

# Psychosis

Psychological, Social and Integrative Approaches

ISSN: (Print) (Online) Journal homepage: <https://www.tandfonline.com/loi/rpsy20>

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To cite this article: Anisha Vyas, Lisa Wood & Susan McPherson (2021): A qualitative exploration of stigma experiences of second-generation British South-Asian people using an early intervention in psychosis service, *Psychosis*, DOI: [10.1080/17522439.2021.1897654](https://doi.org/10.1080/17522439.2021.1897654)

To link to this article: <https://doi.org/10.1080/17522439.2021.1897654>



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Published online: 23 Mar 2021.



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# A qualitative exploration of stigma experiences of second-generation British South-Asian people using an early intervention in psychosis service

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## ABSTRACT

**Background:** Psychosis is known to be associated with high levels of public and internalised stigma, especially for those newly diagnosed. There is currently little know about the stigma experiences of second-generation British South-Asian people experiencing psychosis. This study aimed to explore the stigma experiences of this population who are using Early Intervention in Psychosis services.

**Method:** Semi-structured interviews were conducted with ten British South-Asian adults who had received care from an Early Intervention in Psychosis Service in an urban and diverse area of London. Thematic Analysis was used to interpret findings.

**Results:** Four themes and eleven sub-themes were developed from the data. The main themes were “the burden of silencing”, “unrecognised aspects of their situation by services”, “experience as the other” and “finding ways to cope”. Findings indicate that stigma manifests differently based on individual experiences, culture and multiple intersecting stigmatised characteristics such as race, religion and socio-economic status.

**Conclusion:** Early Intervention in Psychosis Services should ensure a person’s cultural context and experiences of stigmatisation are considered in their care. Also, engagement of local South-Asian communities is needed to develop service provision which is more informed by the social and cultural needs, beliefs and experiences of this population.

## ARTICLE HISTORY

Received 24 November 2020  
Accepted 24 February 2021

## KEYWORDS

Stigma; early intervention;  
first episode; ethnicity;  
discrimination; culture

## Background

Addressing mental health stigma is a priority to the U.K. government (NHS England, 2016). Psychosis is considered one of the most stigmatised mental health problems in the U.K (Wood et al., 2014) and internationally (Thornicroft et al., 2009). Public stigma, the negative reaction that the general population have to people with mental health difficulties (Corrigan & Shapiro, 2010; Corrigan & Watson, 2002), and internalised stigma, the prejudice that those with mental health problems turn against themselves (Corrigan & Watson, 2002; Thornicroft et al., 2009) are both significant issues for people experiencing psychosis.

Stigma is particularly prevalent for those experiencing First Episode Psychosis (FEP). Studies have shown that receiving a new diagnosis and being labelled with psychosis is associated with internalised stigma and shame (Pitt et al., 2009), which in turn socially marginalises and disadvantages diagnosed individuals (Birchwood et al., 2007). Gronholm et al. (2017) conducted a systematic review exploring mental health stigma for those experiencing FEP. Their findings demonstrated that having

a FEP led to judgement and discrimination from others, and that stigma acted as a barrier to help-seeking.

Mental health stigma is a pervasive issue within South-Asian communities (Al-Adawi et al., 2002) in which social-image is considered paramount and anything that taints this image is problematic (Triandis, 1995). Al-Adawi et al. (2002) have asserted that attitudes to mental health in South Asian communities can be more devastating than the mental health experience itself.

There is limited research on the experiences of stigma related to psychosis amongst the British South-Asian population (Bhugra, 2002; Kirkbride et al., 2017). However, studies have found that stigma is problematic for British South-Asian people experiencing psychosis, as it can lead to rejection within their communities and consequent shame and/or reduced likelihood of help-seeking (Islam et al., 2015; Penny et al., 2009). Problematically, no distinction has been made between first-generation and second-generation individuals in these studies. This is significant given that second-generation South-Asians have an increased risk of psychosis in comparison to the majority population (Bourque et al., 2011). Bhugra (2002) suggested this is due to social factors such as cultural identity, alienation and racism rather than the immediate effects of migration. Furthermore, ideas (and related stigma) of psychosis are culture-bound (Kleinman, 1980). Suhail and Cochrane (2002) studied a Pakistani sample of people experiencing psychosis and found that the local culture of the country individuals inhabited influenced their beliefs more than the culture of the country they descended from.

Stigma is a prevalent issue for those experiencing FEP (Gronholm et al., 2017) including British South-Asian people (Islam et al., 2015; Penny et al., 2009). To date there are no qualitative studies known to the authors, which specifically explore the experiences of stigma from the perspective of second-generation, British South-Asian people experiencing psychosis. This study sought to examine how British South-Asian people using an Early Intervention in Psychosis (EIP) Service experience public-stigma and internalised stigma; as well as their experiences of EIP services.

## **Method**

### ***Design and ethics***

Qualitative semi-structured interviews were employed and thematic analysis conducted (Braun & Clarke, 2006). The study adopted a critical realist position which acknowledges that participants' truth is influenced by their own understanding of their subjective experience (Bhaskar, 1975). The study also took a contextualist approach, recognising that subjective experiences can only be understood within a social, historical, power and political context (Willig, 2012).

A favourable ethics opinion was provided by the NHS East of England Essex Research Ethics Committee (Ref 18/EE/0044) and Health Research Authority (IRAS ID 228534) approval was granted. The study was also approved by the recruiting Trust's Research and Development Department and was sponsored by the University of Essex Research Ethics Committee (Ref 17028).

### ***Data collection and procedure***

Participants were recruited from a London NHS Trust. Participants had to be under the care of an EIP service; aged 18 or over; and had to be second-generation British South-Asian (born in the U.K. but whose parents migrated to the UK from India, Pakistan, Bangladesh or Sri Lanka). Participants were excluded from the study if they were unable to speak English; lacked capacity to give informed consent; had an acquired brain injury or severe thought disorder at the time; if substance-misuse was considered to be the acute cause of the psychosis; or they had participated in another research study within the last six months.

Clinical staff in participating EIP services discussed the study with eligible individuals using the information sheet. Individuals directly contacted the first author if they were interested in participating

in the study. Interviews were conducted in private clinic rooms at the EIP service where participants were receiving care. Participants read the information sheet, gave informed consent to participate and were debriefed following the interview. Interviews lasted between 27 and 60 minutes.

Ten people who consecutively volunteered and met the eligibility criteria took part in the study. Individual semi-structured interviews followed a topic guide which provides topic headings but does not provide predetermined questions or a fixed structure for the interview. This allowed the interview to be guided by the participant. All interviews covered three main topic areas; the views and reactions of other people to their psychosis, including changes in relationships and experiences of talking to others about their mental health; participants' self-perception including how they understood their psychosis, how their self-image changed after experiencing psychosis and how culture impacted on their views of themselves; the EIP services and how participants experienced the support they received. Interviews were audio-recorded and transcribed verbatim by the first author.

### **Quality and rigour**

Following Lincoln and Guba (1985) evaluative criteria for qualitative research, the study aimed to incorporate credibility, transferability, dependability and confirmability in order to ensure trustworthiness of the study. Credibility was sought by checking codes with participants to ensure that collected data accurately represented participants' accounts. Transferability was enhanced by discussing the limitations of the study in terms of its context and application to other South-Asian populations. Dependability has been enhanced by detailing the procedure and methodology to improve reliability and consistency of the study. Confirmability was enhanced by two authors coding transcripts to corroborate the identification of codes and provide transparency.

The authors acknowledge that their ethnicity, beliefs and assumptions may have implicitly and explicitly shaped the data collection and analysis (Lincoln & Guba, 1985). The first and second authors identify as second-generation, British South-Asian and mixed British Southeast-Asian women respectively. Shared ethnicity between researcher and participants can enable a stronger foundation to explore experiences relating to culture (Suwankhong & Liamputtong, 2015); although there is also a risk of the researcher being "insufficiently curious" (Suwankhong & Liamputtong, 2015). Therefore, during interviews, the first author made attempts to clarify participants' subjective conceptualisations of psychosis and stigma. Participants' assumptions about the first author's understanding given shared ethnicity were considered in the analysis.

### **Data analysis**

The study employed Braun and Clarke (2006) six-phase Thematic Analysis (TA). A combined inductive and deductive approach was followed, meaning that data were examined both descriptively and interpretively. Surface level data was considered equally as important as the underlying assumptions of participants within the study.

Analysis was undertaken using NVIVO software Version 12 (QSR International, 2018). Transcripts were read multiple times and codes were derived systematically by reading each transcript line-by-line. Analysis was undertaken by the first author; the second author coded a transcript to ensure reliability. Initial codes were fed back to participants to check they reflected participants' experience. Codes were organised and clustered together to form possible thematic categories. All authors discussed the themes and agreed on the final theme structure.

### **Results**

A total of ten participants took part in the study and their demographic information can be found in Table 1. Two women and eight men, aged from 19 to 39 with a range of religious identifications and varied educational attainment participated.

**Table 1.** Participant demographics.

Participant Pseudonyms	Age	Gender	Ethnicity	Religion	Education (highest achieved)	Employment Status
Udit	22	Male	British-Indian	Atheist	A-Level	Student
Tippu	39	Male	British-Bangladeshi	Islam	Primary School	Out of work and looking
Ethan	19	Male	British -Sri Lankan	Hindu	GCSE	Student
Hemisha	19	Female	British-Indian	Hindu	A-Level	Student
Aaliyah	21	Female	British-Bangladeshi	Agnostic	A-Level	Student
Zaair	20	Male	British-Pakistani	Islam	A-Level	Student
Fahad	27	Male	British-Pakistani	Islam	Irish Leaving Certificate	Student
Ali	20	Male	British-Pakistani	Christian	GCSE	Unable to work
Syed	27	Male	British-Pakistani	Islam	A-Level	Student
Anwar	21	Male	British-Bangladeshi	Agnostic	A-Level	Student

**Table 2.** Themes and sub-themes.

Themes	Sub-themes
The burden of silencing	“My family keeps it hush hush” “It’s a bad thing to tell people” “It rips you from yourself”
Unrecognised aspects of their situation by services	“Understanding all these parts of me” “It’s a harsh environment” “Services don’t really see me”
Experience as “the other”	“It’s contagious, it spreads” “I’m not associated with ISIS” “It was safer to be alone”
Finding ways to cope	“Sharing the load” “I needed help to understand”

Four themes and eleven sub-themes are presented below in Table 2. Sub-themes have been named using direct quotes from participants.

### ***The burden of silencing***

This theme conceptualised how participants felt unable to speak about some of their experiences due to the social unacceptability of psychosis and internalised stigma.

#### ***“My family keeps it hush hush”***

Data from eight participants contributed to this sub-theme. It is indicative of the role families played in participants’ silencing and stigmatisation. Participants reported that South-Asian families identified with stigma and shame associated with psychosis, resulting in avoiding discussion of participants’ psychosis experiences within their family:

“We know not to talk about it [psychosis] in our family” (Udit).

“It’s easier to talk about having a boyfriend, than my psychosis and that’s saying something in Asian families” (Hemisha).

This also led to participants being concerned about bringing shame and stigma to their families.

“I feel like with my family there was always that need to make sure everything looked good . . . If something came up about my mental health, my family wouldn’t tell people which kind of made it worse . . . it’s a lot about pride, family pride (Anwar).

#### ***“It’s a bad thing to tell people”***

Participants felt they had to conceal or “silence” their psychosis experiences from people they were close to and more widely in society. They were scared they would be judged by other people and labelled with negative stereotypes of psychosis. Seven participants made comments which contributed to this sub-theme.

“I know when you’re really scared about hearing voices, I just think automatically that everyone’s going to think I’m crazy and like no one is going to talk to me. I won’t be treated the same” (Aaliyah).

“It’s better not to say anything, peoples won’t say nothing to you then, they won’t judge you then” (Tippu).

#### ***“It rips you from yourself”***

Participants described detrimental impacts on their identity resulting from the stigma associated with psychosis. They negatively labelled themselves as “schizophrenic” and condemned themselves based on unfavourable stereotypes of psychosis, which resulted in a critical self-view, shame and distress. This sub-theme concerns six participants.

"I'm a schizophrenic now. I think the fact remains, you're disabled . . . It's tough when everything's shit and all aspects of yourself are just degrading. I miss how I was . . . the reality is looking bleak" (Udit).

"I don't like or know who I am now . . . I feel like I've hit rock bottom . . . I don't think I can get any lower" (Ethan).

### ***Unrecognised aspects of their situation by services***

This theme captured how participants felt the importance of their identity, culture, religion and social environment were not recognised by EIP services. This resulted in participants feeling further stigmatised and negatively influencing their psychosis experiences.

#### ***"Understanding all these parts of me"***

Participants experienced aspects of their identities as being unfavourable (i.e. being South-Asian). Notably, Participants believed they had to change the way they conducted themselves in different social environments and distance themselves from South-Asian culture. Data from seven participants contributed to this sub-theme.

"Being British-Asian, I think that we switch through things in a way that other people don't and we do it very quickly without even realising it. You flip between both worlds and you do that so quickly in different situations and I don't even know how much. I feel like there's a point with adaptability where it gets stressful, really stressful. Especially if you're trying to adapt to different cultures and you're doing it so much on the fly that you start to question your own beliefs, is this my belief or is this someone else's belief that I'm taking in" (Anwar).

The extent to which participants felt they needed to change and adapt was different for each participant depending on their particular situation, with one participant suggesting they would like to relinquish their cultural identity altogether:

"A lot of the time I just want to abandon my culture. I just think I'd rather not be a part of this" (Aaliyah).

#### ***"It's a harsh environment"***

Five participants contributed to this sub-theme. Participants relayed struggling to cope with their living environment such as adversity and social deprivation (e.g. homelessness).

"Been living on the streets, went to the council and didn't get nowhere . . . They were giving me these appointments every single week. If I missed any of them, they would kick me out from them shelters. It's so deep and nasty the things I've been through, the way people treat you . . . I was stressed out and depressed . . . They just want keep the White, English people. I'm the one that's always been targeted. I'm fed up of this country, I don't belong here" (Tippu).

These factors complicated the experience of stigma and psychosis for participants and they felt that this was not understood by EIP services:

"People don't realise what it's like here. I feel like the place where I live and the kind of mentalities around here are harsh . . . Here, people don't want to know about your worries, they don't have time for them" (Fahad).

#### ***"Services don't see really me"***

Participants reported that mental health professionals did not explore and think about the way they understood themselves and their experiences in the context of their cultural and religious backgrounds. Data from six participants contributed to this sub-theme.

"This [the interview] is my first time talking about it all properly, about my background and my religion . . . I think it's something that people don't really pick up on in services. It's kind of mainly focusing on what voices you're hearing or what you're feeling. I think other factors aren't paid attention to. I think they'll look to things like childhood trauma, things like bullying. I don't think

culture is off the bat, considered and therefore reinforced. Then you worry about making professionals uncomfortable. I think I want them to try to understand a bit more that if you're from an Asian background that you need to ask about culture. Just be a bit more careful in your approach" (Aaliyah).

"They [services] don't think about culture . . . I don't think they understand it, but I don't think they ever could unless they experienced it themselves" (Ali).

Participants also commented that they would not bring up their ethnic background with professionals either as it might be awkward for the professional:

"I guess a lot of the religious aspects and beliefs and stuff like that I couldn't really touch on properly. I just didn't want to make her uncomfortable" (Anwar).

### ***Experience as "the other"***

This theme concerns participants' sense of being excluded from society. Participants spoke about how stigma and discrimination influenced their fear of being with other people within the South-Asian community and wider society. Consequently, participants felt more comfortable self-isolating to feel protected from the multiple stigmas they experienced.

### ***"It's contagious, it spreads"***

Participants noted that psychosis experiences were associated with harmful stereotypes. For example, they described a concept within South-Asian communities where a person could "catch" or be infected by psychosis if they were near them. Participants felt that South-Asian communities consequently distanced themselves from those seen negatively and "othered" within the community to avoid contagion. This sub-theme concerns four participants.

"I remember when I was out of hospital I wasn't really in the right state of mind, the way I was acting and stuff like that, they wanted to keep their distance and stuff. I remember trying to sit next to my relatives and they literally got up and moved a couple of spaces away from me. That was bad, I got quite numb after" (Anwar).

"Not everyone in the community are open-minded towards mental health problems . . . some people just say you're going 'coo-coo' and think they'll get it off you" (Zaair).

### ***"I'm not associated with ISIS"***

This sub-theme explores racism (racial public stigma) and islamophobia (religious public stigma), including one participant explicitly referring to people assuming they were a member of ISIS (Anwar). Participants gave varied accounts of prejudice, discrimination and racism which seemed to trigger or interact with voice hearing and feelings of persecution. Data from seven participants contributed to this sub-theme.

"I'm Muslim – people don't like that. It's mostly that fear of different communities and what do they think of me. It's hard to leave the house, my fear plays up on the fact that people are trying to single me out" (Anwar).

"I feel like I am probably open to being attacked again. I used to wear a headscarf and I got attacked. I rather not wear it [headscarf], or I might choose to wear it again later, but for now, I chose not to. I don't want to give people another excuse. They [voices] say 'someone's going to attack you' or I just get a paranoid feeling that I'm going to be attacked . . . it strips away a lot of my confidence" (Aaliyah).

### ***"It was safer to be alone"***

Participants described isolating themselves due to public stigma which impacted on their distress. There was anxiety about how they would be seen and it felt protective to separate from social networks and society in general. Six participants contributed to this sub-theme.

"They think that people who hear voices or see things are automatically going to attack them . . . I didn't want people at school to think that of me, it made me not want to go in" (Hemisha).



"I kind of ostracised myself from people . . . I don't want them to see me differently . . . being by myself was easier" (Syed).

### ***Finding ways to cope***

The final theme explores the value of finding connection and meaning in participants' lives. Understanding within supportive relationships appeared to help participants cope with the impact of stigma. This theme shows how relationships and engaging in values protected participants against stigma.

#### ***"Sharing the load"***

Participants placed significant value on having close relationships with people they could trust and share their experiences with. This was not only related to the secrecy and shame of sharing, but physically not having the right words to describe things in a different language. This demonstrates the practical and emotional barriers to sharing experiences of psychosis. This sub-theme concerns seven participants.

"It's not like the Asian culture demonises you for it, it's more just they don't understand. The best advice I could give would be to get someone you can speak to. I know some bits get lost in different languages, but it's like sharing the load. They'll know what you're going through . . . That would be a very big help" (Syed).

"They [friends] were the only people who didn't change their opinion of me and were always there no matter what or how I felt" (Hemisha).

#### ***"I needed help to understand"***

Some participants praised the support they had been given by services. Most participants who had been offered psychological support, found it meaningful in terms of understanding themselves, their experiences and identifying aspects of themselves they liked. Three participants contributed to this sub-theme.

"I've got proper counselling here and it's been really, really good. It's been brilliant . . . After therapy I realised there's a lot of good qualities that I do have" (Fahad).

"It's been refreshing that someone could follow my train of thought because it's so confusing my own mind . . . but when the psychologist relayed the information back to me, it was actually better than what I could've actually said" (Syed).

Notably, those who felt overlooked by services (described in sub-theme "Services don't really see me"), expressed the most frequent and severe forms of stigma and reported not having been offered psychological input. This highlights how different types of stigma intersect, which may impact disclosure and accessing support.

## **Discussion**

This study explored how British South-Asian people using EIP services experienced public-stigma and internalised stigma, as well as their experiences of EIP services. The findings illustrate that stigma was distressing and manifested differently based on individual experiences, culture and multiple intersecting characteristics. Participants felt that the extent of their experiences were not recognised and understood by EIP services.

The findings demonstrated that participants perceived themselves in a negative and detrimental way and had feelings of shame as a result of their experiences of psychosis (Gilbert, 2010). Participants accounts of self-denigration, despair and low self-esteem, fit with existing research examining the impacts of stigma from psychosis (Birchwood et al., 2007; Corrigan & Watson, 2002; Wood et al., 2017).

Participants described experiencing stigma from their families and communities. Consequently, participants believed strongly that stigma would be very harmful to their families as well as themselves, which is in line with the stigma literature (Knifton, 2012). The current study provides

some important insights into the challenges for second-generation British South-Asian people with psychosis to straddle South-Asian and western cultural understandings of themselves and their experiences of psychosis.

Being positioned between different cultures and generations felt difficult for participants, which has been identified in previous literature (Bhugra, 2002; Kirkbride et al., 2017). Participants reported feeling that they had to adapt to their cultural context, which meant moving between different identities to fit South-Asian and western cultures. Notably, identity development may be problematic for those who move between two cultures (McKenzie-Mavinga, 2009). Participants described distancing themselves from their South-Asian culture as a way of integrating into western society and managing the conflict and perceived social unacceptance of their cultural identity. Although these factors influenced their experiences of psychosis and identity, they were not asked about by EIP services, meaning that cultural factors and complex experiences of second-generation British South-Asian individuals were not addressed in their mental health care.

Participant accounts pointed to a racial stigma where they described experiencing ethnic inferiority to white people (Lowe, 2014). This may be understood through the history of British colonialism in Asia which positioned white people as “superior” (Davids, 2011). Furthermore, participants described experiences of religious stigma, i.e. Islamophobia, which is a clearly documented form of stigmatisation and discrimination in British society (Runnymede Trust, 2017). Studies have shown that religious stigma can influence identity issues, feelings of belonging and lead to individuals becoming more withdrawn (Bonino, 2015; Mirza, 2019). This may be particularly detrimental to people experiencing psychosis who often make sense and cope with their experiences through a religious framework (Heffernan et al., 2016).

Furthermore, some participants felt stigmatised for being from a socially-deprived environment. Being from a low social status has been documented as also being associated with stigma and discrimination (Link & Phelan, 2001). All these types of stigma and discrimination are individually problematic, but when simultaneously enacted were significantly distressing for participants. These multiple facets of stigmatised identities appeared to mirror participants’ confusing and fragmented experiences of psychosis such as paranoia and hearing voices.

Intersectionality is a concept to describe how race, class, gender, and other identity markers “intersect” with one another and overlap (Crenshaw, 1989). This is an important consideration for this study in terms of understanding the complex interactions between factors linked to stigma. It was not possible to understand individual types of stigmatisation in isolation. The findings suggest that the multiple stigmatised identities participants described were intersecting, which seemed to shape their overarching experience of stigma relating to psychosis. Stigmatised identities have been described as multiplicative, interacting in a complicated manner to produce a given experience for individuals (Turan et al., 2019). Participants’ accounts of stigma in the present study were complex and varied, relating to psychosis or other stigmatised identities, or the intersecting nature of all of them (i.e. psychosis, racism, cultural identity, socio-economic status). Analysis sought to differentiate various types of stigma observable in the data, which could have easily been conflated with one another. For example, narratives and context of the participants’ accounts were relied upon to distinguish the form of stigma participants were referring to where possible. However, it is important to note that different types of stigma may not be understood as separate to each other by the participants.

Findings suggest that EIP services may not routinely explore intersecting stigmas or integrate these considerations into treatment. This contributed to the sense of not belonging (Yuval-Davis, 2012), which was confusing and distressing and may have further compounded experiences of stigma, psychosis and feelings of safety.

Recognition theory (Honneth, 1996; 2014) could explain participants’ accounts of feeling unrecognised and misunderstood. They did not only experience stigmatising prejudices towards them but did not feel recognised in their specific situation. Participants did not feel recognised by their families in their psychological singularity. Similarly, they did not feel recognised by EIP services in the

pluralities of their situation. Identity problems (of integration of multiple identities) and lack of self-esteem are closely linked to issues of recognition by others. Therefore, participants' sense of not belonging could also be related to a denial of recognition.

For socio-political context, this study was conducted at a time of a striking 475% increase in Islamophobic street attacks following the European Union referendum (Tell Mama, 2018). Furthermore, discrimination based on race, religion and status have been historically documented in the U.K. (Joseph Rowntree Foundation, 2011; Runnymede Trust, 2017). Indeed, early life experiences, attachments and trauma must be considered with this population (Birchwood, 2003; Read et al., 2014). Alongside this, social hierarchies arguably produce conditions for belonging and those who are perceived as "different" based on certain characteristics can become accustomed to not belonging (Ahmed, 2017). In other words, social structures create conditions for stigmatisation.

### ***Clinical implications***

It is recommended that individualised assessment, formulation and treatment is needed to consider a person's own relationship to their distress, circumstances and possible stigmatisation. Importantly, clinicians should carefully consider the impact on service-users from South-Asian backgrounds in receiving a psychosis-related diagnosis, as it is likely to be associated with stigma and discriminatory experiences. It would be helpful to have a collaborative and open discussion about the pros and cons of diagnosis. A key finding of this study is the different cultural perspectives participants perceived they had compared to their parents. This prevented them from sharing some of their experiences with their families. Therefore, a systemic approach is advocated to facilitate exploration of service-users' and their families' understanding of psychosis and consequential stigma. This could include understanding family-narratives and relational exchanges between family members that maintain cultural and intergenerational misunderstandings (Dallos & Draper, 2010), using family intervention, genograms and timelines.

On a front-line level, professionals need to better understand intersecting stigmas affecting British South-Asian people. This could involve training on racial prejudices, cultural conceptualisations of psychosis and ways to explore these with service-users. Raising issues relating to race can evoke shame, prejudice and avoidance in professionals, preventing them from fully engaging with service-users, and ultimately being complicit in marginalisation (Bhugra & Bhui, 1998; Fernando, 2017). Training may help staff build confidence and skills to sensitively explore intersecting stigmas with service-users.

The significance of negative attitudes towards psychosis in the South-Asian community was stressed by participants. Given EIP services have an ethos of being flexible, outreach work in South-Asian communities is recommended, particularly in places of worship and local South-Asian community centres. This would also enable clinicians to be more aware of present-day socio-political issues relating to British South-Asian people (i.e. Islamophobia) that may impact service-users accessing and using EIP services. It is recommended that EIP services respectfully work with local South-Asian communities to develop a psychological understanding of psychosis, as well as centring the values and strengths that local communities hold. This collaboration could create psychoeducation adapted to the cultural particularities of families. At an organisational level, social equality policies could be regularly reviewed and updated, identifying how to improve engagement with service-users from marginalised backgrounds.

### ***Limitations***

This study should be considered in light of its limitations. The sample consisted of ten people from British South-Asian backgrounds. There are significant differences within British South-Asian backgrounds, ethnicities and experiences, such as religion, thus limiting sample homogeneity. The current study found that participants experiences were idiosyncratic, based on their background,

identity and particular situation. Therefore, care needs to be taken not to conflate the experiences of all British South-Asians when transferring the findings to other contexts.

Notably, most of the sample was predominately male, with two females recruited. Although both female participants spoke in relation to being British South-Asian women, limited data was gleaned due to a small sample of women recruited. British South-Asian women experience distress differently and have higher rates of suicide and self-harm than British South-Asian men (Husain et al., 2006). Furthermore, through a lens of intersectionality (Crenshaw, 1989), women are deemed to face more social disadvantages than men. Therefore, lack of representation of the experiences of British South-Asian women is a shortcoming of the study. This study also did not focus on the perspectives of family, carers and wider British South-Asian communities and future research should explore their perspectives and experiences of stigma. Furthermore, given stigma within South-Asian communities exists, some people may have been deterred in participating in the research as they felt uncomfortable with a researcher of the same ethnicity (Bowes et al., 2000).

## Conclusions

In conclusion, participants reported that they experienced multiple and intersecting stigmas, including mental health, racial, religious and status stigma. Participants also described fragmented identities with difficulties managing the South-Asian and western parts of themselves, which was distressing. Participants also described feelings of shame and concerns about bringing shame to their family. Problematically, participants did not feel that EIP services adequately supported them with these issues. EIP services need to ensure they are assessing and supporting service-users with multiple stigmas and identities. Staff may require further training and support to do this.

## Acknowledgments

This study would not have been possible without each participant who courageously and honestly shared their stories. Also, the contributions of the two service-users who helped develop the study was invaluable.

## Disclosure statement

No potential conflict of interest was reported by the authors.

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