the south Asian category. Thus, there is an element of 'relatability' in this research. Elaborating on this, there are parts of the 'South Asian' cultures that are similar and communities from the 'South Asian' category will be able to relate to findings from this study. For instance, 'South Asian' cultures tend to be collectivist and thus explorations relating to this aspect could be similar in other communities such as the Pakistani communities for example.

In hindsight, this study has the potential to develop in many ways. In this thesis, much of the focus has been on the Gujarati communities and in particular first-generation migrants. I have paid attention to their understandings of 'mental health', their experiences, how their social interactions with one another affect 'mental health' conceptualisation and management. Although this has been indeed valuable and has demonstrated the multifaceted nature of 'mental health' practices, it is by no means the 'full picture'. As explored in all three analytical chapters, many facets are inclusive to the ways in which participants construct meanings and how they respond to them. In relation to chapter 7, which discusses community practices that are in place for management, which are critical in moving 'mental health' care forward. 'Mental health' problems are increasing in the UK and has wider implications for societies and thus the

government and health services give significant attention to the ways in which mental illnesses can be kept to a minimal level as well as the ways in which inequalities can be eradicated (Cox et al., 2004).

In order to provide 'effective' health care, there needs to be an understanding of not only why certain groups of people are more likely to experience 'mental health' problems but also an insight is required into the needs of people and the types of healthcare that would best suit them. Chapter 7 has illustrated that this area indeed is multifaceted, from people approaching temples to talk to religious figures, to ayurveda and the dissatisfaction with western health services. Nonetheless, I recognise that help-seeking is not a simple, straightforward process; rather, it is a key area that needs further scrutiny. Thus, whilst the focus of this thesis has always been to gain the 'communities' perspective, it remains incomplete without the opinions of healthcare professionals. Additionally, this can provide further insight to the ways in which these issues are currently addressed to further our understanding of 'cultural competency' and what it means in the field of providing care for 'mental health'. Despite having an aim to focus on the 'communities' perspective' it should be noted, that I recognise the findings illustrated in this thesis are to some degree my interpretations of their perspectives. Using 'cognitive mapping' allowed me to distinguish the relationships communities were making between various factors but ultimately, I have wholly contributed to the generating data, analysing the information and the write-up of this thesis.

Regarding the epistemological stance of the project, this thesis was qualitative with an interpretivist viewpoint because the underlying focus of the study was to understand phenomena from the communities' perspective based on their lives, interactions, history, accounts and behavior (Strauss and Corbin, 1990; Mason, 1996; Marshall and Rossman, 1999). Therefore, reflecting on what can be known in this study and what constitutes knowledge, requires reflecting back on the participants that took part in this study. It is crucial to note that the findings from this study are not generalizable for this very reason and this thesis can only demonstrate the stories, understandings and experiences of the

participants that were involved in this study. Thus, even if this study was conducted today in Leicester with different respondents, the outcome may have been different. However, this does not mean that it does not have the potential to resonate with members that belong to the Gujarati communities all over the UK and other South Asian communities as discussed above. Inherently, it is likely that some of the experiences will overlap, especially in relation to the prominent role of social capital in the lives of Gujarati communities in Leicester.

Additionally, the stratification in this sample was heavily based upon generations of migrants, primarily focusing on first-generation migrants rather than second-generation migrants. A major reason for this was because they had gone through migration twice, which is a key risk factor for 'mental health' problems. For instance, within the literature in the area, the negative consequences of migration such as loneliness, stress, change, breaking family ties are often pointed out as key factors in increasing the risk of 'mental health' problems (Cochrane et al., 1977; Cochrane, 1983; Beiser et al., 1993; Kuo et al., 1986; Nevo et al., 2006). Although this was very meaningful for this project and the research questions, other areas could have been explored. Due to revealing the strength 'forms of capital' had in conceptualising, experiencing and managing 'mental health' in Leicester, it may have also been fruitful to explore Gujarati communities in other areas that are not so vast in numbers. I reiterate that the findings and debates found may have been different due to the epistemology utilised in this thesis and the key focus on people's interactions and their social experiences contributing to their understandings and conceptualisations of 'mental health'. Furthermore, not only are the findings in this thesis dependent upon the sample but also on the particular time frame this study took place. Merriam (2002) argues:

The world, or reality, is not the fixed, single, agreed upon of measurable phenomenon that it is assumed to be in positivist, quantitative research. Instead, there are multiple constructions and interpretations of reality that are in flux and change over time (p.3).

Thus, if this research was to be carried out in the future, it is likely that the findings disseminated would be different. Additionally, I openly recognise my own influences as a researcher in this study. In the methods chapter, I gave significant attention to self-reflexivity, not only in terms of research which traditionally is associated with a 'rational' approach but also the 'emotional' aspect of research. As Kemmer et al. (2001) argue little attention has been given to 'researcher emotions' and unless emotion in research is acknowledged, not only will researchers be left vulnerable, but our understandings of the social world will remain impoverished. I contend that emotions play a central role in the social world, and therefore need to take center stage. Thus, this thesis is indeed a by-product of many different emotions felt experienced throughout the journey. This is because, emotions have imminently influenced the way I have interacted with my participants, the data analysis stage and writing up this thesis. Furthermore, not only are emotions critical to the production of this thesis but also time in the sense at which point it was written. My experiences have contributed to the perceptions I hold and these have influenced the ways in which this research has been approached but also whilst conducting empirical work and dissemination. I have discussed some of these implications in chapter 3 in the reflexivity section. Consequently, if this thesis was undertaken by a different researcher the findings would be somewhat different, with probable similarities and comparisons. Additionally, it should be noted that the writing up process was undertaken during a particular period of time. Therefore, if I was to engage with the findings at a later point in time, my focus would shift in line with my thinking about the phenomenon, which is imminently interlinked with and influenced by my personal and professional experiences.

Finally, I would also like to explore further not only how my experiences have influenced the research but indeed the ways in which the research has influenced me outside of the research remit. Returning to Elena's statement: '*I am living my PhD, I am so immersed in the topic I am researching, it's almost like I am analysing myself*', I have found myself in similar situations throughout

my research. Although I have never had discussions about ‘cultural change’ with my parents to the degree I have in this study with my participants, the latter has opened doors for me to discuss this area with my parents. As a result of this study and the revelations of ‘miscommunications’ between first and second-generations, I have indeed thought deeply about my own circumstances. After all, I am a second-generation migrant myself, born to twice migrants and indeed many of the discussions resonate with my own experiences. During not only conducting the research, but writing up my thesis I had and continue to have conversations with my parents about my findings and as a result what was deemed as a ‘closed’ relationship has indeed become more ‘open’ since starting this research. I have thought more deeply about my parents’ emotions and the effect their actions are having on their health. In some cases, it has made me more analytical of my own life. I would like to draw your attention back to the anecdote in the introduction of this thesis where I stated, *‘I was raised in a traditional, Indian family to very religious but liberal parents...’* In a similar manner to my participants, I, too, fell under the assumption that my parents were ‘liberal’; a very similar finding that was explored in chapter 6.

Additionally, in the methodology chapter I explored ‘emotion regulation’ and the way in which I silenced my own opinions in interview setting to avoid conflict and a cultural component of ‘obeying’ my elders. Thus, I too have ‘social obligations’ due to the importance I place on cultural values. Joshi and Mclean (1994), and Raval et al. (2007) argue that the regulation of one’s emotions is culturally relevant and in many cases, for Indian cultures, this regulation is explained in terms of culture being collectivist and allocentric, thus silencing emotions will avoid conflict. Subsequently, this thesis has allowed me to explore my own life, both personally and professionally as a researcher. Ultimately, I firmly believe, this is an element of research that we should embrace – after all, being a social scientist does not stop within the boundaries of conducting research. It is thus, important to always question the ways in which our own social lives influence the interactions we have with participants,

the ways in which analysis is approached and more broadly, the nature of research.

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Appendix

1.1 Initial Interview Guide

Introductions

Background

(Language preference)

- Can you briefly explain how you have come to settle in the UK? How was the experience?
- What part of Gujarat do you come from?
- Can you tell me a little bit about your family? (Married, Children)
- Who do you live with? Do you have close family here in the UK? And do they live near you?

Understanding

- What is your understanding of the health issues within the Gujarati community?
- What do you understand by bad mental health?
- Do you know any risk factors that cause mental health problems? Could you name some?
- Do you know anyone who suffers from any mental health problems?
- What are your views on the community with experiences of bad mental health? Is it common or rare? (why do they think)

Help-seeking

Cultural

- Do you feel like illnesses are determined by God? /Do you feel like people who get a mental health problem is because of God's will?

Social

- How close-knit is the wider Gujarati community in Leicester?
- How do you feel when you hear someone in the community has a mental illness? How does the community react?
- Are mental health issues openly discussed?
- In your opinion or experiences, how does the community generally respond if they find out people have gone to the doctors for mental health problems?

Institutional

- How are mental disorders treated in the community?
- Do you feel like the community has access to the appropriate health care in the UK? Or are aware of the services available.

Language

- If you did feel that you needed to go, see a GP do you think they are accessible? Do they understand your cultural needs?
- Do you have a preference of what ethnic background your doctor is from and why?
- Can you describe your experiences with communicating with doctors?

Alternative coping strategies

- Are there other people in the community that assist mental health problems?
- Are there any traditional or Ayurveda remedies you are aware of? In your opinion are they commonly used in the community? (if yes, access?)

1.2 Second Modified Interview Guide

N.B Red indicates the added questions

Introductions

Background

(Language preference)

- Can you briefly explain how you have come to settle in the UK? How was the experience?
- What part of Gujarat do you come from?
- Can you tell me a little bit about your family? (Married, Children)
- Who do you live with? Do you have close family here in the UK? And do they live near you?

Understanding

- What is your understanding of the health issues within the Gujarati community?
- What do you understand by mental health? (*What does depression mean to you?*)
- Do you know any risk factors that cause mental health problems? Could you name some?
- Do you think mental distress is rare in the community? Why may that be

Generational differences and expectations

- *Expectations from parents with regards to knowing how to speak Gujarati*
- *Taking care of elders*
- *Conflicting views on education and career paths*
- *Marriage practices – caste, age, arranged marriages, going to India to look for partners*
- *Religious practices*
- *Opinions/involvement with samaj's and organisations*

Help-seeking

Cultural

- Do you feel like illnesses are determined by God? /Do you feel like people who get a mental health problem is because of God's will?

- **Why do you think people get bad health (and mental health)?**
- What are your views on people putting spells on others? Can this explain mental illnesses?
- Can religion play a role in managing mental illnesses?

Social

- How close-knit is the wider Gujarati community in Leicester?
- How do you feel when you hear someone in the community has a mental illness? How does the community react?
- Are mental health issues openly discussed? (ask further on gossip/fear/stigma)
- In your opinion or experiences, how does the community generally respond if they find out people have gone to the doctors for mental health problems?
- Do you think people in the community are reluctant to accept they have a mental illness, if so why?

Institutional

- How are mental disorders treated in the community?
- Does the community provide services to tackle mental illnesses? What? Uptake etc.
- Do you feel like the community has access to the appropriate health care in the UK? Or are aware of the services available.

Language

- If you did feel that you needed to go see a GP do you think they are accessible? Do they understand your cultural needs?
- Do you have a preference of what ethnic background and gender your doctor is from and why?
- Can you describe your experiences with communicating with doctors?

Alternative coping strategies

- Are there other people in the community that assist mental health problems?
- Are there any traditional or Ayurveda remedies you are aware of? In your opinion are they commonly used in the community? (if yes, access?)

1.3 Example of Demographic Survey



Socio-demographic Survey

Q1. What is your gender? Male Female

Q2. What is your age? _____ Rather not say

Q3. What is your marital status?

Single Married

Never been married Separated

Divorced Widowed

Rather not say

Q4. What is your employment status?

Self-employed Employment full-time

Employment part-time Unemployed

Retired Student

Homemaker Unable to work

Other (please specify) _____ Rather not say

Q5. If employed, what is your job title?

Q6. What is the highest level of education you have completed?

Less than high school Completed some high school

High school graduate Completed some college

Associate degree Bachelor's degree

Completed some postgraduate Master's degree

PhD Law or medical degree

Other advanced Rather not say

Q7. Who lives in your household?

Q8. What type of home does your household live in?

- Semi-detached Detached
Flat Bungalow
Terraced house other (please state) _____
-

Q9. Does you/your family own or rent the home you live in?

- Own (with or without mortgage) Rent
Don't know Rather not say
-

Q10. Where in Gujarat are you from? (Please state town or city)

Q11. How have you settled in the UK?

- Migrated from India Migrated from India via East Africa
Born in the UK Other (please state) _____
-

Q12. Which religious devotional group (dharma) do you belong to? (E.g. Swaminarayan)

Q13. What Gujarati caste do you belong to?

- Brahmin Lohana Sutar Jain Lohar
Patidar Vaishnav Gurjar Modi Rajput
Kutchi Soni Other (Please state) _____
-
-
-

Many Thanks for completing this Survey

1.4 First-Generation Gujarati migrant's data

Participant	Gender	Age	Marital status	Employment status	Education	Migration	Dharma	Caste
Urmila	F	52	Married	Self-employed	N/A	Via East Africa	Jalaram	N/A
Ramesh	M	66	Married	Retired	Bsc	Via India	Sanatan	Mochi
Pratik	M	N/A	Married	Retired	Medical	India via East Africa	N/A	N/A
Kunal	M	49	Married	Full-Time	BA	Via India	Hindu	N/A
Ramila	F	58	Widowed	Full-Time	BA	India Via East Africa	Hindu	N/A
Kamlesh	M	56	Married	Unemployed	None	East Africa	Hindu	Jansanri/ Mochi
Jagdish	M	67	Married	Retired	High school	East Africa	Hindu	Aryan/M ochi
Bharat	M	69	Married	Retired	College	East Africa	Hindu	Mochi
Suresh	M	57	Widowed	Unemployed	College	India	Hindu	N/A
Mahesh	M	67	Married	Retired	College	East Africa	Hindu	Mochi
Mahendra	M	60	Married	Full-Time	NVQ courses	India Via East Africa	Hindu	Patidar
Rashmi	F	53	Married	Full-Time	BA	India	Hindu	Mochi
Poonam	F	N/A	Married	Full-Time	Medic	Uganda	Hindu	N/A
Jayesh	M	63	Married	Full-Time	High School	East Africa	Hindu	Mochi
Vijendra	M	85	Married	Retired	Less than High School	East Africa	Hindu	Sutar
Ketan	M	62	Married	Full-Time	College	East Africa	Hindu	Lohana
Mya	F	54	Married	Unemployed	BA	India	Hindu	Mochi
Neha	F	N/A	Married	Full-Time	College	India	N/A	Mochi
Manoj	M	39	Married	Full-Time	PhD	East Africa	Hindu	Kadwa Patel
Miland	M	78	Widowed	Retired	High school	East Africa	Hindu	Vaishnav

Concluding the Research Journey

Pramila	F	N/A	Married	N/A	N/A	N/A	N/A	N/A
Amit	M	58	Married	Full-Time	NVQ	India Via East Africa	Hindu	Mochi
Alka	F	43	Married	Part-Time	BA	India	Hindu	Lohana/ Gurjar
Sarla	F	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Nayna	F	62	Married	Full-Time	Less than High School	India via East Africa	Hindu	Rajput
Danesh	M	55	Married	Full-Time	College	East Africa	Hindu	Brahmin
Rita	F	63	Married	Self-employed	PGCE	India Via East Africa	Sanatan	Lohana
Sushila	F	55	Married	Full-Time	High School	India	Swamina ryan	Patidar
Raju	M	58	Married	Full-Time	College	India Via East Africa	Pranami	Patidar
Savita	F	61	Married	Retired	College	India Via East Africa	Pranami	Patidar

1.5 Second Generation Gujarati migrant's data

Participant	Gender	Age	Marital status	Employment status	Education	Migration	Dharma	Caste
Yogita	F	N/A	Single	Student	BA	UK born	N/A	Lohar
Anish	M	20	Single	Student	College	UK born	ISCKON	Lohar
Riya	F	29	Single	Full-Time	BA	UK born	Vaishnav	Lohana
Veena	F	22	Single	Full-Time	BA	UK born	None	Lohana
Vikram	M	28	Single	Full-Time	BA	UK born	None	Darji
Chandni	F	19	Single	Student	College	UK born	Sanatan	Lohana
Payal	F	27	Single	Full-Time	BA	UK born	N/A	N/A
Jay	M	N/A	Single	Full-Time	Postgraduate	UK born	N/A	Patidar
Nisha	F	30	Single	Full-Time	BA	UK born	Hindu	Lohana
Shreya	F	22	Single	Full-Time	BA	UK born	shreenathji	Lohana
Rahul	M	22	Single	Student	BA	UK born	N/A	N/A
Tanisha	F	24	single	Full-Time	BA	UK born	Sathya Sai	Brahmin
Kajal	F	22	Single	Full-Time	BA	UK born	Pranami	Patidar
Rishi	M	29	Single	Full-Time	BA	UK born	Swaminarayan	N/A
Deepa	F	24	Single	Full-Time	MA	UK born	N/A	Lohana

