“It’s better to be quiet than share”: Perspectives of secondary-aged students of British Pakistani background in seeking support for Social, Emotional & Mental Health

Ariffa Yaqoob

A thesis submitted for the degree of Professional Doctorate in Child, Community and Educational Psychology

Tavistock and Portman NHS Trust and University of Essex

Date of Submission: July 2024

Abstract

This research explores the perspectives of British Pakistani adolescents on seeking support for Social, Emotional, and Mental Health (SEMH) issues. The study aims to understand the cultural and gender-specific barriers and facilitators that influence help-seeking behaviours in this demographic. Utilising a qualitative methodology, data were collected through semi-structured interviews with adolescents aged 16-18 attending post-16 educational settings. The findings highlight significant cultural barriers, such as stigma, the importance of maintaining family honour, and gender-specific expectations, which inhibit open discussions about mental health and seeking professional support. Female participants reported a relatively higher inclination towards seeking help compared to their male counterparts, who often faced cultural pressures to conform to traditional masculine norms. The research underscores the need for culturally sensitive mental health interventions and greater mental health literacy within the British Pakistani community. It also suggests the importance of collaboration between educational institutions, mental health services, and community organisations to effectively address the mental health needs of British Pakistani adolescents.

Acknowledgements

I would like to express my deepest gratitude to my research supervisor, Dr. Nikki Collingwood, whose arrival at the Tavistock could not have been more perfectly timed. Her unwavering support and guidance have been instrumental in helping me achieve everything I set out to accomplish in this thesis. Without her expertise and encouragement, I have no idea where I would be today.

I am grateful to all the tutors at the Tavistock who have supported me throughout my journey. Their motivation and assistance have been invaluable at every step, and I owe much of my progress to their dedication and encouragement.

A huge thank you to my husband, Raza, who has stood by my side through every hurdle over these past three years. His constant support, motivation, and tireless effort in proofreading the entire thesis have been essential in completing this work. Also, to my parents, who are the only people in the world who pray for me to achieve and surpass their own accomplishments. Their unwavering belief in me and their endless support have been a constant source of strength and inspiration.

Lastly, I would like to extend my appreciation to the 12 participants who generously gave up their time to provide valuable insights into their journeys. Their contributions have been crucial in enhancing our understanding and will undoubtedly help us learn and grow in our field.

Table of Contents

Abbreviations

MH - Mental Health

CYP - Children and Young People

SA - South Asian

UK - United Kingdom

DfE - Department for Education

SEMH - Social Emotional and Mental Health

SEN - Special Educational Needs

EBD - Emotional and Behavioural Difficulties

NHS - National Health Service

BAME - Black, Asian, and Minority Ethnic

CAMHS - Child and Adolescent Mental Health Services

EPS - Educational Psychology Service

UKME - United Kingdom Minority Ethnic

BPS - British Psychological Society

CASP - Critical Appraisal Skills Programme

FG - Focus Group

RTA - Reflective Thematic Analysis

IPA - Interpretative Phenomenological Analysis

EP - Educational Psychology

TREC - Tavistock and Portman Trust Research Ethics Committee

SENCO - Special Educational Needs Coordinator

Chapter 1: Introduction

1.0 Summary

This introduction sets out the context for this research by considering the increasing prevalence of mental health (MH) concerns in children and young people (CYP), before moving on to exploring aspects related to MH in ethnic minority groups, in particular, South Asian (SA) communities. The focus then moves to consideration of mental health in one specific SA community: British Pakistanis. A further factor, gender, is noted regarding seeking help for MH issues, with additional consideration of what support might be available. Relevant psychological theories and models are then proposed in the light of help seeking behaviours, specifically to address MH issues. Finally, the research aims are provided, alongside key research topics to explore as part of the literature review.

1.1 Social, Emotional & Mental Health - The Growing Priority

At the forefront of the political agenda in the United Kingdom (UK), there has been a persistent focus on advancing the mental health and well-being of children and young people (Department of Health, 2015 & Department for Education [DfE], 2017). The term, Social, Emotional and Mental Health (SEMH) is derived from the Special Educational Needs (SEN) Code of practice issued by the Department of Education (DfE) in 2015. Prior to this the category of SEMH was often referred to as Emotional and Behavioural Difficulties (EBD). However, this shift has allowed for a wider spectrum of challenges faced by children and young people (CYP) to be recognised. These challenges involve a variety of barriers to CYP education that present barriers such as attention difficulties, issues around school attendance and behavioural difficulties. A number of recent surveys have identified levels of concern around SEMH in this population. Sadler et al. (2018) found that one

in nine 5- to 15-year-olds were likely to experience mental health difficulties. Another survey carried out by the NHS in 2017 and 2020 around the mental health of CYP in England has recently been followed up in 2022. 2,866 CYP were surveyed in first two waves and again in 2022. The surveyed used the term "probable mental disorder[1]" which encompassed emotional, behavioural, hyperactive disorders and other disorders such as eating disorders (NHS Digital, 2022). The survey found a 15.6% increase in the rate of "probably mental disorder" between 2017 – 2022 for CYP aged 17 to 19 (NHS Digital, 2022). The above statistics highlight the concerning increase of mental health difficulties in children and young people within the UK. These statistics are a cause for concerns as it is believed that difficulties in mental health can have substantial longer-term influence on CYP, impacting their self-esteem, academic achievements, and personal relationships (Zins et al., 2004).

1.2 Social, Emotional & Mental Health – A Growing Priority in Ethnic Minority Communities

A 2021 report by The Health Foundation concluded that the number of CYP experiencing problems around mental health is rapidly increasing (Grimm et al., 2022). Importantly, they also stated that socioeconomic deprivation is a key factor in poor mental health and that although White adolescents are more likely to report worse mental health, suicide rates are similar across all ethnic groups (Grimm et al., 2002). Following on from this, there is increasing recognition in the UK, of the notion that ethnic minority 'communities', particularly the Black (African and Caribbean) and South Asian (Pakistani, Indian, and Bangladeshi) populations, carry a higher stigma regarding mental illness.

[1] The American Psychiatric association (2015) defines "mental health disorders" as *a major disturbance in an individual's thinking, feelings or behaviour that reflects a problem in mental function"*. The use of the term "disorder" can be seen as stigmatising and is much more of a medicalised term, as such, the term "condition" is considered more appropriate (Baron-Cohen, 2000). While the use of the term 'disorder' is not felt to be acceptable by the researcher, statistics and references using this term have been included in this thesis to include relevant information and rationale.

The argument often posits that within these communities, there exists more stigma associated with mental health issues due to specific spiritual, religious, or traditional beliefs. Seeking help for such problems is often stigmatised in these cultural contexts (Knifton, 2012; Shefer et al., 2013). The recent White Paper from the UK Department of Health and Social Care, titled "Reforming the Mental Health Act" (Department of Health and Social Care, 2021) highlighted stigma again as playing a role in the ethnic disparities in mental healthcare pathways. The paper highlighted cultural factors to consider. Individuals from Minority Ethnic groups might delay engaging with professionals due to community perceptions. This delay can stem from issues such as the recognition of mental health problems at early stages, the level of associated stigma, and a general lack of trust in services. Specific cultural challenges could distinctly affect the mental health of Minority Ethnic groups in the UK, which may not be as widespread in the broader population. These challenges encompass experiences such as abuse related to supernatural possession, forced marriages, female genital mutilation, and honour-based violence. Supernatural possession, a belief prevalent in some South Asian cultures, refers to the idea that an individual can be controlled or influenced by a spirit or supernatural entity. This belief often leads to various forms of abuse and can be used to explain behaviours or illnesses that are not well understood within the cultural context. Furthermore, seeking assistance from health services might pose difficulties, as these services might be unfamiliar with addressing or understanding the cultural intricacies linked to these particular issues (Bignall, 2015).

To date, most research on racial disparities in mental health care has focused on access to services (Bhui et al., 2003). However, it is equally important to understand the experiences of care received and engagement with that care. Studies have shown UKME groups exhibit higher levels of mistrust towards mental health services and staff (Henderson et al., 2015). They are more likely to disengage from services against staff recommendations and often experience worse outcomes. These negative experiences are associated with a subsequent avoidance of mental health services (Keating et al., 2004).

1.3 Social, Emotional & Mental Health issues in the South Asian Population

The term South Asian (SA) encompasses a diverse group of people hailing from the Asian subcontinent, including countries such as Pakistan, Bangladesh and India. It is important to acknowledge that within this broad category, there are differences in language, religion, caste, and sect. However, despite these distinctions, they do share common elements of social, cultural and political histories (Cowburn et al., 2015; Sangar & Howe, 2021; Kushal & Manickam, 2014). People living in South Asian countries face a considerable prevalence of "mental disorders" that frequently are not spoken about for various shared challenges (Trivedi et al., 2007). The lack of adequate human resources for mental health in these countries significantly impacts the treatment, diagnosis and prevention of "mental disorders" (Thara & Padmavati, 2013; Trivedi et al., 2007). Moreover, mental health is not adequately acknowledged as a priority in health policies of these nations. Many South Asian countries lack efficient policies, legislation, programs strategic plans and other necessary measures to address MH issues within their communities (Hossain et al., 2019).

Within the South Asian community in the UK , various factors, including gender and age, have been found to contribute to mental health challenges. Research on adults in this group reveals a nuanced prevalence picture. Bebbington et al. (2009) discovered that South Asian females, collectively, exhibited higher rates of common "mental disorders" compared to individuals with Black or White backgrounds. These findings underscore the impact of cultural attitudes and other influences on mental health issues in South Asian communities, emphasising the importance of culturally sensitive approaches to MH support (Race Equality Foundation, 2015). Gov UK statistics show that 12.9% of Asian males and 23.6% of Asian females experienced a common "mental disorder" in 2014 (GovUK, 2014). Conversely, Weich et al. (2004) observed elevated rates of common mental disorders in middle-aged Pakistani men and older Indian and Pakistani females, with notable lower prevalence in Bangladeshi females. According to MacLellan et al. (2023), cultural attitudes

promoting a "just getting on with it" mindset may contribute to this variation and discrepancy in reported numbers.

Studies exploring MH experiences among the SA community within the UK have highlighted key themes such as; shame, honour, stigma, discrimination as well as systemic barriers that hinder help seeking (Connor et al., 2016; Sangar & Howe,2021). Furthermore, these experiences of MH have been found to impact participation and engagement from those from SA background (Virdee et al., 2017). Some other key themes drawn upon throughout the literature is the belief from those in the SA community that MH illnesses could be a result of witchcraft, Blackmagic, punishment from God or even a test from God therefore making them less likely to access services and professionals but instead seek support from faith leaders (Bhikha et al., 2015; Ahmed et al., 2017; Islam et al., 2015).

From a children and young people (CYP) point of view, a study conducted by Haringey Clinical Commissioning group (2017) looking at Child and Adolescent Mental Health Services (CAMHS) access for Black, Asian, and Minority Ethnic (BAME) children and young people in Haringey revealed that UKME children were notably under-represented in mental health services.. The 2015 CAMHS Review and subsequent Transformation Plan identified a concerning under-representation of BAME children and young people accessing services. This highlights a potential gap in mental health support for these communities, indicating a need for targeted interventions to improve access and engagement.

Moreover, data from the 2015 audit showed that while the service profile closely aligned with the demographic data from the 2011 Census for most ethnic groupings, there was a notable under-representation of Black African children and young people in CAMHS services. This disparity underscores the importance of addressing barriers that may prevent certain ethnic groups from accessing mental health support. It also emphasises the need for culturally sensitive approaches to

mental health care that cater to the diverse needs of BAME individuals in the community (Swaile, 2017).

Additionally, data from April 2017 highlighted in the report conducted by Swaile (2017) collaborative efforts between Barnet, Enfield, and Haringey Mental Health Trust and Mind in Haringey to engage with faith and community groups. These initiatives aim to promote emotional wellbeing within under-represented communities and explore the reasons behind the variance in access to CAMHS services. By working closely with local organisations and community leaders, the Trust was attempting to take proactive steps to bridge the gap in MH service provision and address the specific needs of BAME populations in Haringey. Overall, these findings underscore the ongoing efforts to improve access to CAMHS for BAME communities in Haringey. By identifying and addressing disparities in service provision, implementing targeted interventions, and collaborating with local stakeholders, the aim was to ensure that all children and young people, regardless of ethnicity, have equal access to essential mental health support and resources.

Qualitative investigations within the South Asian community highlight numerous intersecting cultural elements that require deeper examination within this demographic. However, existing research is constrained by varied sample compositions, including mixed ethnicities, diverse mental health experiences, and origins from different countries. Some studies merge the experiences of ethnic minorities as a whole rather than looking at different norms between the groups (Dein & Sembhi, 2001; Weatherhead & Daiches, 2010). Therefore, it would be necessary to focus specifically on individual communities within the South Asian community to gain deeper insight and understanding. The research findings from Iqbal et al (2012) suggest that grouping diverse ethnicities under broad categories like "South Asian" may lead to statistical inaccuracies, especially for specific groups like Pakistanis. Participants in the study expressed concerns about having to select the "South Asian" box when providing ethnicity data, as this oversimplification may obscure significant differences in health outcomes and healthcare needs among distinct ethnic subgroups, such as

Pakistanis. When individuals from Pakistani backgrounds are forced to select a generic category like "South Asian," their unique health concerns and risks may not be adequately captured. This could result in the underrepresentation or misrepresentation of health issues specific to the Pakistani community in healthcare statistics and resource allocation decisions. Therefore, emphasising the importance of collecting detailed and accurate ethnicity data to ensure that the healthcare system can effectively address the diverse needs of different ethnic groups, including Pakistanis, and mitigate health disparities (Iqbal et al., 2012) .

Individuals of Pakistani ethnic origin in the UK often associate mental health issues with religion and frequently resort to traditional or religious methods, often turning to treat possession (Bhui et al., 2008). Studies suggest differences in seeking help between generations, with younger individuals leaning towards more Western approaches (Tabassum et al., 2000). The significant stigma surrounding mental health problems and the fear of hospitalisation are felt to be substantial factors that hinder the seeking of assistance among the Pakistani community (Bradby et al., 2007; Gunasinghe et al., 2019). A more recent study conducted by Ayub and Macaulay (2023) looked at the perceptions of British Pakistani Muslims towards mental health. Their findings revealed that those from within this community were more likely to turn to Islam as a means of gaining stronger MH. A second theme highlighted was a fear of public opinions, this was described as a barrier to seeking help due to the stigma around MH within the community.

1.4 Social, Emotional & Mental Health – Is Gender a Factor in Seeking Help For Mental Health?

While cultural background could be considered as one factor related to differences in seeking help for mental health, the discussion in sections above has also highlighted that gender appears to be a factor which is linked to either prevalence or likelihood of acknowledging that help is needed.

As initially noted, MH issues among secondary-aged students are on the rise, however, the reported figures based on gender during adolescence show inconsistent patterns. According to statistics, the rates of probable mental disorders among individuals aged 11-16 in the UK were similar for females at 22% and males at 18.8%. However, in the age group of 17-24, young females exhibited a notably higher rate (31.2%) compared to young males (13.3%) (NHS Digital, 2022). Cybulski et al. (2021) conducted a study revealing an increase in disorders like anxiety, depression, eating disorders, and self-harm among adolescent females in comparison to males. Additionally, it was found that females are more likely to receive a diagnosis of a mental health disorder by the end of secondary school compared to males (Hamblin, 2016). Nevertheless, it is suggested that the number of young individuals seeking help, particularly females, has risen over the years due to factors such as reduced stigma, increased awareness, and changes in diagnostic criteria, potentially contributing to the increased rate of diagnosis (Newlove-Delgado et al., 2022).

There has been research looking into gender differences with regard to seeking help for mental health issues. In this thesis, help-seeking will be characterised as actively reaching out to healthcare services or reliable individuals within the community to enhance one's well-being (Rickwood et al., 2015). This encompasses the pursuit of understanding, guidance, treatment, and comprehensive support during periods of distress or when confronting stressful situations (Rickwood & Thomas, 2015). According to McKenzie et al. (2022) males often hide emotional struggles due to societal expectations that dictate they should endure pain stoically. This reluctance to express emotions, rooted in the fear of appearing less masculine, contributes to shame and inhibits seeking support for mental health issues (Lin & Parkin, 1999; Yousaf et al., 2015). Embarrassment, fuelled by societal norms and bullying, becomes a significant obstacle, not only preventing formal help-seeking but also hindering the public display of emotions. The pressure to conform to stereotypes like "big boys don't cry" creates cultures where negative emotions are stigmatised, making it challenging for

men to show vulnerability and, consequently, seek therapeutic support (Branney & White, 2008; Vogel et al., 2011).

1.5 Social, Emotional & Mental Health – What is Available To Support Children and Young People?

In the UK, statistics reveal that 1 in 4 individuals aged 11–16 sought support for mental health and well-being in school in 2021 (NHS Digital, 2022). Recent surveys indicate that 83% of young people are aware of how to access mental health and well-being support from school, and 79% believe they can readily avail this support if needed (NHS Digital, 2022).

As technology advances, platforms like Kooth (2023) and Young Minds (2023) offer online support for children and young people regarding well-being and mental health. However, the extent of awareness and utilisation of these platforms remains uncertain. Reports suggest that Kooth (2021) had 3,500 young individuals accessing its site, with 39% of those under 18 presenting suicidal thoughts and a 27% increase in those displaying self-harm (Central and North West London NHS, 2023).

The Green Paper from the Department for Education (DfE, 2017) underscores the importance of early intervention and preventative measures, particularly within educational settings. The recommendation includes the establishment of a new mental health workforce with community-based teams providing support and the encouragement for all schools and colleges to designate a lead responsible for mental health matters. This led to the creation of the Educational Mental Health Practitioner (EMHP) role. EMHPs specialise in evidence-based interventions tailored to address mild-to-moderate mental health and emotional well-being concerns, collaborating with key school staff to address these issues (Anna Freud National Centre for Children and Families, 2023). Ellins et al. (2023) looked into the implementation mental health support teams in schools and colleges. One key

finding was the lack of clarity surrounding the role of EMHPs within the teams, which created challenges for effective implementation.

Criticisms of the EMHP role included concerns about the efficacy of standardised Cognitive Behavioural Therapy interventions, with data indicating that these interventions were not universally effective for all children. Additionally, there were reported difficulties in retaining EMHPs, with a significant percentage leaving their positions due to factors such as workload pressures and limited career progression opportunities. Despite these challenges, EMHPs were acknowledged for their crucial role in providing mental health support to children, particularly those who have been historically under-served. Positive impacts of the EMHP role included increased access to mental health support for children in educational settings and a reduction in mental health inequalities among students. The study highlighted the importance of addressing training and development needs to enhance the effectiveness of EMHPs in delivering tailored and culturally sensitive mental health interventions to meet the diverse needs of students.

Current initiatives rolled out in schools are interventions such as using Emotional Literacy Support Assistants (ELSAs) or other interventions in regards to helping support young people with SEMH such as; support groups, support from external agencies or the use of Educational Psychologists. Research indicates that interventions led by ELSAs have a positive impact on children and young people (CYP). Engaging in ELSA programs has been associated with enhancements in various areas including confidence, interpersonal relationships, academic performance, overall well-being, and emotional literacy (Alemdar & Anılan, 2020). Additionally, ELSA interventions have been correlated with increased participation in learning activities, a heightened sense of security in the school environment, and improved attendance rates among students (Purcell et al., 2023). These findings underscore the pivotal role ELSAs play in nurturing the emotional well-being and development of students within educational institutions. The efficacy of the program in fostering

emotional regulation, social competencies, academic progress, and overall welfare highlights the significance of delivering tailored assistance to address students' emotional needs in educational settings (Purcell et al, 2023).

A review by Lynch et al. (2022) revealed that family and friends play crucial roles in the pathways of children and young people seeking help, either facilitating or posing barriers to accessing professional services. Seeking help from formal services can elicit feelings of discomfort, vulnerability, and a sense of losing control for young individuals. Conversely, turning to a previously accessible and trustworthy informal relationship can provide a sense of certainty (Coleman-Fountain et al., 2020).

1.6 Theoretical Underpinnings around Seeking Support For Mental Health

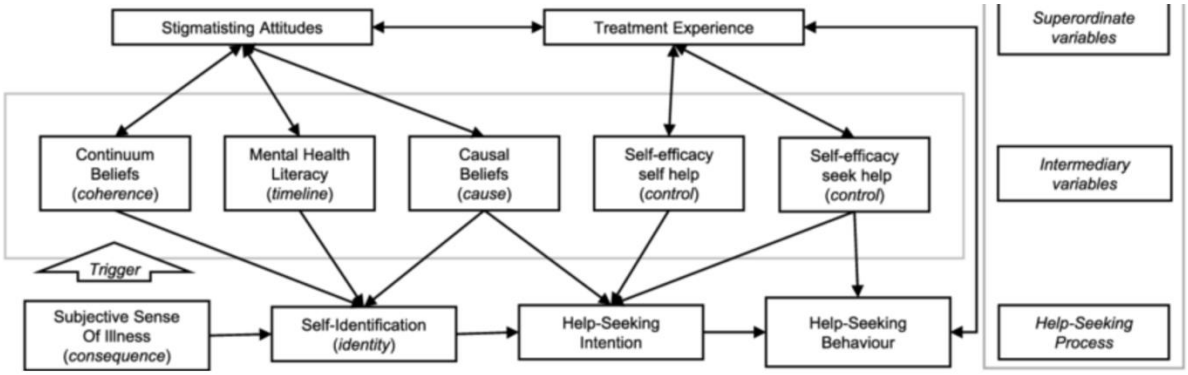
The Seeking Mental Health Care model by McLaren et al (2021) is a comprehensive framework designed to predict help-seeking behaviour for depressive symptoms (see figure 1) by considering a range of attitudinal and cognitive variables. This model encompasses broad factors such as stigma and treatment experiences, along with intermediate attitudinal variables like continuum and causal beliefs, depression literacy, and self-efficacy. As detailed by McLaren et al. (2021), the model offers a validated conceptual framework for understanding the help-seeking process in individuals with untreated depressive symptoms, focusing on internal influences in decision-making.

The Seeking Mental Health Care model by McLaren et al. (2021) can be particularly linked to the British Pakistani community through its comprehensive consideration of attitudinal and cognitive variables influencing help-seeking behaviour for depressive symptoms. In this community, mental health stigma is a significant barrier, with cultural beliefs often viewing mental illness as a sign of

weakness or a taboo subject (Memon et al., 2016). The model's focus on stigma and past treatment experiences highlights the need for culturally sensitive mental health services, which can improve trust and treatment outcomes (Haque et al., 2015). Furthermore, causal beliefs about mental health, influenced by traditional and religious perspectives, align with the model's emphasis on continuum and causal beliefs, aiding in the development of interventions that respect and integrate cultural and religious contexts (Ciftci et al., 2013). The model also underscores the importance of depression literacy, which is often limited in the British Pakistani community due to a lack of education and awareness (Shah, 2010).

Figure 1

The Seeking Mental Health Care Model Illustration (McLaren et al., 2021)



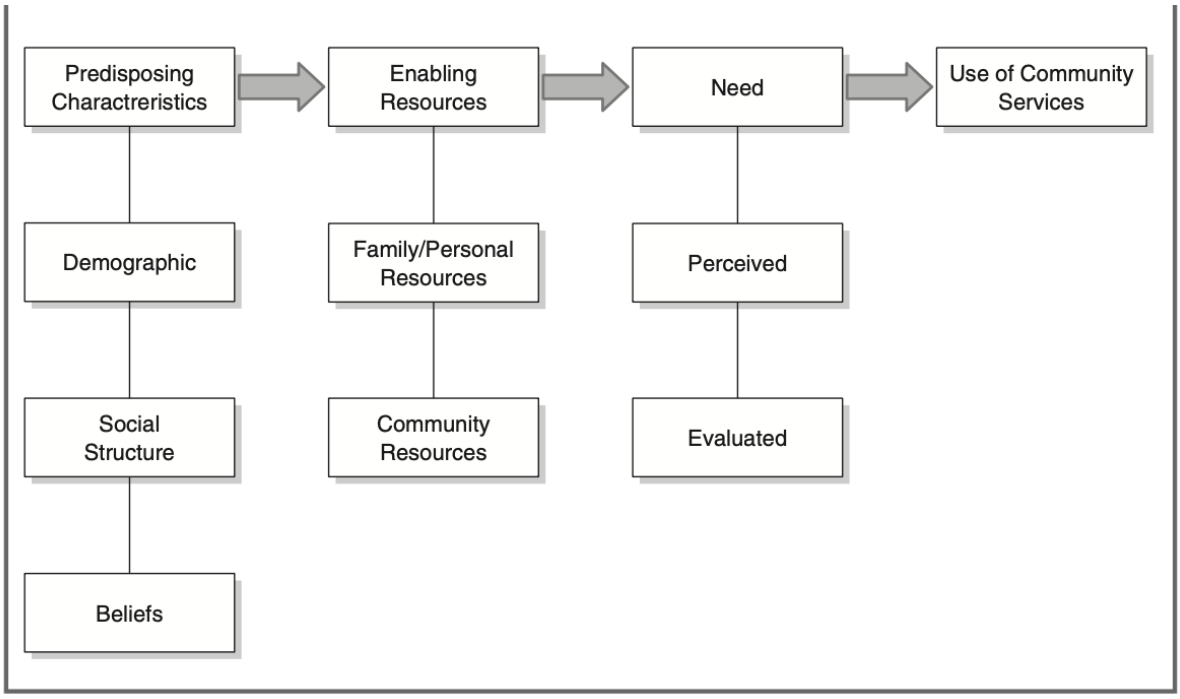
The Social Behaviour Model, as described by Anderson (1995) (see figure 2) , suggests that individuals' decisions to use community services are influenced by predisposing characteristics (such as demographics, social factors, and personal beliefs), enabling resources (like access to services and community resources), and perceived need for services. Moreover, the model emphasises the perceived need for services, influenced by individuals' subjective evaluations of their own health or social needs. By integrating these factors, the Social Behaviour Model provides a robust framework for understanding how individuals navigate and utilise community resources, offering insights crucial

for designing effective interventions and policies aimed at improving service accessibility and utilisation across diverse populations.

The Social Behaviour Model (1995), is particularly pertinent to understanding help-seeking behaviours within the British Pakistani community, especially in relation to mental health services. This model examines predisposing characteristics, enabling resources, and perceived need for services, all of which interplay uniquely in this context. Predisposing characteristics, such as demographics and personal beliefs, underscore the significant impact of cultural norms and social expectations. Within the British Pakistani community, there is a pronounced stigma associated with mental health, driven by concerns over family honour and fear of social judgement (Iqbal et al., 2012; Pilkington et al., 2011). These cultural pressures often lead individuals to seek help from religious or traditional healers rather than mental health professionals, due to beliefs in supernatural causes of mental health issues, such as Jinn possession (Khalifa et al., 2011). Enabling resources also play a crucial role, where barriers such as language difficulties, lack of culturally sensitive services, and limited awareness of available mental health support hinder access (Memon et al., 2016; Ali et al., 2016). Community resources, when culturally tailored, can enhance help-seeking behaviours, but these need to be more widely available and known (Sangar & Howe, 2021). Lastly, the perceived need for services is influenced by individuals' subjective evaluations of their mental health needs, often suppressed by the internalisation of stigma and a belief in handling issues privately within the family (Pilkington et al., 2011).

Figure 2

The Social Behaviour Model Illustration (Phillips et al, 1998)



1.7 Research Purpose and Aims

There have been indications of an escalation in mental health issues across different demographics in the UK. However, certain groups have been highlighted as particularly concerning in the introduction above which include secondary aged students and those from ethnic minorities, such as those from a South Asian background, specifically British Pakistani. Individuals from either of these groups are deemed vulnerable for a variety of reasons, and as such research which includes them is deemed important to understand particular factors (relevant to age and culture) which may be linked to mental health concerns. Moreover, the discussion in the introduction has also noted indications that there are differences in help seeking behaviours (as well as the likelihood of seeking help) which may be linked to gender and cultural factors. Therefore, research to gain insight into barriers and facilitators to seeking support would be welcomed so that possible adaptation could be made to increase likelihood. Furthermore, consideration of the intersection of these two factors

(gender and culture) may require further exploration to provide greater insight for the purposes of providing specific, targeted support.

Educational Psychologists (EPs) are expected to engage with a diverse range of children and young people (CYP) of different ages and backgrounds. Both the British Psychological Society (BPS) and Health and Care Professions Council (HCPC) proficiencies stress that EPs should demonstrate an understanding of cultural influences on development, possess knowledge of evidence-informed strategies for promoting mental health (BPS 1.5), and apply diversity and cultural differences effectively (BPS 3). Limited research by EPs exists on supporting the British-born Pakistani community, highlighting a gap in understanding and assistance. Considering the UK's multicultural society, it is imperative for EPs to enhance cultural competency/ curiosity and awareness around sensitive topics to effectively support individuals who may feel marginalised. The role of the EP has extended to looking at the whole child rather than heavily focussing on Cognition and Learning, therefore SEMH is much more relevant to the role of the EP today.

2.0 Introduction

Mental health issues are a growing concern across different demographics in the UK (Health Foundation, 2021). However, certain groups have been highlighted as particularly concerning in the introduction above which include secondary aged students and those from ethnic minorities, such as those from a South Asian (SA) background. Despite the increasing acknowledgment of mental health issues among this community, research on how they seek help is still limited, particularly in children and adolescents. Studies exploring mental health (MH) experiences among the broader, older SA community within the UK have highlighted key themes such as; shame, honour, stigma, discrimination as well as systemic barriers that hinder help seeking (Connor et al., 2016; Sangar & Howe,2021). There are differences in help seeking behaviours (as well as the likelihood of seeking help) which may be linked to gender and cultural factors (Hamblin, 2016; Newlove-Delgado et al., 2022) As such, individuals from this group might be particularly vulnerable and therefore, research to gain insight into barriers and facilitators to seeking support would be welcomed so that possible adaptation could be made to increase likelihood. This literature review therefore seeks to examine factors that influence individuals from ethnic minority groups, including British Pakistanis, to seek help for their mental health. Furthermore, this review aims to bring together and analyse available literature to better understand any demographic and cultural factors, which is a focus of the current research.

In examining the literature, it is evident that various terms are used to describe related concepts. Terms like "mental health," "mental illness," "emotional wellbeing," and "social emotional and mental health (SEMH)" are often used interchangeably. Despite these differences in terminology, there is a general agreement in the literature that these terms are intrinsically linked to social and

emotional wellbeing. This variation in language highlights the complex nature of mental health issues and the intricate factors influencing individuals' experiences and behaviours.

2.1 Literature Review Strategy

2.1.1 Approach to Literature Review

An initial scope of the literature was undertaken as part of the preparation for the proposal in May 2023 This initial scope identified a limited number of articles in the area of seeking support for mental health extremely limited around British Pakistani adolescents. As such, it was decided that the review of literature needed to be broadened to allow for the inclusion of research involving participants beyond adolescence. However, accessing support or help seeking was for mental health or emotional needs was a central focus. Therefore, the literature review is aimed to answer the following literature review question:

What are the barriers and facilitators in relation to seeking help for their Social, Emotional, Mental Health or Emotional Wellbeing for individuals with Pakistani heritage?

A systematic literature review was used since it provides a structured and comprehensive approach to identifying, evaluating, and synthesising all relevant research on a particular topic (Gough, Oliver, & Thomas, 2017). This method is distinguished by its rigorous and replicable process, involving clearly defined inclusion and exclusion criteria, systematic search strategies, and a detailed analysis of the findings from included studies. By minimising bias through explicit and standardised procedures, a systematic review ensures that the results are robust and reliable, making it a preferred method for this research.

A systematic literature review is a methodical and structured way of reviewing the literature on a particular topic. It aims to minimise bias by using explicit and standardised procedures. This process typically involves several key steps: defining a clear, focused research question, developing a predefined protocol outlining the methodology, conducting a comprehensive search using multiple databases and search engines, screening and selecting studies based on predefined criteria, systematically extracting relevant data, assessing the quality and risk of bias in the included studies, and finally analysing and synthesising the findings (Higgins et al., 2019). This structured approach ensures that the review is thorough and replicable, making it easier for other researchers to verify the findings and build upon the research.

Compared to other types of literature reviews, such as narrative reviews, systematic reviews are more rigorous and less prone to bias. Narrative reviews provide a broad overview of a topic but are often subjective and may not use a standardised methodology. Scoping reviews are used to map the key concepts underpinning a research area and the main sources and types of evidence available but do not typically assess the quality of evidence (Petticrew & Roberts, 2006). In contrast, systematic reviews follow a strict protocol and often include meta-analysis to statistically combine results from different studies, providing more robust estimates of effects or associations.

The systematic review approach was chosen for this research to ensure comprehensiveness, transparency, and minimisation of bias. By considering all relevant literature, the review provides a thorough overview of the research landscape. The systematic process also makes it easier for other researchers to replicate the study and verify the findings, enhancing the reliability and validity of the conclusions. This method is particularly useful in fields like mental health, where research findings can vary widely, and there is a need for clear, evidence-based guidance (Higgins et al., 2019).

2.1. 2 Searching the Databases

A literature review was conducted in December 2023 and followed up in January 2024 to encompass research across various fields, a selection of databases was made, including PsycINFO, SocINDEX, ERIC, and PsychArticles. The rationale for using PsycINFO, SocINDEX, ERIC, and PsychArticles in the literature review was to ensure comprehensive coverage of relevant literature from multiple disciplines pertinent to the research topic. PsycINFO was selected for its extensive coverage of psychological research and related fields such as psychiatry, sociology, and education, which are crucial for understanding mental health issues. SocINDEX was chosen for its focus on sociology and related disciplines, including social work and social psychology, providing valuable insights into the social and cultural factors influencing mental health and help-seeking behaviours. ERIC was included to capture research on mental health in educational settings, which is particularly important for studying children and adolescents and understanding how educational environments impact mental health and help-seeking behaviours. PsychArticles offers full-text articles from a wide range of psychology journals, providing access to empirical studies, literature reviews, and theoretical papers, making it a rich resource for in-depth research on mental health topics. By selecting these databases, the review ensures a thorough exploration of the psychological, sociological, educational, and empirical aspects of mental health and help-seeking behaviours among British Pakistani adolescents, supporting a nuanced understanding of the factors influencing mental health support within this demographic. Simultaneous searches were conducted on these databases using EBSCOhost. Additionally, Google Scholar was explored to ensure comprehensive coverage of relevant information not captured by the databases above.

The table below shows the search terms used when searching the literature. Various combinations of the following keywords were utilised.

Table 1

List of search terms

Terms used for searching the literature. **Topics**	**Associated Terms**	**Fields Considered**
Mental Health	"Mental health" "Mental Illness" "Mental disorder" "Emotional wellbeing" "Wellbeing" "SEMH" "Social, Emotional Mental Health"	Title and Abstract
South Asian or BAME or Ethnic Group	"SA" "British Asian" "Pakistani "BAME" "ethnic minority" "minoritised"	Title and Abstract
Help Seeking	"Help Seeking" "seeking support" "Support" "attitudes" "barriers" "facilitators" "CAMHs" "Pastoral support"	Title and Abstract
Participants	"Adolescents" "Children and Young people" "Teenagers" "secondary aged" "Adults"	Title and Abstract

2.1.3 Inclusion and Exclusion Criteria

The search returned a total number of 364 articles, these were further narrowed down by reading titles and abstracts not all articles produced were about adolescents and the majority was outside the age range (A flowchart of the literature search can be found in appendix 1) . It is significant to highlight that the term 'South Asian' also surfaced literature exclusively focused on Indians and Bangladeshis. In certain literature where 'South Asian' and ‘BAME’ was employed and Pakistani or “Asian/ British Asian” participants were included in the larger participant group, these studies were retained because of the scarcity of research exclusively focusing on the target group. Furthermore, it was noted that there was limited availability of literature focused on adolescents, so research was included if it contained literature strongly relevant to participants from the British Pakistani community (children, adolescents, and post-18-year-old individuals, e.g., university students). The initial inclusion criteria for the literature search focused specifically on adolescents; however, due to the limited availability of relevant studies, the criteria were broadened to include literature on adults as well. This adjustment was made to ensure a comprehensive review of the topic, as it became evident that there was a significant scarcity of research exclusively focused on British Pakistani adolescents and their mental health needs.

The reasons for use of terms associated to mental health was to ensure to cover a wider scope of research around this topic. If articles focused on seeking help for physical illnesses rather than mental health or SEMH needs, they were excluded as the primary focus of the research is around help seeking in relation to mental health and SEMH.

Limiters were applied, which included a requirement for the literature to be written in English and published between 2014 – 2024. Originally these dates were chosen to ensure literature was recent and therefore most relevant, however due to the lack of studies available the period was subsequently expanded and covered the period (2010 – 24).

All articles included in the review were taken from peer reviewed journals. Finally, if the studies were conducted outside the UK they were excluded. This criterion was important because the current research was interested in aspects related adolescents born in the UK and seeking support available in the UK. This last exclusion criterion further reduced the final number of studies included for the literature review. Consequently, 8 studies were incorporated due to their direct relevance to the literature review question. These articles specifically addressed mental health in British South Asians, barriers to help-seeking among British South Asians, British Pakistanis and British South Asian Young people. The literature review by Ineichen (2012) is included in this research as the review provides a comprehensive overview of mental health issues among British South Asian adults, offering crucial insights into cultural, socio-economic, and generational dynamics. Serving as a valuable scoping review, it synthesises studies to highlight mental health disparities and cultural influences, identifying gaps and forming a foundation for further research.

In interest of academic rigor, there are several inherent limitations that should be acknowledged when citing literature identified via another literature review. One significant concern is the risk of secondary bias, as the cited review reflects the original author's choice in study selection, inclusion criteria and thematic focus. These decisions may introduce subjectivity, and any biases present in the original review are compounded when referenced in a subsequent review. Additionally, literature reviews often lack access to primary data, preventing a direct evaluation of the robustness or methodologies of the studies they synthesise. This distance from original evidence can limit critical appraisal and the ability to assess the strength and reliability of the findings.

Another limitation is the potential for narrowed scope and overgeneralisation. Literature reviews often synthesis diverse studies, which may lead to conclusions that are too broad or not entirely applicable to specific research contexts. Moreover, such reviews may focus on a subset of perspectives, omitting alternative findings that could provide a more comprehensive view. Lastly

citing a literature review risks duplicating rather than expanding upon existing interpretations, which could reduce the novelty and depth of current analysis.

Despite these challenges, referencing a literature review can be valuable when its themes align closely with the current research, as it helps contextualise findings within the broader academic landscape. The studies included in the literature review can be found in Appendix 1a.

2.1.4 Review of the Quality of the Literature

Prior to identifying key themes in the papers incorporated in the literature review, a critical appraisal was undertaken which considered aspects such as those linked to appropriateness of: the research design, methods to collect data; participant selection; as well as looking at aspects related to ethic and value of the research. The evaluation of qualitative and Systematic review articles was conducted using the Critical Appraisal Skills Programme (CASP, 2011) framework.

Appendix 2 provides a summary of this appraisal of literature. It is useful to note that the study designs were varied, providing a mix of quantitative and qualitative data. Some limitations highlighted through the completion of the CASP were the use of unvalidated questionnaires used in the study by Khalifa et al (2011) could impact reliability. Studies used a small sample size so this could impact generalisability (Memon et al., 2016; Sangar & Howe, 2011; Aliet al 2016). In the CASP analysis of the study by Khalifa et al. (2011), two key points of consideration are the recruitment strategy and the relationship between researchers and participants. The study employed a convenience sampling method, recruiting participants from mosques, Islamic centres, and shopping areas in Leicester. While this approach effectively targeted locations with high Muslim populations, it may not have captured the full diversity of the Muslim community, potentially introducing selection bias. A more representative sample could be achieved through random or stratified sampling, broader recruitment sites, and online platforms. Regarding the researcher-participant relationship,

the use of anonymous self-report questionnaires minimised social desirability and interviewer biases but limited deeper interaction and contextual understanding.

The study by Memon et al. (2016) effectively explores perceived barriers to accessing mental health services among Black and Minority Ethnic (BME) communities in Southeast England through qualitative focus group discussions. The thematic analysis identified key themes, including personal and environmental factors and the relationship between service users and healthcare providers. While the recruitment strategy targeted the intended population, it introduced potential selection bias, as the sample was predominantly university-educated and may not fully represent the BME community's diversity. Data collection was thorough and ethically sound, with rigorous analysis involving iterative coding and independent review.

To provide meaningful understanding of the limited available research, the findings from the studies were synthesised to find overall themes that lay across some or all of those identified.

2.2 Themes Identified in The Review of The Literature

The themes which emerged from the literature included additional insight into the prevalence and specific experiences within minority ethnic communities across both the adult and CYP populations. Another important aspect highlighted the role of beliefs and religious figures in the context of mental health. In terms of factors influencing help-seeking for mental health, a number of factors were identified through the review. Alongside socio-economic, language and educational factors, there were important sub-themes related to the impact of culture from a number of perspectives (professional relationships, practices and pressures, gender and mixed cultural identities).

2.2.1 Prevalence and Experiences of Mental Health Concerns

2.2.1.1 Adult populations

The mental health needs of South Asians, as well as other BAME (Black, Asian, and Minority Ethnic) groups, have been consistently identified as inadequately addressed (Ineichen, 2012). According to some authors, the mental health disparities among British South Asians' stem from a mix of cultural, socioeconomic, and generational dynamics (Ineichen, 2012; Bains &Gutman, 2021; Soorkia et al., 2011). Establishing mental health prevalence rates within this demographic poses challenges due to the wide array of presentations and differing conceptualisations of mental health across cultures. The difficulties in recognising and quantifying mental illness among British South Asians stem from factors such as cultural variations in symptom manifestation, reliance on alternative health services, and the perception of mental health as not strictly medical. These obstacles potentially lead to the underreporting or under detection of mental health concerns, including anxiety and depression, within the South Asian community (Ineichen,2012).

Nevertheless, British South Asians have been noted to experience elevated levels of psychological distress, as indicated by Pilkington et al. (2012). The occurrence of common mental illnesses exhibits notable variations within distinct BME (Black and Minority Ethnic) communities. Memon et al, (2016) highlight the significant barriers to accessing mental health services among Black and Minority Ethnic (BME) communities in Southeast England, focusing on systemic, cultural and individual challenges. While the study itself does not provide primary epidemiological data on prevalence rates, it contextualises its findings within existing literature. For instance, Pilkington et al. (2012) reported elevated levels of psychological distress among South Asian women in Britain, often linked to stigma, racism and socioeconomic challenges. Similarly, other studies have documented a higher incidence of psychotic disorders among Afro-Caribbean men, influenced by delayed engagement with mental health services and systemic discrimination. These findings underscore the interplay of cultural, socioeconomic and systemic factors in shaping mental health disparities,

reinforcing the need for culturally tailored mental health interventions to address these vulnerabilities (Memon et al, 2016; Pilkington et al, 2012). This diversity in mental health needs emphasises the crucial need for culturally sensitive and customised mental health services for minority ethnic groups (Memon et al, 2016; Pilkington, 2012, Moller et al, 2016).

In regard to gender, research indicates that South Asian women in the UK face unique cultural and systemic barriers contributing to significant mental health challenges. Pilkington et al. (2012) highlight how factors such as shame (izzat), the preservation of family honour and limited acculturation significantly deter women from seeking psychological help, leading to increased susceptibility to psychological distress. These cultural pressures, combined with stigma surrounding mental health, create a challenging environment for addressing mental health issues within this demographic. Similarly to what has been mentioned above, factors that contribute to this susceptibility encompass socio-economic difficulties, encounters with racism, social exclusion, and residing in economically disadvantaged areas. While these elements contribute to the increased prevalence of mental health issues, they do not fully explain all the variations in reported levels of distress among South Asian women (Moller et al., 2016). Addressing these factors through culturally sensitive and easily accessible mental health services is pivotal in bolstering the mental well-being of the South Asian community in the UK.

2.2.1.2 Children and Young People

In terms of children and young people in this population, the literature reviewed provided the following insight into prevalence and experiences of mental health. Bains and Gutman (2021) conducted a study on the mental health of ethnic minority populations in the UK, examining the developmental patterns of mental health from early childhood to mid-adolescence. The investigation centred on internalising and externalising issues in children from diverse ethnic backgrounds, such as Indian, Pakistani, Bangladeshi, Black Caribbean, Black African, and other/mixed

ethnicities, in comparison to White children. They found that children from ethnic minority backgrounds, including British South Asian and Pakistani children, demonstrated higher levels of internalising problems than their White counterparts from ages 3 to 14. The study emphasised the persistent ethnic disparities in child psychopathology, underscoring the necessity for tailored interventions and culturally competent care to address mental health gaps in ethnic minority populations. These findings emphasise the significance of recognising and mitigating mental health discrepancies in ethnic minority children and adolescents. It highlights the need for promoting well-being and implementing effective support and interventions for these vulnerable populations.

Findings from Bains & Gutman (2021) indicated that children from ethnic minority backgrounds showed elevated levels of internalising problems when compared to their White counterparts. These discrepancies were evident until the age of 7 for most minority groups. Specifically, Pakistani children were identified as exhibiting heightened levels of internalising problems in comparison to White children. This disparity in internalising problems persisted throughout the developmental trajectory from ages 3 to 14 years, highlighting a specific vulnerability in this aspect of mental health among Pakistani children in the UK. The study also highlighted disparities in mental health trajectories, revealing that Pakistani children, alongside other ethnic minority groups, exhibited distinct developmental trajectories of internalising problems compared to White children. These disparities persisted, and intriguingly, factors such as child sex, socioeconomic status, maternal depressive symptoms, or maternal immigrant status did not account for the observed differences in mental health outcomes. This suggests the presence of other contributing factors that warrant investigation.

2.2.2 Religious Beliefs and Mental Health

Khalifa et al. (2011) investigated beliefs concerning Jinn (Spirits), black magic, and the evil eye among Muslims, exploring the potential influences of age, gender, and first language on these

beliefs. The study aimed to discern the prevalence of such supernatural beliefs within the studied Muslim population and understand how these beliefs might shape individuals' perspectives on health and illness. Additionally, the research sought to illuminate the cultural and religious factors that contribute to beliefs in Jinn, black magic, and the evil eye, offering insights for healthcare providers on effectively addressing these beliefs in clinical practice. The research revealed that a significant portion of participants held the belief that mental health problems could be caused by afflictions from Jinn, black magic, or the evil eye. Conditions such as schizophrenia, depression, anxiety, behavioural changes, personality alterations, and other mental health issues were cited as examples of ailments attributed to these supernatural sources.

Furthermore, the study highlighted the prominent role of religious figures and faith healers as primary sources of care for individuals with mental health problems in Islamic societies. In summary, the study emphasised that beliefs in Jinn and related supernatural entities can shape mental health beliefs and practices among Muslims, highlighting that these needs may be underrepresented in statistics as those of Muslim background are less likely to consult these issues with a medical professional. This underlines the importance for healthcare providers to be aware of and sensitive to these cultural and religious beliefs when working with Muslim patients.

2.3 Factors Impacting Accessing Support for Mental Health

2.3.1 Demographics

A literature review conducted by Ineichen (2012) explored the prevalence of mental illness, factors contributing to mental health discrepancies, utilisation patterns of mental health services, and attitudes towards mental health within British South Asians. The literature review highlighted that the rates of mental illness and suicide among British South Asian adults might be lower than those in the general UK population, considering diverse measures and psychiatric conditions. However, the research underscores the necessity for additional investigations to obtain a more comprehensive

understanding of mental health matters in this population. Socioeconomic disparities were highlighted as a key factor in the role of mental health disparities among British South Asians. with Indian South Asians generally having a higher socioeconomic status compared to Pakistani and Bangladeshi South Asians. These differences contribute to varied mental health patterns within the South Asian community, suggesting a need for disaggregated data to better understand and address these disparities. The study highlights that poorer socioeconomic conditions among Pakistani and Bangladeshi South Asians are linked to higher rates of mental health issues, underscoring the importance of targeted interventions to address these inequalities. Memon et al. (2016) explored the perceived barriers to accessing mental health services among black and minority ethnic populations in Southeast England. Through this research, economic constraints emerged as a substantial obstacle, limiting individuals with insufficient financial resources from accessing essential mental health services.

2.3.2 Communication and Education

Communication barriers were also highlighted as a notable challenge in the Memon et al. (2016) study, highlighting that language barriers impacted the quality of communication between the service users and the health care providers. Participants also expressed concerns about mental health needs not always being adequately recognised or addressed by service providers, leading to gaps in care provision. Moreover, South Asians often face obstacles in accessing services due to cultural and linguistic barriers (Moller et al., 2016; Ali et al., 2017; Pilkington et al., 2012).

Linked to this, Pilkington et al. (2011) highlighted the significant influence of education levels on the intention of British Muslims of South Asian origin to access psychological services. The findings indicated that higher levels of education were associated with a greater intent to seek psychological support..

Higher education is often linked to increased mental health awareness and literacy, enabling individuals to recognise symptoms, understand the importance of seeking help, and be aware of available support services. This heightened awareness can lead to a proactive approach towards mental well-being and a greater willingness to access professional help. Additionally, education reduces stigma surrounding mental health by exposing individuals to mental health education and discussions, fostering a positive attitude towards mental health services and encouraging help-seeking without fear of judgment. Higher education also equips individuals with critical thinking and problem-solving skills, empowering them to overcome barriers to accessing mental health services. Furthermore, education increases self-efficacy and confidence in managing health-related decisions, leading to a proactive approach in seeking mental health support and advocating for their own well-being.

2.3.4 Cultural Dynamics in Relationships with Professionals

Moller et al. (2016) sought to investigate the attitudes and beliefs of second-generation South Asian females residing in Britain towards counselling. The study identified various barriers hindering SA females' access to mental health (MH) services in the UK. These obstacles encompass a lack of understanding of Asian culture, predominantly White service providers, challenges with interpreters, fear of gossip, and limited awareness of available services. Additional barriers included attributions related to mental distress, stigma, mistrust, and the insufficient visibility of services. Furthermore, the study revealed that participants harboured certain stereotypes about counsellors based on their ethnicity. Specifically, White counsellors were perceived as culturally ignorant but non-judgmental, while Asian counsellors were viewed as untrustworthy but adept at understanding cultural issues. This underscores the intricate dynamics and perceptions surrounding the counselling profession, emphasizing the need for counsellors to be conscious of and address these stereotypes to deliver effective and culturally sensitive support to SA females in the UK.

The study by Memon et al. (2016) also found that cultural insensitivity played a role in preventing those from BME background accessing support. Instances of cultural naivety, insensitivity, and discrimination within mental health services were reported by participants, underscoring the necessity for culturally competent and sensitive care (Memon et al., 2016).

Key findings from Soorkia et al. (2011) indicated that a stronger connection to ethnic identity correlated with more negative attitudes towards help-seeking. Individuals who consider ethnicity a prominent aspect of their identity may harbour less favourable attitudes towards seeking help, potentially due to perceived cultural disparities with mental health services. The findings also showed that increased cultural mistrust was linked to more negative attitudes toward psychological help-seeking. Participants expressing mistrust toward individuals of White ethnicity demonstrated more unfavourable attitudes, irrespective of ethnic identity and Asian values.

2.3.5 Cultural Practices and Social Pressures

Research has shown that the key factors that contribute to barriers to help seeking in UKME groups, particularly those of South Asian background are around; shame, honour and stigma (Mollet et al, 2016; Sangar & Howe, 2021; Soorkia et al., 2011; Pilkington et al., 2011).

An implicit barrier mentioned in the literature is the close-knit nature of SA communities, where the concept of shame is utilized to police and regulate behaviours. Barriers such as the potential visibility of seeking help within the community, leading to questions from acquaintances or someone familiar with the family, could influence an individual's decision to receive assistance (Sangar & Howe, 2021). According to Sangar and Howe (2021), this mentality may cause individuals to internalise shame, becoming both the oppressor and the oppressed. Pilkington et al. (2011) looked at factors affecting intention to access psychological services amongst British Muslims of South Asian origin. The study focused particularly on shame, acculturation, biological/ social – environmental beliefs and the educational levels among the participant group. Their key findings

highlighted that there was an increased level of shame surrounding mental health which played a significant factor on intent to see help from psychological services.

Soorkia et al. (2011) examined the factors shaping attitudes toward seeking professional psychological assistance among South Asian students in Britain. Their findings highlighted that attitudes toward seeking psychological help were significantly predicted by ethnic identity, cultural mistrust, and adherence to Asian values. Those students with greater adherence to traditional Asian values showed a negative association with attitudes toward psychological help-seeking. This association may reflect the prevalent stigma and shame surrounding mental disorders and seeking psychological help within the South Asian community.

A significant obstacle to seeking help within the female Pakistani community, is the apprehension of shame, stigma, and the potential compromise of family honour (Soorkia et al., 2011). Preserving family reputation holds paramount importance in South Asian and Pakistani cultures, and concerns related to anonymity and confidentiality create additional obstacles to seeking assistance. Individuals from the Pakistani community often feel uneasy divulging mental health concerns to practitioners of the same ethnicity, intensifying the barriers to help-seeking (Moller et al., 2016). Another cultural conflict regarding seeking help revolves around the societal expectations for ideal behaviour imposed on South Asian individuals, leading them to conceal mental health issues and heightening the reluctance to seek assistance (Soorkia et al., 2011).

Memon et al. (2016) looked at obstacles hindering access to mental health services among UKME populations in Southeast England. Key study findings encompassed the identification of personal, environmental, and relational factors as significant barriers to mental health service access for UKME populations. Their first theme (Personal and environmental factors) highlighted that the researchers found that participants in the study highlighted various challenges related to mental health recognition within UKME populations. One significant barrier was the difficulty in recognising

symptoms of mental illness and a general reluctance to accept a diagnosis. This hesitancy was notably influenced by cultural norms discouraging open discussions about psychological distress within families. Another critical aspect was the presence of negative perceptions and social stigma within UKME communities, hindering individuals from seeking help for mental health issues. Participants expressed concerns about the impact of cultural beliefs on the decision to seek assistance, reflecting the complex interplay of cultural factors in help-seeking behaviour.

Similar to those factors highlighted above with older participants, other research has highlighted a similar range of cultural and community barriers in relation to help seeking from young people in UKME groups. The literature reveals a significant limitation related to the presence of stigma surrounding mental health (MH) disorders, coupled with associations of shame and honour (Moller et al., 2016; Sangar & Howe, 2021; Soorkia et al., 2011; Pilkington et al., 2012). Studies indicate that participants generally hold negative attitudes towards seeking psychological help, particularly those with a stronger emphasis on their cultural identity (Moller et al., 2016; Soorkia et al., 2011). Stigma emerges as a significant barrier to MH services for children and young people (CYP) in the UK, with ethnicity playing a crucial role in determining their likelihood of accessing professional services (Ribeiro et al., 2022).

Stigma was also a key theme in the findings from Ali et al. (2016). The research focused on Pakistani young people's perspectives regarding barriers to accessing mental health services in Peterborough. Stigma was found to be a significant obstacle to seeking assistance for mental health issues. The results indicated that the stigma associated with cultural and social perception of mental illness had a profound impact on the participants' willingness to access mental health services. Numerous participants expressed reservations about revealing mental health problems due to concerns about judgment and negative perceptions from others. This stigma resulted in a reluctance to openly discuss mental health issues and seek help, leading to delays in accessing appropriate support and interventions.

Furthermore, the study illuminated how participants perceived potential consequences of disclosing mental health concerns, such as being labelled or facing social repercussions. This fear of stigmatisation further discouraged young Pakistani individuals from seeking help and sharing their experiences with others, including mentors or older students at school. The participants' hesitancy to confide in mentors or peers about their mental health struggles reflected the pervasive impact of stigma on help-seeking behaviours and highlighted the need for destigmatisation efforts within the community. Addressing stigma through education, awareness campaigns, and culturally sensitive approaches to mental health care is crucial in dismantling barriers to help-seeking and promoting mental well-being among young people in the Pakistani community.

2.3.6 Cultural and Gender Intersectional Nuances

Sangar and Howe (2021) delved into how discourses of shame and mental health influence help-seeking behaviours in British-born South Asian (SA) females. The study highlighted the gendered nature of shame, suggesting that SA females perceive shame differently from their male counterparts. Shame is utilised to monitor and regulate behaviour within the SA community, and the fear of bringing shame upon the family or community becomes a significant barrier to seeking help within the SA community. This cultural nuance is particularly pronounced among women, who are often seen as the bearers of family honour and, therefore, more susceptible to the pressures of maintaining a respectable social image.

Gender disparities within SA communities were consistently addressed in the studies, with females experiencing a higher degree of shame and honour compared to males. This is often rooted in cultural expectations and traditional gender roles, which place a higher burden on women to conform to societal norms. Sangar and Howe (2021) found that SA females are more likely to internalise feelings of shame, which can exacerbate mental health issues and deter them from seeking professional help. This internalisation of shame is linked to concerns about marital

prospects, family reputation, and the potential social repercussions of being labelled as having a mental health issue.

In contrast, males in SA communities were found to exhibit more negative attitudes towards mental health compared to females (Sangar & Howe, 2021; Soorkia et al., 2011). These attitudes can stem from cultural norms that emphasise male strength and stoicism, discouraging men from expressing vulnerability or seeking help for mental health issues. The stigma associated with mental health can be compounded by expectations of masculinity, where admitting to mental health struggles may be perceived as a sign of weakness.

Soorkia et al. (2011) further elaborate on the intersection of culture and gender by highlighting how these factors influence mental health perceptions and help-seeking behaviours. For instance, SA men may be more prone to dismiss or minimise mental health problems due to cultural conditioning that valorises resilience and self-reliance. This can lead to underreporting of mental health issues and a reluctance to engage with mental health services.

The intersectional nuances of culture and gender also manifest in the types of support systems utilised by SA individuals. Women may be more inclined to seek informal support from close family members or female friends, whereas men might avoid discussing mental health altogether. The reliance on informal support networks can be both a strength and a limitation, as these networks may lack the expertise to address serious mental health issues and can sometimes reinforce stigmatising beliefs.

Additionally, the studies highlight the role of intergenerational differences in shaping mental health attitudes. Younger SA individuals, especially females, who are more acculturated may experience a conflict between traditional cultural values and the more liberal attitudes towards mental health in the broader society. This can create a sense of ambivalence and confusion about

seeking help, as they navigate between maintaining cultural integrity and addressing their mental health needs.

2.3.7 Mixed Cultural Identities

The study by Pilkington et al. (2011) implied that participants with higher levels of acculturation may be more inclined to utilise mental health services compared to those with lower levels of acculturation who may be more inclined to get support from informal sources. This aligns with findings from Soorkia et al. (2011) where it was found that those who had greater ethnic identification were associated with more negative attitudes towards help-seeking. This suggests a complex interplay between cultural identity and mental health service utilization, highlighting the need to consider individual variations in acculturation and ethnic identity.

It is important to note that a high percentage of those from South Asian backgrounds are likely to be Muslim or adhere to a faith that includes supernatural beliefs. Khalifa et al. (2011) found that 60% of their participants believed in Jinn possession and related this to causing mental and physical problems. Consequently, they were more likely to seek help from a faith leader than from mental health services. This underscores the role of religious and cultural beliefs in shaping help-seeking behaviours, which may sometimes act as barriers to accessing formal mental health care.

Further elaborating on these findings, the research by Pilkington et al. (2011) and Khalifa et al. (2011) suggests that acculturation can serve as both an obstacle and an enabler in the realm of accessing mental health services. Elevated levels of acculturation may enhance awareness and openness to mental health services, fostering a greater willingness to seek professional help. However, they could also give rise to stigma or cultural conflicts, acting as deterrents to seeking assistance. For instance, individuals who become more acculturated might experience a conflict between traditional cultural values and the perceived values of the host culture, leading to internalized stigma and reluctance to seek help.

Additionally, the studies indicate that the process of acculturation involves not only the adoption of the host culture's practices but also the negotiation and sometimes rejection of certain cultural norms. This can impact the willingness to engage with mental health services that are perceived as incongruent with one's cultural or religious beliefs.

Grasping the impact of acculturation on shaping help-seeking behaviours is essential for crafting culturally sensitive interventions that cater to the distinct needs and challenges confronted by British Muslims of South Asian descent. For example, integrating faith leaders into the mental health care process or providing culturally tailored psychoeducation might bridge the gap between traditional support systems and formal mental health services. Moreover, training mental health professionals in cultural competence and increasing community outreach can enhance the accessibility and effectiveness of mental health care for these populations.

Furthermore, it is important to consider the role of social support networks, which can vary significantly across different levels of acculturation. Those with lower levels of acculturation might rely more heavily on familial and community support, which can serve as both a resource and a limitation depending on the attitudes towards mental health within those networks. Conversely, individuals with higher levels of acculturation might have more diverse support networks, including peers and professionals outside their immediate cultural group, which can influence their help-seeking behaviours and attitudes towards mental health services.

2.4 Limitations of Studies Included in Literature Review

The study on attitudes toward seeking professional psychological help among South Asian students in Britain by Soorkia et al (2011) acknowledged several limitations: The method used to gain insight, was self-report surveys, answers could potentially have been influenced by social desirability bias or inaccurate self-perception. The sample, comprising South Asian students in

Greater London, may limit the generalisability of the findings to other regions or non-student populations. Objective behavioural indicators of help-seeking were not incorporated in the study, which could have provided additional insights into actual help-seeking behaviours among South Asian students. Although the study included 148 participants, accounting for incomplete questionnaires, a larger sample size could have heightened the statistical power and robustness of the findings.

Although the study by Pilkington et al. (2011) highlighted important factors that can play a role in facilitating or inhibiting seeking help amongst British Muslims of South Asian origin, there were some limitations. These included sampling bias in that the research enrolled participants predominantly from Muslim community centres and online platforms, potentially introducing a bias towards individuals with elevated levels of religiosity. This constraint hinders the applicability of the results to a more extensive population of British Muslims of South Asian descent, encompassing those with lower religious adherence or distinct patterns of seeking assistance. The research also concentrated on British Muslims of South Asian heritage as a uniform group, neglecting the diversity present in terms of cultural backgrounds, beliefs, and experiences. Differences within this population may influence help-seeking behaviours disparately, emphasising the need for a more nuanced exploration of cultural diversity to gain deeper insights.

Mermon et al. (2016) research sample comprised 26 adults from UKME backgrounds, recruited via community partnerships and gatherings. The predominant presence of university-educated participants might not adequately reflect the varied socioeconomic and educational backgrounds prevalent in UKME communities. The restricted diversity within the sample could potentially impact the generalisability of the findings to the broader UKME population. Similarly to Pilkingon et al. (2011) there is potential bias in recruitment, the method of recruitment via community partnerships and gatherings has the potential to introduce selection bias, given that individuals actively participating in community organisations may hold distinct perspectives on

mental health services compared to those who are not involved. This has implications for the comprehensiveness and representativeness of the identified barriers (Memon et al., 2016).

The review conducted by Ineichen. (2012) concentrates on reviewing and synthesising existing literature on mental health among British South Asian adults. Despite not involving direct participant interaction or primary data collection, the study lacks explicit justification for the chosen methodology, considerations of the participant-researcher relationship, and detailed information on the rigor of data analysis methods.

Khalifa et al. (2011) did not explicitly provide a rationale for selecting a quantitative approach (specifically, a self-report questionnaire) over a qualitative method. The research primarily focused on investigating beliefs concerning Jinn, black magic, and the evil eye among Muslims and examining demographic influences. The consideration of the relationship between participants and researchers was not extensively addressed in the study. Detailed insights into how the researchers managed the participant-researcher relationship, particularly in dealing with sensitive topics such as beliefs in supernatural entities, were not provided. Regarding data analysis, the study mentioned utilizing descriptive and non-parametric statistics for analysis. However, it lacked in-depth information on the specific analytical methods employed or the rigor of the data analysis. A more detailed account of the analytical approach and the measures taken to ensure the robustness of the analysis would have enhanced the study.

2.5 Summary of Literature Review Findings

Through this literature review on factors influencing help-seeking behaviour in UKME population with a particular focus on British Pakistanis for mental health concerns, several key aspects were identified.

Firstly, the literature review provided further understanding of the prevalence of mental health issues among adults and children/young people (CYP) within the South Asian and other UKME groups. However, it was noted that establishing accurate prevalence rates is challenging due to cultural variations in symptom manifestation and differing conceptualisations of mental health and the influence of religious beliefs within these communities.

Secondly, significant barriers to engaging with and accessing mental health services were highlighted. These included demographic aspects linked to socio-economics factors and accessibility linked to communication and education. Factors linked to culture were particularly significant as potential barriers to seeking support. Perceived and experienced cultural insensitivity or misunderstanding by professionals who do not share a similar cultural background was highlighted as a barrier. Another important barrier linked to cultural practice and social pressure was stigma. The literature appeared to show that stigma plays a crucial role in discouraging young Pakistani individuals from seeking help, with fear of stigmatisation preventing them from sharing their experiences with mentors or peers. The nuances between culture and gender was identified and how these may prevent seeking support. Interestingly, the literature did not explicitly highlight a range of gender-specific barriers to help-seeking behaviour in males. This gap suggests a need for further exploration to understand the distinct challenges faced by different genders within this community. Finally, the literature also noted emerging differences in seeking support arising from acculturation to a more western cultural perspective of mental health. .

Significant gaps identified in the literature include the limited focus on specific age groups, particularly adolescents, and a lack of detailed exploration of the impact of acculturation on mental health help-seeking behaviours. Many studies predominantly included participants who were university-educated, which may not accurately represent the broader socioeconomic and educational spectrum of the South Asian community. Furthermore, there was a paucity of research examining the role of religious beliefs and the influence of faith leaders on mental health perceptions

and help-seeking behaviours within this demographic. The themes emerging from this literature review indicate a need to explore this topic further with regard to specific areas. Importantly, there were significant gaps related to the age range of participants (younger than 18) and the specific cultural ethnicity—British-Pakistani (rather than grouping different ethnic minorities together). Additionally, there is a need to explore gender-specific factors, particularly pertaining to males, which may influence help-seeking behaviour in this community. Finally, the research did not necessarily highlight any factors related to experiences or factors within the educational setting.

Chapter 3 Methodology

3.0 Summary

This chapter outlines the research methodology employed in this study, which aims to explore the perspectives of British Pakistani adolescents around seeking help for mental health. It provides an overview of the relevant research paradigm, including the aims and theoretical perspectives, as well as the ontological and epistemological foundations underpinning the study. The chapter details the qualitative method approach used, specifically the use of semi-structured interviews, and provides comprehensive information on participant recruitment, data collection, and data analysis (Reflective Thematic Analysis). Additionally, it addresses the quality criteria and ethical considerations relevant to the research, emphasising the measures taken to ensure credibility, transferability, confirmability, dependability, and reflexivity. Finally, the chapter discusses the relevance and potential impact of the research on educational psychology practice, particularly in understanding and addressing the mental health needs of British Pakistani adolescents.

3.1 Research Paradigm

3.1.1 Research Aims and Relevant Theoretical Perspectives

The objective of this research is exploratory, seeking to enhance comprehension and generate novel insights within the field. It endeavours to delve into the thoughts and opinions of male and female adolescents of British Pakistani background concerning issues related to mental health and the resultant impacts of seeking support in this domain. Furthermore, the research aims to uncover their perspectives on how cultural and gender norms influence their behaviours when seeking help for mental health concerns. Given the aims of this research, the following research questions were identified:

1. What are the perspectives of adolescents of British Pakistani background in seeking support for Social, Emotional & Mental Health (SEMH) needs?

In particular, there were two sub questions which literature review had identified as important areas to consider:

1a. What role does culture play in shaping British Pakistani adolescents' experiences of help-seeking for mental health needs?

1b. What role does gender play in shaping British Pakistani adolescents' experiences of help-seeking for mental health needs?

Given the focus of the sub-questions, the critical theory of Intersectionality is highly relevant to this research. Intersectionality theory, rooted in critical race and feminist scholarship, challenges traditional approaches that view social categories in isolation. It emphasises the intricate interactions between various dimensions of identity and power dynamics (Crenshaw, 1989). For instance, a Black woman may face discrimination not only based on her race or gender individually but also due to the intersection of these identities, leading to unique experiences of oppression.

This framework acknowledges that individuals hold multiple social positions that intersect and shape their lived experiences. By considering these intersections, intersectionality theory provides a more comprehensive analysis of inequality and privilege within society. It highlights how systems of oppression are interconnected and how individuals may experience compounded forms of discrimination (Collins & Bilge, 2016).

In educational contexts, understanding intersectionality can help identify and address disparities in areas such as classroom interactions, curriculum design, disciplinary practices, and access to resources (Gillborn, 2015). Recognising the diverse identities and experiences of students enables educators and administrators to create more inclusive policies and practices that cater to the needs of all students. Moreover, intersectionality theory encourages a critical examination of power structures and social norms that perpetuate inequality. It calls for a shift towards more equitable and

just systems by challenging assumptions of universality and promoting diversity and representation (Cho et al., 2013).

Overall, intersectionality theory serves as a valuable tool for promoting social change, fostering inclusivity, and advancing understanding of the complexities of identity and oppression in various spheres of life, including education. By applying intersectionality, the research can delve into the nuanced ways British Pakistani adolescents navigate their cultural and gender identities in relation to mental health. This approach allows for a comprehensive analysis of how overlapping social positions and power dynamics shape their experiences and perspectives, providing deeper insights into the complexities of their mental health journeys (Atewologun, 2018).

According to Kincheloe and McLaren (2011), critical social theory does not determine how we see the world but helps us devise questions and strategies for exploring it. Critical social theory is particularly concerned with issues of power and justice and the ways that the economy, matters of race, class, and gender, ideologies, discourses, education, religion, and other social institutions, and cultural dynamics interact to construct a social system. This perspective is essential in understanding the broader socio-political context that shapes the mental health experiences of British Pakistani adolescents and provides a framework for addressing the power imbalances and social injustices they face.

3.1.2 Ontology and Epistemology

Ontology explores the nature of existence and what constitutes truth (Effingham, 2013). It can be understood as a continuum, ranging from the belief in an objective reality independent of human perception to the view that reality is socially constructed through human interactions (McLaughlin, 2012). In the context of this study, Critical Realism (CR) serves as the foundational ontology (Bhaskar, 1978), accommodating both objective elements and subjective experiences. Critical realism asserts the existence of diverse realms of reality that transcend our immediate perceptions (Bhaskar & Danermark, 2006; Archer et al., 1998). This philosophical stance is particularly pertinent as it allows for an examination of the objective existence of mental health support systems, educational institutions, and community organisations relevant to British Pakistani adolescents' experiences, while also exploring how these objective realities intersect with subjective interpretations influenced by cultural and gender norms. By adopting critical realism, the research aims to uncover how these intersecting factors shape adolescents' perceptions and behaviours in seeking support for Social, Emotional, and Mental Health (SEMH) needs, thereby providing a comprehensive analysis of the complexities inherent in their mental health journeys.

In the context of this study, the chosen epistemological perspective of Social Constructionism aligns closely with the research design and data collection methods employed. Social Constructionism, as explained by Burr (2015), posits that knowledge is not discovered but actively constructed through social interactions, language use, and cultural contexts. This perspective is particularly relevant to understanding how British Pakistani adolescents perceive and navigate mental health support systems, influenced by their cultural and gender identities. By adopting Social Constructionism, the research acknowledges that knowledge about mental health and help-seeking behaviours is shaped by the language and social interactions within the British Pakistani community, reflecting Burr's (2015) tenets.

Moreover, the role of the researcher as a "co-constructor" of knowledge is integral in this epistemological stance. By engaging in Reflexive Thematic Analysis (Braun & Clarke, 2006), the researcher actively interprets and constructs meanings from the qualitative data collected through semi-structured interviews. Reflexive thematic analysis encourages the researcher to reflect on their own perspectives and biases, acknowledging their role in shaping the analysis process. This approach resonates with the principles of Social Constructionism, where knowledge is co-created through interactions between the researcher and participants, and where the researcher's reflexivity ensures transparency and rigor in interpreting the data (Braun & Clarke, 2019).

Therefore, by embracing Social Constructionism as the epistemological framework and employing Reflexive Thematic Analysis in data analysis, this study aims to uncover nuanced insights into how British Pakistani adolescents conceptualize and engage with mental health support. This approach allows for a deeper exploration of the participants' lived experiences and perspectives, capturing the complexity of their interactions with cultural norms, gender roles, and social structures in relation to mental health.

3.2 Research Design and Rationale

The purpose of this research is exploratory in that it seeks to develop greater understanding of the perspectives of adolescents from British Pakistani backgrounds in seeking support for their SEMH needs. This exploratory approach is highly appropriate for several reasons outlined in the literature. Firstly, it emphasises transparency and accountability by allowing researchers to openly showcase the decision-making process and methodological choices throughout the study (Kalu & Bwalya, 2017). This transparency is crucial when delving into sensitive topics such as SEMH needs among adolescents of British Pakistani background, ensuring that the research process is clear and accountable. Secondly, employing an exploratory approach enables researchers to demonstrate confirmability, ensuring that the findings are derived from the data rather than personal biases (Kalu & Bwalya, 2017). This is essential when exploring the perspectives of adolescents from specific

cultural backgrounds, as it helps in presenting unbiased and reliable research outcomes. Thirdly, an exploratory approach facilitates the in-depth exploration of the perspectives of adolescents from British Pakistani backgrounds regarding SEMH needs (Kalu & Bwalya, 2017). This depth enhances the transferability of the findings to similar contexts or individuals, ensuring that the research outcomes are relevant and applicable beyond the immediate study situation.

Moreover, qualitative research, particularly through an exploratory approach, allows for the collection of rich and in-depth data (Kalu & Bwalya, 2017). This is crucial when investigating the complex and nuanced perspectives of adolescents from diverse cultural backgrounds, such as British Pakistani youth seeking support for SEMH needs. The detailed insights gained through this approach provide a comprehensive understanding of the challenges and experiences faced by this specific group.

Lastly, reflexivity is another critical aspect of qualitative research that an exploratory approach supports (Kalu & Bwalya, 2017). Reflexivity involves researchers being aware of their biases and the impact of their presence on the research process. When exploring the SEMH needs of adolescents from British Pakistani backgrounds, reflexivity becomes essential in understanding how cultural factors may influence the participants' perspectives and experiences. The researcher's experiences and additional reflections will be discussed further in the discussion chapter. An exploratory approach allows researchers to navigate these cultural sensitivities with care and reflexivity.

This study employed a qualitative methodology to capture rich and in-depth data through semi-structed interviews, allowing for an exploration of the participants' realities (Coolican, 2014). Qualitative research centres on the nuances of language and offers a comprehensive understanding of research questions that may not be fully captured by statistical data (Howitt, 2016). Potential data collection methods were considered, including focus groups and questionnaires. However, these

alternatives were ultimately not used for specific reasons related to the research context and objectives.

Focus groups (FGs) could have provided valuable insights by allowing participants to construct meaning collectively (Bryman, 2012). According to Holland et al. (1998), FGs facilitate understanding of how individuals perceive themselves in relation to others, making them particularly effective for exploring socially produced and culturally constructed worlds. Wilkinson (1998) also notes that FGs can reduce power dynamics between the facilitator and participants, fostering a more naturalistic production of social systems. However, FGs were not used in this study due to potential issues such as dominant voices overshadowing quieter participants, leading to a decreased variety of views shared and possible groupthink (Cyr, 2019; Hollander, 2004). These dynamics could bias the data towards particular viewpoints (Viscek, 2010), which was not aligned with the study's aim to capture diverse individual experiences.

Questionnaires were another alternative considered for data collection. They can efficiently gather data from a large number of participants and provide a structured format for responses, which is beneficial for quantitative analysis (Gill et al., 2008). However, questionnaires were not chosen due to their limitations in exploring complex and nuanced personal experiences, which were crucial for understanding the Social, Emotional & Mental Health (SEMH) needs of adolescents of British Pakistani background. Semi-structured interviews, in contrast, allow for deeper exploration of individual perspectives and enable the researcher to probe into specific areas based on participants' responses, thus capturing richer and more detailed data (Smith & Osborn, 2008).

The strengths of semi-structured interviews include their ability to facilitate an in-depth understanding of participants' experiences, their flexibility in adapting to the flow of conversation, and the rich, qualitative data they produce (Willig, 2013). However, they also have limitations, such

as being time-consuming to conduct and analyse, and the potential for interviewer bias influencing participants' responses (Creswell, 2013). Despite these limitations, semi-structured interviews were deemed the most appropriate method for this study due to their ability to capture the nuanced and personal experiences of adolescents from British Pakistani backgrounds.

Finally, in line with a qualitative approach, Reflective Thematic Analysis (RTA) was used to analyse the findings from the participants. The researcher's preference for RTA over other analysis methods, such as Interpretative Phenomenological Analysis (IPA), stems from RTA's focus on identifying themes inherent in the data (Byrne, 2022). In contrast, IPA tends to concentrate more on individual lived experiences, particularly regarding seeking help for mental health issues. Since this study aims to uncover novel themes and patterns within this population, RTA aligns more closely with the research objectives. The flexibility of RTA, not tied to a specific theoretical framework, makes it particularly suitable for this research, given the current lack of substantial existing studies in this area. RTA also considers individual perspectives and experiences, aligning with the researcher's use of semi-structured interviews. Furthermore, RTA acknowledges the researcher's inherent biases and subjectivity. Once the data is categorised, reflexivity encourages the researcher to evaluate whether their personal judgments or beliefs have influenced the analysis. This reflective approach highlights the systematic and iterative nature of Braun and Clarke's thematic analysis method, emphasising the active role in deriving insights from qualitative data while respecting participants' perspectives. Given the researcher's ethnic/cultural background, this aspect felt important as this aspect is particularly important as the researcher shares the same ethnic and cultural background as the participants (British Pakistani).

This shared background can significantly enhance the research process, as it fosters a deeper understanding and empathy towards the participants' experiences. The researcher's insider status can facilitate trust and openness in interviews, leading to richer and more nuanced data. However, it also necessitates rigorous reflexivity to manage potential biases that may arise from the researcher's

preconceptions and personal experiences. The researcher must continuously reflect on how their positionality influences the data collection and analysis processes, ensuring that the participants' voices are authentically represented and not overshadowed by the researcher's own perspectives.

3.3 Research Participants

3.3.1 Recruitment

Following ethical approval (Appendix 3), recruitment for participant took place. Participants were recruited through a multifaceted approach. Initially, emails were sent to local schools, with contact information for school receptionists and SENCOs obtained from the local authority EPS. The email advertisement requested that the message be forwarded to eligible individuals within the school. The email included a flyer (see Appendix 4) with brief information about the study, a QR code for interested participants to complete a short questionnaire with their details, a participant information sheet, and a consent form (see Appendix 5).

However, only a few schools responded to acknowledge the email, and one school indicated they had only one Pakistani pupil in their entire sixth form and felt it was not suitable for them. Subsequently, EPs were asked to share the flyer and information sheet with their link schools, hoping that familiar connections would prompt SENCOs to respond. This resulted in 12 potential participants responding from 3 schools, with a majority of participants from one school.

3.3.2 Participants

The study aimed to enlist 6-8 participants, including both males and females, for participation in semi-structured interviews. This participant count is considered suitable for the research, allowing for the appreciation of rich, individual data while also considering the practicality

of transcribing and analysing within a specified timeframe (Fugard & Potts, 2015). In the end 12 participants (6 males and 6 females) were recruited who met the following inclusion criteria:

- Participants identified as British Pakistani
- Participants were between the ages 16-18 years
- Participants were currently attending an educational provision

An overview of participants is outlined in Table 2. The participant's names have been anonymised based on the researchers choice of name. The high number of participants from one school in this research is due to the challenges in recruiting participants and the significant interest shown by students from that particular school. Despite efforts to engage multiple schools, responses were limited. However, the enthusiastic response from one school provided an opportunity to gather a substantial amount of rich data. Including these additional participants, even from the same school, enhances the robustness of the study by providing a deeper and more nuanced understanding of the experiences and perspectives of British Pakistani adolescents.

Table 2

Summary of Participants

Pseudonym	Gender	Age	School (Pseudonym)
Esa	Male	17	Crescent Secondary
Aron	Male	17	Meadow School
Aliya	Female	17	Crescent Secondary
Amelia	Female	17	Crescent Secondary
Amal	Female	17	Crescent Secondary
Aisha	Female	17	Vale Academy
Imaan	Female	17	Vale Academy
Rohaan	Male	17	Crescent Secondary

Saira	Female	17	Crescent Secondary
Walid	Male	17	Crescent Secondary
Isaac	Male	16	Crescent Secondary
Ahmed	Male	17	Crescent Secondary

3.3.3 Data Collection

The questions included in the semi-structured interview were developed through a collaborative process involving research supervision and a deliberate intent to keep the questions broad. This approach allows participants to provide more comprehensive and nuanced answers, which can offer richer insights into their experiences and perspectives.

During the development phase, the researcher worked closely with their supervisor, drawing on their expertise and guidance to formulate questions that would effectively elicit detailed and meaningful responses. This collaboration ensured that the questions were aligned with the study's objectives and could adapt to the flow of conversation during the interviews (Braun & Clarke, 2013).

The decision to keep the questions broad was informed by the desire to allow participants to express their thoughts and feelings without being constrained by overly specific prompts. Broad questions facilitate a more open dialogue, enabling participants to highlight issues that are most relevant and significant to them. This flexibility is particularly valuable in qualitative research, as it respects the participants' perspectives and experiences, leading to more authentic and valuable data (Smith, Flowers, & Larkin, 2009).

Furthermore, this approach aligns with the principles of Reflexive Thematic Analysis (RTA), which emphasises the importance of capturing the depth and complexity of participants' responses. By allowing for expansive answers, the researcher can better understand the context and nuances of

the participants' experiences, which is crucial for generating meaningful themes during the analysis phase (Fugard & Potts, 2015).

The pilot interview was conducted to ensure all research questions were easily understood. The participant was briefed on the study's objectives and then asked the planned questions. Any confusion was addressed with follow-up questions to clarify understanding. Feedback from the participant was used to refine and simplify the questions. This process ensured that in the main interviews, all research questions were clear and easy for participants to understand, leading to accurate data collection.

The interviews were conducted in the local council building and ranged from 30-60 minutes. The interview schedule, which can be found in the appendix (Appendix 6), provided a flexible framework that allowed for adaptation as the interviews progressed. This flexibility was essential for responding to the unique flow of each conversation and for probing deeper into areas of interest that emerged during the interviews (King & Horrocks, 2010). The initial set of questions served as a guide, but the interviewer adjusted the questions based on the participants' responses to ensure a comprehensive exploration of their experiences and perspectives.

3.3.4 Data Analysis

3.3.4.1 Transcription

The interviews were recorded and transcribed via Microsoft Teams, which transcribed the data to an appropriate level of detail. Once transcribed, the audio recordings were relistened to ensure accuracy. Names were pseudonymised immediately after transcription to maintain confidentiality. This approach was chosen because the transcription process itself provides valuable analytical insights, allowing the researcher to engage deeply with the text (Frost, 2011). Additionally, theoretical decisions about what is essential for analysis and what can be omitted can be made

during transcription (Dunne et al., 2005). By relistening to the audio and rereading the transcripts, the researcher could understand the context and narrative of the data while identifying key themes.

3.3.4.2 Analysis

The data collected from the semi-structured interviews was analysed using Reflexive Thematic Analysis (RTA), a methodology introduced by Braun and Clarke in 2019, building upon their original 2006 thematic analysis model. RTA follows a six-phase process:

- Familiarisation with Data**:** Initially, the transcripts were read and re-read to gain a thorough understanding of the data, capturing the essence of the participants' experiences and contexts
- Generating Initial Codes: The next step involved systematically coding significant segments of the interviews to capture statements, emotions, and attitudes related to SEMH help-seeking behaviours. This process included identifying meaningful aspects of the participants' experiences and deriving codes from data units representing these aspects. An example of this can be seen in Appendix 7.
- Searching for Themes: Themes were generated (As shown in Appendix 8) by identifying patterns and connections among the codes. This iterative process involved grouping related codes to develop themes that reflected shared meanings and concepts across the data, constantly refining and adjusting to ensure accuracy.
- Reviewing Themes: The themes were then reviewed, utilising supervision to ensure they accurately represented the participants' narratives. This process involved continuously comparing themes with the coded data to refine and clarify them, maintaining fidelity to the participants' voices and ensuring the themes were internally coherent and distinctive (see Appendix 9 for reviewed themes).

- Defining and Naming Themes: Each theme was carefully named to encapsulate the perspectives, alongside barriers and facilitators identified by British Pakistani adolescents in relation to SEMH help-seeking, ensuring that the names were reflective of the participants' perspectives. Theme names were reflected on during research supervision (See appendix 10) There felt an importance to ensure that theme names reflected the research questions, encapsulating both ethnicity and gender.
- Writing Up: The final stage involved writing up the thematic findings into a coherent narrative that presented a comprehensive understanding of SEMH support-seeking behaviours among British Pakistani adolescents. This narrative included direct quotations to illustrate each theme and provide context for interpreting findings, ensuring a balance between analytic narrative and illustrative extracts to convey a convincing and well-organised story about the data and topic.

This whole process was undertaken over a period of 3 months and resulted in a number of key themes and subthemes which responded to the research questions posed at the start of this chapter and will be outlined in detail in the Findings chapter.

3.4 Quality Criteria

Yardley (2008) outlined four principles to ensure trustworthiness in qualitative research: sensitivity to context, commitment and rigor, coherence and transparency, and impact and importance. In this section these principles will be, reframed within the concept of trustworthiness, which replaces traditional notions of validity and reliability to align with the study's ontological and epistemological positioning. While Lincoln and Guba's (1985) criteria – credibility, transformability, dependability and confirmability are widely recognised, Yardley's principles were chosen as they provide a comprehensive framework that emphasises the researcher's reflexivity and the broader

impact of the study. The following sections clarify how the researcher addressed trustworthiness, ensuring that the findings are credible, contextually relevant and transferable to similar settings.

3.4.1 Sensitivity to context

Sensitivity to context involves an awareness of the socio-cultural setting of the research and the relationship between the researcher and participants. In this study, understanding the cultural nuances of British Pakistani adolescents was essential to exploring their SEMH help-seeking behaviours. Sensitivity was upheld by leveraging the researcher's shared cultural background with the participants, fostering trust and enabling a nuanced exploration of sensitive topics. A comprehensive literature review informed the study design, ensuring the cultural and contextual relevance of interview questions. Trustworthiness was enhanced by maintaining consistency in the interview schedule across participants while allowing flexibility for follow-up questions based on individual responses. The researcher's cultural familiarity enabled recognition of subtle and culturally specific issues, ensuring a deeper and more empathetic engagement with participants' experiences.

3.4.2 Commitment and rigor

Commitment and rigor refer to the depth of engagement with the research topic and the thoroughness of the data collection and analysis process (Yardley, 2017). The researcher demonstrated commitment by acquiring proficiency in qualitative methods and investing time in meticulous data collection. Rigor was ensured by seeking external validation through research supervision, during which a knowledgeable supervisor reviews and verified the coded themes. Supervision sessions enabled critical discussions about thematic analysis, with a focus on participants' language and underlying emotions. These discussions ensured that the data analysis was thorough and reflective of participants' lived experiences. The iterative process contributed to

the dependability and credibility of findings, as the analysis was consistently refined and cross-validated.

3.4.3 Coherence and transparency

Coherence and transparency emphasise the clarity and consistency of the research process and findings. Providing a transparent account of how themes were derived (see appendix 6-10) and how the researcher's perspective was managed ensures that the research process is coherent and traceable. This transparency allows others to follow the research journey, understand the decisions made at each stage, and evaluate the reliability of the findings. Professional ethics were upheld to minimise any bias in the research (Zohrabi, 2013). Content validity was ensured through a pilot study, which provided feedback on the clarity of terminology and questions and identified any ineffective questions (Sue & Ritter, 2012). Open-ended questions were used in interviews, allowing participants to influence the data more than the researcher. Nonetheless, transparency was maintained by acknowledging the potential for researcher influence (Yardley, 2008).

Coherence and transparency were achieved by coding and analysing the entire dataset, from which final themes were derived. Quotations were used throughout the analysis to ensure transparency and clearly illustrate how themes were formed.

3.4.4 Impact and importance

The study aims to provide valuable insights into SEMH support-seeking behaviours among British Pakistani adolescents, thereby contributing to both academic knowledge and practical interventions. This principle underscores the relevance and significance of the research, ensuring that it addresses pertinent issues and has the potential to influence practice and policy.

The literature reveals significant concerns and a notable lack of knowledge in understanding SEMH support-seeking behaviours among British Pakistani adolescents. This gap in understanding is

exacerbated by the rapidly changing demographics in the UK, which highlight the increasing diversity and the specific challenges faced by UKME groups in accessing mental health services. Particularly concerning is the limited research on gender differences in how adolescents from these backgrounds in particular from British Pakistani background seek and perceive support for their mental health needs. This critical gap hinders the development of effective, culturally sensitive interventions tailored to meet the needs of diverse youth populations.

By focusing on British Pakistani adolescents, this study aims to fill these gaps and provide nuanced insights into the factors influencing SEMH support-seeking behaviours within this demographic. By doing so, it not only contributes to advancing academic knowledge but also offers practical implications for developing targeted interventions that can effectively address the barriers these adolescents encounter. Ultimately, this research has the potential to inform policy decisions and improve the provision of mental health services for British Pakistani youth, thereby promoting better overall mental health outcomes in this community.

3.4.5 Reflexivity

Berger (2015) described reflexivity as "the process of a continual internal dialogue and critical self-evaluation of researcher's positionality" (Berger, 2015, p. 220), highlighting the importance of researchers focusing on their role in knowledge creation and monitoring how their beliefs and biases may impact the research. To address this, a research diary was maintained to reflect on both the research process and the personal characteristics of the researcher, considering how these might influence the study.

By making these reflections explicit, the aim was to evaluate the success of attempts to remain neutral. Reflexivity was prioritised throughout the research project with the aid of both supervision and the research diary, ensuring that the research question formulation, participant

recruitment, and theme generation were not unduly influenced by the researcher's biases. Supervision was used alongside the research diary to provide continuous reflection and critical evaluation at all stages of the research.

3.5 Ethical Considerations

Ethical approval for the research was obtained from the Tavistock and Portman Trust Research Ethics Committee (Appendix 3). The study was conducted in accordance with the BPS Code of Human Research Ethics (BPS, 2014). Participants received an information sheet detailing the aims of the research, their right to withdraw at any time before the data coding began, and assurances of data anonymity. This information was also discussed with participants prior to the interviews to ensure clarity. Informed consent was obtained from all participants before the interviews commenced.

Participants actively consented to participate in the study and agreed to have their data collected in compliance with BPS guidelines (2014) and the Data Protection Act (UK Government, 2018). At the conclusion of the study, all participants were fully debriefed and offered the opportunity for follow-up support. All data was anonymized and securely stored using encryption. Upon completion of the research, all information will be confidentially destroyed. The research was supervised by a qualified Educational Psychologist who is also a university tutor. Informed by the BPS (2021) code of human research ethics, the researcher considered the following ethical issues as outlined below.

3.5.1 Risk

The study acknowledged a potential risk factor associated with the involvement of school-aged students (16-18 years old), who may face challenges related to their mental health. Participants were informed through the Information Sheet and Consent Form that research sessions would likely involve discussions on sensitive topics concerning their cultural background, norms related to mental

health, and potential obstacles to seeking support. Consequently, participants could experience stress, apprehension, or anxiety while addressing these subjects.

The Information Sheet specified that semi-structured interview questions would explore participants' perspectives on mental health within their age group, the accessibility of support services, and their views on barriers and facilitators to accessing these services. Participants were also encouraged to share insights into how cultural norms and attitudes towards mental health might influence their willingness to seek help. The primary objective of the study was to investigate broader perspectives rather than delve deeply into participants' personal mental health experiences, unless voluntarily disclosed.

Before the interviews took place, participants were informed about the content of the interview and assured that they had the right to withdraw from the interview at any point without consequence. At the conclusion of each interview, participants underwent a debriefing session. During this time, information about local and national services for support with Social, Emotional, and Mental Health needs was shared with participants to ensure they had access to resources beyond the study.

3.5.2 Informed Consent and Right to Withdraw

Aligned with the BPS (2021) guidelines, parental consent was not required for individuals aged 16, as per the Mental Capacity Act, which defined them as adults. The researcher verified that selected participants did not possess additional vulnerabilities and exclusively involved individuals capable of providing informed consent in accordance with the Mental Capacity Act. Participants received comprehensive information about the research along with a consent form for review and signature. They were informed of their right to withdraw from the study at any point up until data analysis. Participants were provided with a specific deadline, in line with BPS (2021) guidelines, indicating the deadline for withdrawal.

3.5.3 Confidentiality and Anonymity

Participants received information that their interviews would be recorded, and verbatim excerpts would be included in the write-up. They were assured that everything discussed during the interviews would remain confidential, with their names pseudonymised in publications and transcripts, and all data analyses conducted on a password-protected computer. Any identifying details, such as names of peers or family members, would be altered or omitted to ensure anonymity. Participants were also informed that confidentiality would be upheld according to legal requirements and local safeguarding procedures.

Additionally, due to the small sample size, participants were notified that some experiences shared in the study might be recognisable to those familiar with the research project. They were briefed on the potential dissemination of the research through presentations to professionals, a written thesis, and journal articles.

3.6 Relevance and Impact

This research holds significant relevance for Educational Psychology (EP) practice on multiple fronts. Firstly, individuals from Ethnic Minority (EM) backgrounds are less frequently referred to EPs or Child and Adolescent Mental Health Services (CAMHs) teams compared to their White counterparts (Edbrooke-Childs & Patalay, 2019). Understanding the potential reasons for this discrepancy becomes crucial for addressing the provision of support both within and outside of school environments.

Secondly, there is a scarcity of research in this specific field, presenting an opportunity for EPs to make a substantial impact by comprehending British Pakistani culture and its influence on young British Pakistani males and females. This research could empower school staff to delve deeper into behaviours exhibited by British Pakistani individuals, steering clear of exclusions and challenging

stereotypes. The research could be extended to the wider south Asian community, but it is important to note that though there may be shared characteristics amongst those categorised as “South Asian” it is a mix of individuals who have very different religion and cultural norms.

In terms of practical implications, EPs can offer informed recommendations to schools regarding support for male and female individuals within British Pakistani communities. They can aid schools in understanding potential barriers, social norms within the culture, and culturally sensitive approaches to practice. EPs may also recognise the necessity of incorporating relevant questions during consultations and challenging prevailing discourses about those from British Pakistani communities. By identifying questions that uncover unmet needs within the British Pakistani community and addressing potential cultural barriers to help-seeking behaviours (Sangar & Howe, 2021), EPs can utilise consultation to question schools' approaches to certain behaviours and ensure access to appropriate support.

Crucially, cultural awareness is imperative to challenge negative discourses surrounding families and communities. This research aims to underscore the significance of understanding cultural differences around mental health and raise awareness among those working with ethnic minorities. Furthermore, the growing practice of anti-racist work within organisations emphasises the importance of considering all races when discussing barriers faced by marginalised groups in relation to race and ethnicity.

Ultimately, it is hoped that this research can pave the way for systemic changes in schools, such as implementing whole-school approaches that encourage safe spaces, standardised language around mental health, destigmatise mental health needs, and dispel myths surrounding mental health and the associated support systems.

Chapter 4: Findings

4.0 Chapter Overview

This chapter presents the findings of this research through the use of Reflective Thematic Analysis (RTA). The analysis resulted in six themes. Each theme responds to the overall research question (What are the perspectives of secondary-aged students of British Pakistani background in seeking support for SEMH); while some themes more pertinently respond to sub-question around culture (RQ1a. What role does culture play in shaping British Pakistani adolescents' experiences of help-seeking for mental health needs?) or gender (RQ1b. What role does gender play in shaping

British Pakistani adolescents' experiences of help-seeking for mental health needs?) Participant (pseudonyms used) quotes are used to illustrate themes and subthemes throughout this section.

Theme	Sub Theme
There is no 'safe' in safeguarding	
"Log Kya Kahenge" – What will other people say	Silence or Stigma
	Reputation is Key
What Empowers me and Disempowers me in the Community and in School	Quality of adult relationships in school
	Just getting on with it in the community
Being Britishstani	British Vs Pakistani Culture
	Parenting in a British Pakistani Culture
Bound by Gender Roles	Mask-Culinity
	Fake it 'till you make it

4.1 Summary of Themes

Five themes and eight subthemes were identified overall in response to exploring perspectives of British Pakistani adolescents in seeking support for SEMH. The main themes include: There is no 'safe' in Safeguarding; "Log kya kahenge" - What will other people say?; What empowers and disempowers me in School and the Community; Being 'Britishstani'; Bound by Gender Roles. They refer to aspects which the researcher, following analysis, felt participants had indicated as barriers as well as facilitators towards seeking help and support for their mental health needs. Table 3 below identifies links between themes and subthemes.

Table 3

Table showing themes and linked sub themes.

4.2 There's No "Safe" in Safeguarding

The first theme deals with a significant barrier regarding how 'safe' and containing safeguarding is perceived when to seeking support. There is a sense of lack of trust in the system and suspiciousness:

'…You can sign all those forms, it's private, confidential but really it's not' (Ahmed L40)

Participants describe how sharing or disclosing information within the school system could lead to information being passed on to the safeguarding team. Participants had a view or perception that if information is passed on to the safeguarding team this can lead to "the problem becoming bigger" or family being alerted. Participants expressed their interpretations and knowledge of the safeguarding process and system within their schools. It was noted how they only shared so much information if they need to, to avoid 'triggering safeguarding':

'…So you would... If I come to you and be like, I don't know, I cut myself because of these thoughts, you're going to be like, well, okay, you're not going to tell me you're going to speak to someone, but obviously you're going to do that yourself because you think it's dangerous for me ' (Ahmed, L103)

Only sharing limited if any information means that participants are aware that safeguarding will not be alerted, meaning that the problem could stay within their control and family would not become aware nor would the problem become any bigger:

'… I personally would, but I feel like I know who I speak to and to what extent I would go because I feel like I know that if I say to you much or if I show that I'm very bad, two things they will raise safeguarding that will go back to my family ' (Aisha, L94)

A common perception among participants was that sharing anything with the possibility that safeguarding is alerted is not worth the risk of family finding out or the problem becoming bigger. There appeared to be an appreciation around what can be shared and what cannot be shared and a unknown fear around repercussions of oversharing with professionals thereby communicating a feeling of this not being a 'safe' thing to do.

Similarly to Ahmed, Imaan expressed how she was aware of what type of information sharing could lead to safeguarding concerns being raised. There appeared to be a feeling amongst most participants around how safeguarding felt like a big risk factor in family finding out about any problem the participant may be going through.

'…So you know, if I was say for example, I hypothetically self-harming, I wouldn't go to a teacher because I know that that would you know they would raise safeguarding and my family would find out and it's it would be a big mess. So I think that is definitely one of the biggest barriers that a lot of students have' (Imaan, L48)

Imaan also expressed that despite your relationship with your teacher, worries about safeguarding concerns being raised would still prevent from sharing. Despite having positive relations with teachers and school staff there seemed to be a view that participants would avoid oversharing as no matter who it is you are sharing with, they would need to follow certain procedures that would

again bring your 'problems' to spaces and people you did not want to share with such as your family finding out.

> *'…I think this is a very tricky one because yeah, there's uh.I have favourite teachers and teachers that I have good professional relationships with, but I think there's always a limit no matter who the teacher is, because of course they can really safeguarding and it can lead to a bunch of things'* (Imaan, L47).

From a more culturally nuanced aspect related to safeguarding, there was a collective sense of perception that norms within the British Pakistani culture would be perceived negatively by those outside of the culture. Therefore, sharing any personal things about oneself or their family could cause a much bigger problem for the person who shared. So, it felt it is much safer to share with someone who has the same cultural norms. It should be noted that the use of the term 'brown culture' is a common term used amongst the younger ethnic minority generation. This is a term that is often used when speaking of similarities in one another cultures and expressing how they may have had similar upbringing than those of White background. This suggests a connection amongst different ethnic minorities not just within the British Pakistani community

> . '…*Yes, there was a fear it would come out in safeguarding and then my family would find out about, because they see something as not normal, whereas that is something that's normal within brown culture and they think it's something serious. But if you shared with a teacher who is brown, they understand those are norms and understand it better*.' (Esa, L39)

This was expressed by other participants who felt if they went to another teacher, implying one who is not of the same cultural background, that teacher will go and tell the safeguarding team.

'…If we tell a different teacher and they'll have to always tell the safeguarding team' (Aliya, L26)

There was also a feeling that teachers or support staff may make extreme assumptions and stereotypes around why young British Pakistanis might be wanting help. A sense of prejudice and stereotypes appeared to be embedded in the participants' thinking and feelings. They communicated a sense of judgment by those who don't share the same ethnicity as them. The quotes indicate concerns around perceived assumptions and preconceived ideas about what is the 'norm' in their culture.

'*…I feel like, and some people see British Pakistanis, and when they hear they have mental health issues the first thing they think of, oh they are getting married off'* (Saira, L39).

The biggest worry within this theme expressed by participants were two things; firstly, parents or family will be told, and secondly, sharing the problem will lead to a bigger problem with wider social care services.

'…*Some people also think sharing to the school can make the problem bigger, the school might share it with social services, and then you might end up in foster care*.' (Walid, L24)

'…*I don't think they will even share with teachers because it might come out to your parents, they might tell your family about your problems*.' (Saira, L51)

'…*And then after that, after the repercussion of that, if police going to come to my house, or teachers are going to speak to me, and then social workers are going to come to my house, speak to me. Then maybe because of that, I might do it more*.' (Ahmed, L104)

It was noted that participants were aware about boundaries and triggers, in relation to what and how much they shared with school staff and other professionals. There was a sense of fear that sharing too much could cause external professionals such as social services getting involved. This was seen as a huge deterrent for participants and social services were perceived in a negative way.

In summary, this theme indicates that participants feel a sense of uncertainty and lack of trust in the systems around them. Participants felt the need to be vigilant about what they are choosing to share and with whom. They are extremely cautious of what staff members they deem as 'safe' and those who can be seen too risky.

4.3 "Log Kya Kahenge" (What Will Other People Say)

"Log Kya kahenge" is an Urdu saying that translates to 'what will other people say?' and is also a common saying amongst Pakistanis. Some view it as a saying which is intended to evoke fear about public opinion around one's personal life, and could be used to 'control' inappropriate behaviours. Within this theme, participants expressed numerous ways as to how reputation of the family within the community could be impacted if they were to express and seek support for SEMH concerns, and how on most occasions, it's probably better to keep things to yourself to avoid others in the community finding out.

4.3.1 Reputation is key

Reputation is a very important thing within the Pakistani/ British Pakistani community. From participant views collected, there was a sense that the views of the community held a higher level of

importance and weight in comparison to participants needs for seeking help. There was a strong view on 'gossip' and how seeking help from outside the family, whether that's with friends, community members or professional in or out of school will lead to gossip and negative perceptions being built up around and about you.

> '*…I know some of my friends didn't actually get support because their parents don't want them to because they don't want people to find out, like in the community, because that's friends, you know? … So they find it difficult to ask for help, It's just that people like to gossiping and then turn it into something that is not*.' (Amal, L33)

> '*…What they've shared within the community, so what they've heard about other people's family, they've been telling and sharing it, so you feel like that's what makes you uncomfortable that actually if it comes out in the community* (Ahmed, L39)

Within this subtheme there was a link to perspectives shared in the theme "There is No 'Safe' in Safeguarding" in that whatever is shared outside of immediate family will eventually land into the knowledge of the community and this would be something much larger than just keeping the problem either to yourself or within your family. There was also a belief that if you were to share in school with peers/teachers or to any professional, eventually the information would become public and despite being told sharing would be private and confidential, participants had a feeling or fear that this was not necessarily true. Participant perspectives in this area indicate a fear around their perceived lack of agency in that they stated they would not have control over who would know about their 'problems' if they shared with school staff / peers.

There was also a sense that this would lead to gossip around the community and school and a belief that any gossip would be bigger than the truth, so there was a belief that there is no point in

sharing. Participants expressed how gossip would then impact your family's reputation and that is why they are told not to share their problems outside the family. Reputation seemed like a very important part of the culture, and it was felt that it was more important to uphold the family's' value within the community than seek help for any concerns around mental health and social emotional wellbeing.

> '*…Because that will impact your emotions and your reputation. People gossip and ruin your family reputation'* (Walid, L34)

> '*…But in the culture that if we if someone hears like on the road, if another Pakistani family hears they will start spreading and telling everyone else and it just looks bad on your name'* (Aliya, L67)

4.3.2 Silence or Stigma

This sub theme focused on how school staff, professionals, friends and family as well as those in the community could make a negative value judgement/gain a negative perception of you if you were to seek help for SEMH or disclose SEMH concerns and how sometimes it is better to keep information and feelings to yourself or deal with it alone to prevent this.

> '*…With stigma, I mean, like so when, like you hear that, you know, in with our parents and you might hear like, oh, like she, her daughter said, she's got depression. Like it's seen as a bad thing. Depression isn't seen as something good. It's seen as. What did you do wrong in order for you to get that depression*?' (Aisha, L57,58)

Participants showed insight into stigma around SEMH within the British Pakistani / Pakistani culture and how mental health is seen as a negative thing. Participants also shared how you are more likely to be blamed for experiencing any SEMH problems, and that those in the community would more likely blame you instead of help show you how to get support. The accusation of it being your own fault if you were to get any SEMH concerns is your own fault seems to be an internal belief within participants, a perception that is most likely reinforced by the British Pakistani/ Pakistani community and through personal experience within the family or extended family.

> '*…think in the Brown community especially and the British Pakistani community, I think it is quite there's a massive stigma around mental health even… even though it's aware that females are more emotional, there's still definitely a stigma to if you feel low and don't feel like getting out of bed like there's just a lack of understanding in my opinion'* (Imaan, L56)

This quote also conveys a sense that there is a lack of understanding and psychoeducation around mental health within the British Pakistani/ Pakistani community and how this then impacted the lack of support within the community. It also highlighted why many young people felt they could not reach out to others within the community because they have a preconceived idea that everyone in the community feels and has the same thoughts around mental health.

4.4 What Empowers and Disempowers Me in School and The Community

In this theme facilitators and barriers linked to the school and the community are explored, highlighting what participants felt empowered and disempowered them in relation to accessing support from within the community or school. Aspects such as lack of trust; peers; teacher cultural or ethnic backgrounds; personal boundaries and quality of relationships were highlighted by participants as potentially being both facilitators and barriers to seeking help for SEMH within the educational context. The second subtheme explores what opportunities participants feel are

available in the community for seeking support, alongside those 'dismissive' aspects which reduce motivation to reach out.

4.4.1 Quality of Adult Relationships in School

Participants shared that lack of trust was one of the key factors that played a part in them not sharing with school staff. There was a belief or fear that something may be raised to safeguarding or that staff would share with other staff members.

> '*…I feel like if I was in that situation and then I told like a teacher, I would trust him and I would like tell them. But then if they start going telling the safeguarding team and then they'll have to do something about it. And then like then I wouldn't trust them. And if they like they take you out of lessons and stuff like people be asking or why they taking you out. I feel like it's more around students finding out stuff*' (Aliya, L33-37)

> '*…Yes, when like you get pulled out of lesson like people question though, she was pulled out'* (Aisha, L10)

It was highlighted that school staff would "pull out" or "take you out" of your class showed that participants felt that this was publicising their needs and highlighting to peers that something is 'wrong'. This contributed to the narrative around people gossiping and questioning around why they might be seeking help. In addition, the words indicate lack of agency and link to feelings of being disempowered.

Participants expressed how sharing in school would possibly lead to peers finding out they are seeking support for SEMH or have their problems become more known so they would much rather avoid seeking support in school. The quote below illustrates how participants felt that they would be 'exposed' to their peers. There is also clearly a negative association with seeing a therapist,

though they may not feel this rationally, their internal beliefs show this through their fear of peers potentially gossiping or knowing what support they have access too.

'…*How comes she was pulled out and then, you know, they just connect the dots… like she's … probably going to see a therapist*" (Aisha, L 10-12)

Another barrier expressed by participants was that it is much harder to share with teaching staff who are White or do not share the same religion or culture as them.

'I feel like its harder, to approach someone who is White' (Esa, L32).

This quote illustrates the difficulty in finding the right person and that they participants might feel White staff members would not understand their needs and norms.

Participants also felt that teachers sometimes can probe for more information, and they do not feel comfortable sharing, and this can lead to them avoiding sharing altogether because it feels like an invasion of their privacy

'…*You know, it just feels like that's kind of digging your personal life when you just wanna tell them one thing. They just wanna dig into it with like this breach of, like personal space'* (Aron, L34,35)

'…*I think it was just that she just asked me to tell her like my whole life story, and I didn't really like that*' (Amal, L9)

These quotes a profound need for personal boundaries and a discomfort with intrusive questioning. The use of words and phrases like "digging," "breach," and "just wanna tell them one" underscores this sentiment. "Digging" evokes a sense of unwelcome excavation into one's private

life, suggesting a forceful and unwarranted probing beyond what one is willing to share. This term implies an invasive and almost aggressive attempt to uncover personal details, reinforcing the participants discomfort with such inquiries.

The word "breach" further intensifies this feeling by suggesting a violation or breaking of personal space. It conveys a sense of trust being compromised, as if an invisible line has been crossed, resulting in a deep sense of discomfort and defensiveness. This breach is not merely an overstep but an intrusion that disrupts the sense of safety and privacy. The phrase "just wanna tell them one thing" highlights the desire for controlled and limited sharing. It suggests that the speaker is comfortable with divulging a specific, perhaps less intimate detail, but feels pressured or overwhelmed when pushed to reveal more. This phrase encapsulates the struggle between maintaining personal boundaries and the external pressure to disclose more than what feels safe or appropriate.

Together, these terms illustrate a powerful narrative about the importance of respecting personal boundaries and the discomfort that arises when those boundaries are challenged. They reflect a deep-seated need to control one's own narrative and the anxiety that accompanies unwanted intrusion into one's personal life.

However, particular relationships with school professionals and their personal qualities were recognised as important facilitators for seeking help for SEMH issues. For example, in response to a question around viability of seeking support from teachers, a participant stated that:

> '*…I feel like they would, but it depends then as well if say the relationship with teacher is… I feel like sometimes if they've had like a bad experience with that teacher, they wouldn't. But then, if they like the teacher and then they would and it would the learning hub, I feel like*

they're really nice in there or some of them are anyways, so I feel like with that you can like I thought that is more. It's easier to go to the learning hub than it is to the other teachers' (Saira, L15 & 16)

This quote also illustrates something about the context of where things can be shared and provides insight in the importance of having environmental supports (such as smaller, learning hubs). Having staff that are approachable and able to build positive relationships with students in perceived safe places was therefore identified as an important factor.

Linked to this, another helpful aspect communicated by participants were that if that those staff members who are culturally informed or culturally curious are also more easier to approach.

' when I was in high school, one of the close people I thought was comfortable was speaking to was a White male teacher… how he interacted with students like I'm much more understanding, but he was like also. Even though he was a White male, he was like it's but like the cultured White people like he would understand like that, like my school was predominantly like coloured people and, like, Pakistani people like brown people and black people and then White people.' (Amelia, L 67-74)

The quote above demonstrates that cultural awareness among professionals or school staff fosters a safer environment for participants to express their concerns. When staff understand cultural norms or exposure to a particular community, participants feel more comfortable discussing familiar topics, leading to the development of positive relationships.

Participants expressed the longing and importance of having those who either understood cultural differences or those who shared the same cultural norms as them to make them feel more comfortable seeking support.

> *'Yes, It's just like, I don't know, it's just the way you would explain things to a brown person. It's very different from a White person because sometimes you're, like, switch up your languages and like you start speaking in Urdu or just like on, I don't know, it's just, I don't know, it's hard to explain, but it feel like way more in the zone and more comfortable speaking to someone like that'* (Esa, L34)

Interestingly, although only mentioned by two participants, there was a perspective highlighted that sharing with those who are not Pakistani is easier as they feel less judged and that they see mental health as a normal thing.

> '*…Yeah. I'd say if it was me, as a Pakistani, if it was someone who was a White therapist, it would be easier because I would feel less judged, I'd feel like they think is normal'* (Aisha, L30)

> '*…depends on the people you share with if it was a White person like the.. the librarian I was speaking to she said I can bring anything to her and she's treating me like a regular boy'* (Esa, L74)

These perspectives are in contrast to what other participants mentioned in relation to trust in staff who do not share the same ethnicity as them. However, it may also highlight and link to the stigma within the Pakistani community and how sharing with those who don't share the same ethnicity as you makes it easier as they do not hold the judgemental or negative preconceived views and ideas around mental health and emotional wellbeing. Furthermore, it was interesting to note the

use of the words "normal" and "regular." Participants felt that when working with staff who do not share their ethnicity, their Pakistani norms were viewed through a British lens. This allowed them to discuss issues without the labels and stigma often present in their own community. These quotes indicated that SEMH concerns might not be considered "normal" or important within the Pakistani community. However, being seen by a White professional meant these concerns were viewed as "normal," making it easier to share them. Additionally, the reference to being treated like a "regular" boy by a White professional suggested that participants were not confined to male stereotypes within the Pakistani community. They felt more comfortable expressing themselves, believing that it is more widely accepted for males to share and express SEMH concerns within British culture.

4.4.2 Just Getting on With It In the Community

Participants shared how they felt there was not a lot of opportunities for support within the community and if there was there was a lack of explicit of knowledge about how to get any. There is a sense of helplessness and just acceptance of this fact illustrated in the quote:

> '…*You'll get through it only by it, like there's no one actually providing the support'* (Aisha, L63)

At a deeper level, this quote reflects an emotional experience of isolation and self-reliance. The statement underscores a feeling of abandonment, suggesting that individuals within the community often feel they must navigate their challenges alone. The phrase "you'll get through it" conveys a sense of inevitability and enforced self-sufficiency, indicating that external help is

perceived as non-existent or inaccessible. This sense of being left to one's own devices can lead to a resigned acceptance of the status quo, where individuals might believe that seeking help is futile. The statement about no one providing support highlights a perceived gap between the community's needs and the availability or awareness of resources.

Participants expressed how the community don't see Mental health as a real thing and that it should not be spoken about. Participants also shared how the majority view in the British Pakistani/ Pakistani community is that everyone goes through something and eventually they get over it so you should just get over it as well and eventually you will overcome whatever the SEMH need may be.

> '*… They think you should not talk about mental health and they don't really believe in mental health… they see it as weak and that you should not talk about it to other people*' (Amal, L20-21)

> '*…And it's I think it's made to seem like you should be ashamed if you do go to a professional about how you feel, and I think a lot of people do hide their mental health issues* (Imaan, L67)

The above quotes reveal a deeper emotional burden where individuals are pressured to suppress their struggles to avoid being perceived as weak. There is an indication that the community's apparent dismissal of mental health issues creates an environment where vulnerability is not tolerated, and seeking help is stigmatised. This may result in a collective silence, reinforcing the notion that emotional struggles should be endured privately and without external support.

The second quote highlights the shame and secrecy surrounding mental health issues. The expectation to hide one's struggles fosters a culture of concealment, where seeking professional help is seen as something to be ashamed of. This creates an internal conflict for those who need support

but fear social repercussions. Additionally, the use of "hide" suggests a deliberate and conscious effort to keep mental health issues out of sight, indicating that individuals may go to great lengths to avoid detection or scrutiny. This could involve masking symptoms, pretending to be okay when they are not, or avoiding situations where their struggles might be exposed. Both quotes illustrate a deeper emotional landscape marked by isolation, shame, and the pressure to conform to communal expectations. Participants are communicating a profound sense of being misunderstood and unsupported, which exacerbates their mental health challenges. The prevailing attitude that everyone should simply "get over it" dismisses the validity of their experiences and discourages open conversations about mental health. This cultural backdrop is likely to make it difficult for individuals to seek help, leading to prolonged suffering and a lack of emotional resilience within the community.

Participants also discussed the community's views on seeking help when support is available. There is a prevailing belief that seeking help for SEMH needs is shameful, and it is better to avoid accessing support to prevent being labelled or stigmatised. As mentioned in the earlier theme (Silence or Stigma), it is preferable to stay silent and endure rather than seek assistance.

> '…*People do go through things and maybe as like within the mosque or as in the beginning, we should provide even more support like I do, get the praying and that all will help… But maybe the person also just need someone to talk to so that there's… there's… the, you know, you should pray to remember God and you'll get through it'* (Aisha, L86,87)

In this quote the participant is expressing a nuanced view on the role of religion and community support in addressing SEMH needs. It is acknowledged that prayer and religious practices are important and can be helpful. However, it's also recognised that sometimes individuals need more than just spiritual guidance—they need someone to talk to. There is a sense frustration and a desire for change. The participants appears to be wanting a more holistic approach to support within

the community, one that includes both spiritual and emotional components. Her mention of providing "even more support" indicates a recognition that current efforts are insufficient. The quote reflects a longing for a more compassionate and comprehensive support system that addresses both the spiritual and emotional needs of individuals.

Participants suggested that British Pakistanis often prefer to seek help and support from their family first rather than reaching out to others outside their immediate family. This preference is driven by a sense of loyalty and trust within the family unit. Additionally, there is a concern among some individuals about burdening others with their problems and worries, which leads them to keep their issues to themselves. The quote below highlights both the reliance on family for support and the tendency to internalise problems to avoid being a burden on other

'*…I think many like British Pakistanis would try talk to their family like for the first thing when they're looking for help. I wouldn't just bridge out to other people and take their problems elsewhere, but some people may feel like it's a burden to even put your pressures and like your worries and other people. . So they just keep to themselves'* (Aron, L18-20)

Participants revealed that they are more likely to seek support from family members rather than external sources. Although this might seem like a facilitator for help-seeking behaviour, it actually represents a significant barrier. They discussed how sharing problems with others can feel like a burden, leading them to keep their issues to themselves. Walid's quote encapsulates this sentiment:

> "...*Pakistanis don't really get help from the school, they would rather go to the family, going to school for help makes you seem like a 'pussy'*" (Walid, L22).

The deeper meaning of these words in this context involves the interplay of cultural and gender expectations, stigma, and the perceived burden of sharing. Participants feel that seeking help outside the family, such as from school, carries a negative connotation and diminishes their perceived strength. The term "pussy" indicates a fear of being judged as weak or unmanly. The emotions at play include shame, fear of judgment, and a sense of duty to protect others from their burdens. This cultural pressure creates an internal conflict, where participants feel constrained to only confide in family members. However, even within the family, there are barriers, as sharing problems can be seen as placing an undue burden on loved ones. This results in a cycle of silence and self-reliance, where participants feel isolated and unsupported despite being surrounded by family.

Despite the barriers to seeking support for SEMH issues identified above, some participants highlighted supportive aspects within their community. The qualities of the Imam emerged as a crucial supportive factor where participants felt more comfortable discussing their concerns.

> *"...And so the younger imam, he does like speeches which are quite relatable and he speaks like how we usually speak, like in our slang*" (Aliya, L18).

There was an appreciation for the Imams relatability and his use of familiar language, which helps bridge the gap between traditional religious roles and contemporary social understanding. This relatability makes it easier for participants to approach him with their issues, facilitating more open discussions about SEMH. Furthermore, the support provided in the mosque was also indicated:

> "...*I don't know, like a session that they used to do or just knowing that you could go to someone in the mosque to talk about like a problem or something that's going on in the world that you felt more comfortable talking to them*" (Ahmed, L28).

This above quote highlights the value of having designated sessions or simply knowing that support is available within the mosque. This availability appears to create a safe space where participants might feel more comfortable sharing their problems, which is particularly important when they cannot discuss certain issues elsewhere, such as in school. There appears to be a sense of relief and comfort in finding a supportive outlet in the mosque in the words: *'just knowing'*. They experience a contrast between the isolation and stigma associated with seeking help outside the family or community and the acceptance and understanding found within the mosque. The younger imam's social awareness and relatable communication style appear to be key factors in this supportive environment.

The mosque's role becomes even more significant in the context of current events, such as the increasing aggression in Palestine. Participants noted that while they were not allowed to discuss these issues in school, the mosque provided a venue where they could express their concerns and seek support. This highlights the mosque's function not only as a religious centre but also as a community hub where individuals can find solace and solidarity during difficult times.

> "...*I would feel more comfortable going there because I feel like number one, I can really say anything because I know everyone around me is good and everyone is the same as me, whereas in school it's different, I don't want to say something that I don't mean and it's taken the wrong way or something*." (Rohaan, L18).

The quote above underscores the comfort and safety participants feel within their own community compared to the uncertainty and potential misunderstandings they face in external settings like school.

Participants shared concerns about not being understood in school when discussing certain topics. They feared that religious and cultural norms might be misinterpreted negatively, leading to referrals for safeguarding.

> *'Cuz I feel like if I speak ta a White person and slip and say something, if you like, that's not normal but it is normal in our culture and they don't have that'*

This reflects a broader anxiety about how their expressions and behaviours might be perceived outside their community, reinforcing a sense of alienation and mistrust. Participants worry about being misunderstood or judged, which inhibits them from sharing their true thoughts and feelings. This fear of misinterpretation creates a significant barrier to seeking support for SEMH needs, as participants feel they must navigate potential cultural biases and prejudices.

> *'…but whereas going to a staff member who is who looks more like you or shares a similar skin colour it would be easier to talk to them so yeah from personal experience it's definitely easier to talk to people who do look like you all like sound like you'* (Amelia, L86)

In summary, there is a duality in this theme. Seeking support at school is dependent on the relationships and shared understanding; however there is lack of consistency around the cultural identity of the adult who may be a source of support. Similarly, there is stigma and a need to hide and not show weakness which is a barrier to seeking help in the community. However, there is also a sense of comfort and safety within their community stems from shared beliefs and cultural understanding. Participants feel more at ease discussing their issues with someone who shares their religion and cultural background, knowing that they are less likely to face judgment or misunderstanding.

4.5 Being 'Britishstani'

This theme explores how cultural identity within the family context impacts participants seeking help and support for SEMH concerns. The theme explores how young people of Pakistani heritage in growing up in Britain today are grappling with differences in approaches taken in families and how this might affect them.

4.5.1 British Vs Pakistani Culture

Participants expressed varying views around traditional Pakistani culture and how the culture is shifting as the generations become more accultured to British culture.

> '*…I feel like as a Pakistani like it's more you should keep all your emotions to yourself and if you express it to someone that's seen as being weak. But then in that as you get older like you, you understand more that was better to talk to people and tell people. If you have people around, you understand it help you, then you get more free with them and express yourself more. like the back in the day, them olden views'* (Aliya, L41 -44)

This participant delves into the emotional journey shaped by cultural expectations and personal growth. Initially, there's a sense of internalised pressure to conform to societal norms dictating emotional restraint, particularly within the Pakistani context. The mention of feeling like one should "keep all your emotions to yourself" suggests a burden of silence, perhaps accompanied by feelings of isolation and the fear of being perceived as weak. The word "weak", implying a stigma attached to vulnerability and the expression of emotions. It may evoke feelings of inadequacy or

shame, as the participant grapples with the internalised belief that sharing one's feelings is synonymous with displaying weakness.

The word "free" in the statement carries significant emotional connotations, particularly highlighting a sense of liberation and comfort. It suggests a feeling of unrestricted expression, unburdened by the weight of cultural expectations or fear of judgment. In the context of expressing oneself, feeling "free" implies a sense of emotional safety and acceptance within one's social circle. It evokes feelings of openness and authenticity, where individuals feel empowered to share their thoughts, feelings, and struggles without reservation.

This emotional freedom is closely linked to a lack of judgment or gossip. When individuals feel "free" to express themselves, they are less inhibited by concerns about how their words or actions might be perceived by others. There's a sense of trust and mutual respect within the social environment, fostering an atmosphere of empathy and understanding. Moreover, the word "free" also suggests a release from the constraints of cultural barriers and stigma. Participants may experience a sense of relief in being able to express themselves authentically, without the fear of facing discrimination or ostracization based on cultural norms or expectations especially in relation to “olden views” of keeping emotions to yourself. This could also be linked to the dual cultures and raise the questions around is one culture more “freeing” than the other. Pakistani culture holds a lot of stigma around SEMH whereas talking about and sharing thoughts and feelings around SEMH is promoted in British culture.

Participants expressed how Pakistani cultural perspectives might reinforce them to show their success either through material wealth or status of job role to mask any mental health concerns and to avoid talking about them.

'*…like, especially in the Pakistani community, is all about like being rich, like having all these cars having a big house just riding around those cars and stuff and just feel like it's never the mental health part. Never ever comes into it and I feel like every single person I know in the brown community, like in the school, like I got, a few friends, they have problems like you can definitely catch out and see those qualities in them*' (Esa, L71)

The statement highlights the dichotomy between external displays of success and internal struggles within the Pakistani community. The emphasis on material wealth and status, such as cars and big houses, serves as a facade to mask underlying mental health concerns. This societal pressure to prioritise appearances perpetuates a culture of silence around mental health issues. There is a pervasive emphasis on projecting an image of success and prosperity to maintain social standing. This focus on external indicators of achievement often comes at the expense of addressing internal struggles like mental health issues. Individuals may feel compelled to prioritise their external image and suppress signs of vulnerability, creating a disconnect between outward appearances and inner experiences, and reinforcing the stigma surrounding mental health. The quote highlights the prevalence of mental health challenges despite the cultural reluctance to acknowledge them, underscoring the complexity of navigating societal expectations while grappling with personal well-being.

Furthermore, the phrase "catching out" likely refers to the ability to discern or recognise signs of mental health issues in others. It signifies the awareness and perception of subtle indicators or behaviours that may suggest underlying struggles. This phrase is significant because it highlights the pervasive nature of mental health challenges within the Pakistani community, despite the cultural reluctance to openly discuss them. The phrase "catching out" may also imply a sense of vigilance and attentiveness to the well-being of others. It underscores the importance of empathy and understanding in identifying and supporting individuals who may be experiencing mental health

difficulties. It may also highlight what the participant may be seeing in others that he can relate to therefore making it easier for him to “catch out”.

Participants discussed the prevalence of blame within the Pakistani community when it comes to SEMH needs. They noted that blame is often directed either towards the family, accused of causing the issues, or towards the individual experiencing SEMH needs themselves.

> ‘*…Its just seen as “what did you do wrong”. It’s a bit like, so you even if you do say you've got depression, you feel like just get up and get over it or it's just a phase… And asking what's actually caused this? And like, how can we help? It's more like you don't know what you're talking about. Everything that happens to everyone, they just get over it. You should do the same*’ (Aisha, L61-64)

The above quote reinforce that cultural pressures may result in a feeling of ‘it is not worth sharing problems and best to avoid this by keeping it to yourself’. It may also highlight a dismissive attitude towards mental health issues within the Pakistani community. The phrase "It's just seen as what did you do wrong" suggests a tendency to attribute mental health struggles to personal failings or weaknesses, rather than recognising them as legitimate health concerns. The sentiment of "just get up and get over it" suggests a lack of understanding or empathy towards the complexity of mental health conditions such as depression. This expectation to simply overcome challenges without acknowledging the underlying causes can leave individuals feeling invalidated and unsupported in their experiences. Furthermore, the notion of mental health issues being dismissed as "just a phase" implies a lack of recognition of their lasting impact and the need for professional intervention. This minimisation of the severity of mental health struggles can deter individuals from seeking help and delay their access to appropriate treatment.

4.5.2 Parenting in a British Pakistani Culture

This sub theme provides further insights into barriers and facilitators in relation to help seeking behaviours. Participants shared their perspectives on how British Pakistani Parenting styles impact their decision in either seeking or avoiding help.

> '*…So for people who have like, who are more traditional, I think, I will say I come from a traditional family, but the talk of emotional wellbeing is there but within my wider family. I . I would say their parents are from Pakistan, whereas my parents are British born, I feel like my parents are more open to the conversation, for them I feel like the children will have to bring up the conversation. The don't mind the conversation, but wouldn't bring up first, so it would take encouragement, yeah*' (Amelia, L40-43)

The above quote seems to reflect on the difference in attitudes towards discussing emotional well-being between traditional Pakistani parents and those who are British-born. Traditional parental views, often associated with families originating from Pakistan, may lean towards a more reserved approach when it comes to discussing emotions. There might be cultural norms or expectations that prioritise stoicism and resilience, leading to a reluctance to openly address emotional issues. In these families, discussions about mental health and emotional well-being may be limited or even taboo, and children may feel hesitant to broach such topics with their parents. Conversely, British-born parents, may adopt a more open-minded stance towards discussing emotions. Growing up in a different cultural context, they may be more accustomed to expressions of emotions and comfortable engaging in conversations about mental health. However, as noted, while parents are open to these discussions, they may not necessarily initiate them. Instead, they may encourage their children to take the lead in starting such conversations.

The term "encouragement" indicates that despite being open to discussing emotions, British-born parents may need their children to initiate these conversations. This suggests a supportive environment where children are encouraged to express themselves but also highlights the importance of active communication and initiative from both parents and children in fostering discussions about emotional well-being.

The quotes below reflect the understanding among participants that there is a generational gap in awareness and education about mental health, particularly between parents who were born in Pakistan and those who were born and raised in the UK

> '…*So I do think with the if you're from back home, it's a bit like it was never a thing when you were growing up, so it can't be a thing now. But if you're born and raised here, it's a bit like, you know, schools did teach you about it.* (Aisha, L114)

Participants shared that parents who emigrated from Pakistan often did not receive education or exposure to discussions about mental health while growing up. As a result, they may lack understanding or awareness of mental health issues and may not prioritise discussions about them within the family. This lack of education and exposure is seen as a contributing factor to the reluctance or avoidance of discussing SEMH needs within these families. However, participants also recognise that parents who were born and raised in the UK were more likely to have been exposed to education about mental health, potentially through schools or other resources. Consequently, they may be more open to discussing SEMH needs with their children. The participants' acknowledgment of this generational difference in education and awareness regarding mental health demonstrates empathy and understanding towards their parents. Instead of blaming their parents for their lack of

knowledge or reluctance to discuss SEMH needs, participants attribute it to the historical context and cultural norms prevalent in their parents' upbringing.

Recognising the limitations imposed by cultural and generational factors, participants implicitly excuse their parents from blame for not discussing SEMH needs. They understand that their parents may not have had the same opportunities for education and awareness about mental health as they have had growing up in a different cultural context.

> *'Because my mom, she's even told me that she's way more open minded. But my dad again goes back to the whole old thing, like he hasn't really experienced the whole mental health thing, which isn't his fault' '* (Esa, L61)

There was also an acknowledgement that British (White) people are more open to talking about Mental health and that British parents, in particular have a different approach, making it easier for British children to discuss their needs with their parents.

> '…Probably, it's just I wanted to say this it's like at home. You're surrounded by like people who are very different from can I say like White people? Yeah, like brown people in a family in, in your house. Like the way things go around I feel like it's very different from a White family than a brown family I've been in like White people's house and seen like, I don't know if it's just while I was there about seeing, like, it's very different from how my family would act in certain situations, how their family would act in certain situations' (Esa, L27-29)

The participant is expressing a sense of cultural awareness and perhaps a degree of cultural identity. The use of phrases like "at home" and "surrounded by people who are very different" suggests a reflection on their own cultural background and the dynamics within their family

compared to those of White families. There may be a sense of curiosity or observation, as they compare the behaviour and dynamics of White families to those of their own brown family. The phrase "I've been in White people's house" indicates a sense of exposure to different cultural environments, leading to comparisons and observations about how things are different between the two. There also felt like there was a want for what was experienced when visiting a White family's home. The contrast between the environment at home, which differs from that of White people, contributes to a perception of home as a challenging space for sharing and expressing emotions. This discrepancy in cultural norms may lead to a sense of cultural clash and hinder the ability to freely communicate feelings. Although the participant refers to "White people," it seems indicative of a broader absence of British cultural practices at home. This lack of alignment with British culture may result in difficulties in feeling a sense of belonging, particularly for individuals navigating dual cultural identities, such as being both British and Pakistani.

Another perspective shared by participants was that British Pakistani/ Pakistani parents would discourage you from accessing support or talking about SEMH needs as this would make you look bad within the community.

> '*…I think of course it causes it just drops the bomb in the home. Some parents might take it quite well, but then some parents might take it as you've like... They're gonna take it in a way, that you're trying to, like, make me look like a bad parent. So, like all about image and stuff. So, it depends really on the family that person has and the parents who you have a well enough understanding of mental health, but a lot of the time it could be just about imaging images*' (Imaan, L52-55)

The excerpt highlights the complex dynamics that occur within families when mental health issues are brought into discussion. There's a recognition that some parents may react positively,

while others might perceive it as a personal attack on their parenting skills. This reaction often stems from concerns about maintaining a certain image or reputation within the community, reflecting the importance placed on societal perceptions and appearances. There is a sense of apprehension, fear, frustration and of uncertainty regarding how parents will react to discussions about mental health, coupled with the fear of being misunderstood or judged. Additionally, there may be frustration with the societal pressure to prioritise image over addressing the real and valid concerns related to mental health. This excerpt can be linked to the earlier discussion about image and material wealth being used as a facade to conceal internal struggles. In both instances, there's an underlying theme of the pressure to uphold appearances and avoid discussions about vulnerable topics like mental health. The emphasis on maintaining a certain image serves as a barrier to addressing internal mental states openly and authentically within families.

Overall, these subthemes shed light on the complexities surrounding discussions about mental health within families, highlighting evolving British-Pakistani cultural identity, as well as the impact of societal norms and expectations on individuals' abilities to express themselves and seek support for their mental well-being. Participants highlighted that parents' views on SEMH issues varied based on their level of education on the topic and whether they held more traditional Pakistani views or more British views. Those with one British-born parent found it easier to communicate about SEMH, as these parents tended to have a better understanding of the topic.

The complex dual culture of being British Pakistani can complicate openness about SEMH concerns. Individuals may find it challenging to be fully open due to differing cultural attitudes towards mental health within the family. Consequently, they might feel more comfortable discussing SEMH issues in environments like school, where British cultural norms predominate, compared to at home.

4.6 Bound by Gender Roles

This theme highlights the participant perceptions of how expectations around gender roles within British and Pakistani cultures may impact on help-seeking behaviours and how this may engender permissions for one gender to access support in comparison to the other.

4.6.1 Mask-Culinity

Several participants noted that within societal norms, males expressing emotions is often deemed unacceptable and can lead to negative labels such as "weak," "lower in status," and "less masculine." Specifically, there were mentions of associating emotional expression with being perceived as "gay" in a derogatory manner, indicating a broader lack of acceptance of diverse sexual orientations.

> '…*Well boys usually only share the problem, they don't really share their feelings or emotions because someone might see you as a 'pussy', because people will see you lower as*' (Walid, L28)

> *'…it would be seen as like gay or umm, especially in the Pakistani community being gay, it's like it's not allowed. Umm, you've seen as like gay and stuff. It's just not something I wanna be. Umm, I know like this whole like generation. Like the we have like the whole woke community and how people see like being LGBTQ and everything is fine. But in our culture So that's definitely like, you know, you can't do that type of stuff. So yeah, so sharing your emotions is seen as getting, yeah, if you like mental health in the Pakistani community, it's tied to being LGBTQ and gave those two things are tied together'* (Esa, L78-82)

The extracts highlight a sense of confusion and conflict regarding societal expectations and cultural beliefs surrounding emotional expression and LGBTQ+ identities within the Pakistani

community. The use of the word "tied" is significant as it suggests a strong association between sharing emotions and being LGBTQ+ within this community. This connection implies a perception that expressing emotions or experiencing mental health issues aligns with or leads to being identified as LGBTQ+, reinforcing the stigma surrounding both topics. This may reflect the internal struggle faced by individuals navigating societal norms and personal beliefs, especially when those norms clash with more inclusive ideologies. The contradictions within their cultural context likely contribute to feelings of confusion and being pulled in different directions.

The quotes also delve into the deeply ingrained societal perceptions and expectations surrounding masculinity and emotional expression within the Pakistani community. They highlight the prevailing notion that sharing emotions is viewed as a feminine trait, leading to boys who express their feelings being labelled with derogatory terms such as "pussy" or "gay." Furthermore, the quotes reveal the internal conflict and emotional turmoil experienced by individuals who feel pressured to conform to traditional gender roles and societal expectations. There is a sense of fear and reluctance to express vulnerability due to the perceived threat to one's masculinity and social standing. The use of terms like "gay" reflects the stigma surrounding LGBTQ+ identities within their cultural context, further exacerbating the reluctance to share emotions. Emotionally, these quotes seem to convey a sense of frustration, fear, and internalised stigma. There's a recognition of the societal barriers that prevent boys and men from openly discussing their emotional struggles, leading to a cycle of silence and emotional repression. The fear of being ostracized or ridiculed for deviating from traditional gender norms adds to the emotional burden, reinforcing the pressure to conform to societal expectations of masculinity.

The role of how a British Pakistani male should behave and act is reinforced by cultural stereotypes and male family members who remind the younger generations how to behave and act seems to be an important consideration indicated in the quote below. Another factor was the role of

the father in the British Pakistani household and how he is there to provide financially and does not complain about any difficulties again reinforcing how males should act within the household.

> *"…So you think about like the dad he could have financial problems himself like he's worried about work so much like he's providing for you but that's all he's thinking about like he's not focusing like his mind's on one like thing so you come up to him and tell him oh yeah dad I need um what um oh yeah I need help with this homework can you help me he's gonna be like no go ask mum or like go ask your brothers or sisters if you like"* (Ahmed L87)

The concept of physical strength is often closely linked to societal perceptions of masculinity. This traditional view suggests that men are expected to embody physical robustness—having muscles, being tall, and generally exuding physical power. This association with strength, however, creates a challenging dynamic when it comes to emotional vulnerability. The following quote highlights the stereotype that boys are seen as weaker individuals if they express their emotions, despite their physical strength.

> "*Whereas for boys they're just seen weaker as a person, this is a stereotype. Yeah, like they usually like cause they're strong and we got muscles, their tall. But and that isn't necessary in a boy. Yeah, like they usually like cause they're strong and we got muscles, their tall. But and that isn't necessary in a boy*" (Aliya, L53&54)

This stereotype imposes an unrealistic expectation that boys and men should not display emotional vulnerability, as it contradicts their perceived physical strength. The focus on physicality suggests that strength is solely measured by one's external attributes, ignoring the importance and necessity of emotional resilience and openness. The idea that physical attributes aren't necessarily what defines a boy underscores the recognition that true strength encompasses more than just

physical prowess. It calls into question the restrictive norms that equate masculinity solely with physical strength, ultimately advocating for a broader, more inclusive understanding of what it means to be strong and masculine.

The quote below highlights the social repercussions and fear of judgment faced by individuals when they consider seeking support for mental health issues within their community. The concern about how others might perceive them creates a cycle of stress and avoidance of seeking help as a male in the British Pakistani community.

> "*…No, no, it's not, it's like the community will find out and then think like this guy but then they might like view me in a different way. Mm-hmm. Like their views might before be like, 'He's very quiet.' Then they'll be like, 'Oh, he's a bitch. He cuts himself well, what a guy,' and they're just... So it's that cycle of actually even if I was to seek support and then you hear that, then you're going to more stress*." (Ahmed, L107)

This quote underscores the fear of social stigma and the intense pressure to maintain a certain image within the community. The participant expresses concern that seeking support for mental health issues would lead to a negative shift in how others perceive them. Initially seen as "quiet," they fear being labelled with derogatory terms such as "bitch" or having their self-harm used against them as a point of ridicule. The participant appears afraid of being judged and ridiculed, which adds to their existing stress. This fear may prevent them from seeking the support they need. There is a deep sense of shame associated with both the mental health struggles themselves and the potential community reaction to these struggles. The anticipation of negative judgment and gossip can lead to feelings of isolation, as the individual may withdraw further to avoid these potential reactions. The use of terms like "bitch" and references to self-harm highlight the severe and

damaging judgments that can occur, illustrating the harsh social environment that discourages openness about mental health.

The participant's words may reflect a broader issue within the community were maintaining an external image of strength and composure, as mentioned earlier around material status and wealth is prioritised over addressing internal struggles. This dynamic creates a significant barrier to mental health support, perpetuating cycles of silence, shame, and untreated mental health issues.

Overall, there is an acknowledgement that boys do have emotions and may not necessarily feel 'strong' all the time but due to societal and cultural pressures and stereotypes they had to put on a facade and adhere to gender stereotypes.

4.6.2 Fake It 'Till You Make It

This subtheme examines how participants perceived the barriers and facilitators faced by females in the British Pakistani community when seeking support for SEMH. Key findings highlight that while women are expected to be emotional, making it seemingly easier for them to share, SEMH issues remain a taboo within the community. Thus, although emotional expression is more acceptable, having deeper SEMH concerns may still be viewed as problematic.

The below quote highlights the supportive nature of female relationships within the British Pakistani community, particularly in the context of shared problems. She suggests that girls who experience similar issues tend to form close bonds, providing each other with understanding and support.

> *'…Umm, I feel like, you know, girls who have the same problem. They become closer to each other and then even like I like you, you could talk to each other about your problems and then you could kind of like understand each other and give each other help*' (Aliya, L57&58)

The quote emphasises emotional proximity and connection among females facilitate help-seeking behaviours, as the ability to discuss problems with someone who understands and shares similar experiences creates a safe space for expressing emotions. This close bond can mitigate the stigma associated with SEMH concerns, as shared empathy reduces the fear of judgment. The trust and safety fostered by these relationships encourage more open and honest conversations, offering a valuable support network that provides practical advice, emotional support, and a sense of belonging. When girls regularly talk to each other about their problems, it normalises seeking support and can gradually challenge cultural taboos around discussing mental health, promoting a healthier approach to emotional wellbeing.

Participants noted that females found it easier to share emotions, as it was considered a 'feminine trait' and almost expected from them to be expressive and open about their feelings, contrasting with the societal norms for males.

> *'…No, there's not. I think for girls it's completely different, I think girls are easily allowed to talk about it because they're girls, I don't know, it's just something like it's girls they can talk about because they're very emotional as it is because they're females but men are just like shown to be like the tough ones so it's like if you talk about your feelings or you're just you're just a wimp'* (Ahmed, L69)

However, while the majority acknowledged this expectation for females to be emotional and share emotions, there was also discussion about the specific expectations placed on females within British Pakistani culture. Despite the general expectation for females to be emotional, there was a contradictory pressure for them to exhibit stability in mental health and emotional wellbeing, particularly in preparation for marriage. This expectation may stem from the desire for potential

suitors to perceive them as emotionally stable and suitable partners, or from the expectation that they should provide stability within a marital relationship.

> **'…***And I think, in regard to females, especially in my own culture, they it's as if there's no time for it. It's, you know, we just need to be able to have the skills to have a husband someday and be a wife and you know, parents don't really acknowledge in the moment. How their child is feeling, is just all about .If they are ready for the future, and if they can make the parents look good because daughters are known known as the pride and joy in peoples families'* (Imaan, L80-83)

There's a poignant observation about the pressure placed on females within her culture to prioritise preparation for marriage and familial expectations over their emotional development as individuals. This emphasis on conforming to traditional gender roles and cultural expectations overlooks the holistic development of individuals. Instead of fostering emotional intelligence and self-awareness, the focus is solely on acquiring skills deemed necessary for marriage and fulfilling familial obligations. This narrow perspective neglects the complexity of human beings as multifaceted individuals with emotional needs and experiences beyond their gender and cultural roles. The part of the quote emphasising daughters as the "pride and joy" of families highlights the pervasive focus on image within the British Pakistani community. Just as males may feel pressured to present a successful external image through material wealth, females are expected to uphold the reputation and honour of their families by embodying idealised qualities of virtue and stability.

Moreover, this cultural expectation may place immense pressure on daughters to conform to traditional roles and behaviours that align with the community's standards of respectability. It suggests that a daughter's value is often measured by her ability to fulfil societal expectations and enhance her family's reputation, rather than prioritizing her individual well-being and emotional

fulfilment. This emphasis on external appearances and reputational concerns further reinforces the tendency for individuals, both male and female, to conceal their struggles and prioritize maintaining a facade of success and stability, even at the expense of their mental health and emotional authenticity. Thus, the interplay between gender expectations, familial reputation, and societal image ideals perpetuates a cycle of pressure and concealment within the community.

In the quotes below, there are indications of the pressure on females to maintain a facade of emotional stability can lead them to suppress their true feelings and struggles, fearing that any display of vulnerability could tarnish not only their own reputation but also that of their families. This societal expectation often results in individuals feeling compelled to keep their emotions to themselves, avoiding seeking support or opening up about their struggles:

> '*…I'd rather them just not know. Then me just get through it myself. So it's not like I'm fearful of anything. We're like, I don't want them to like, you know, they wouldn't be accepting. They probably would, but they just won't provide the support anyway, so it's a bit like there's no point you knowing'* (Aisha, L100-103)

> '*…Other girls, they they do express how they feel and yeah, but especially as I feel like more Pakistani girls keep themself like to themselves'* (Aliya, L50)

The participant is expressing a preference for keeping their difficulties hidden rather than risking potential judgment or lack of support from their family. There appears to be a palpable sense of resignation in the participants words, indicating an emotional burden and a feeling of being unsupported by their family. Despite the acknowledgment that their family may not necessarily be unaccepting, the lack of perceived support or understanding creates a barrier to seeking help, leaving the individual to navigate their challenges alone. This highlights the emotional toll of

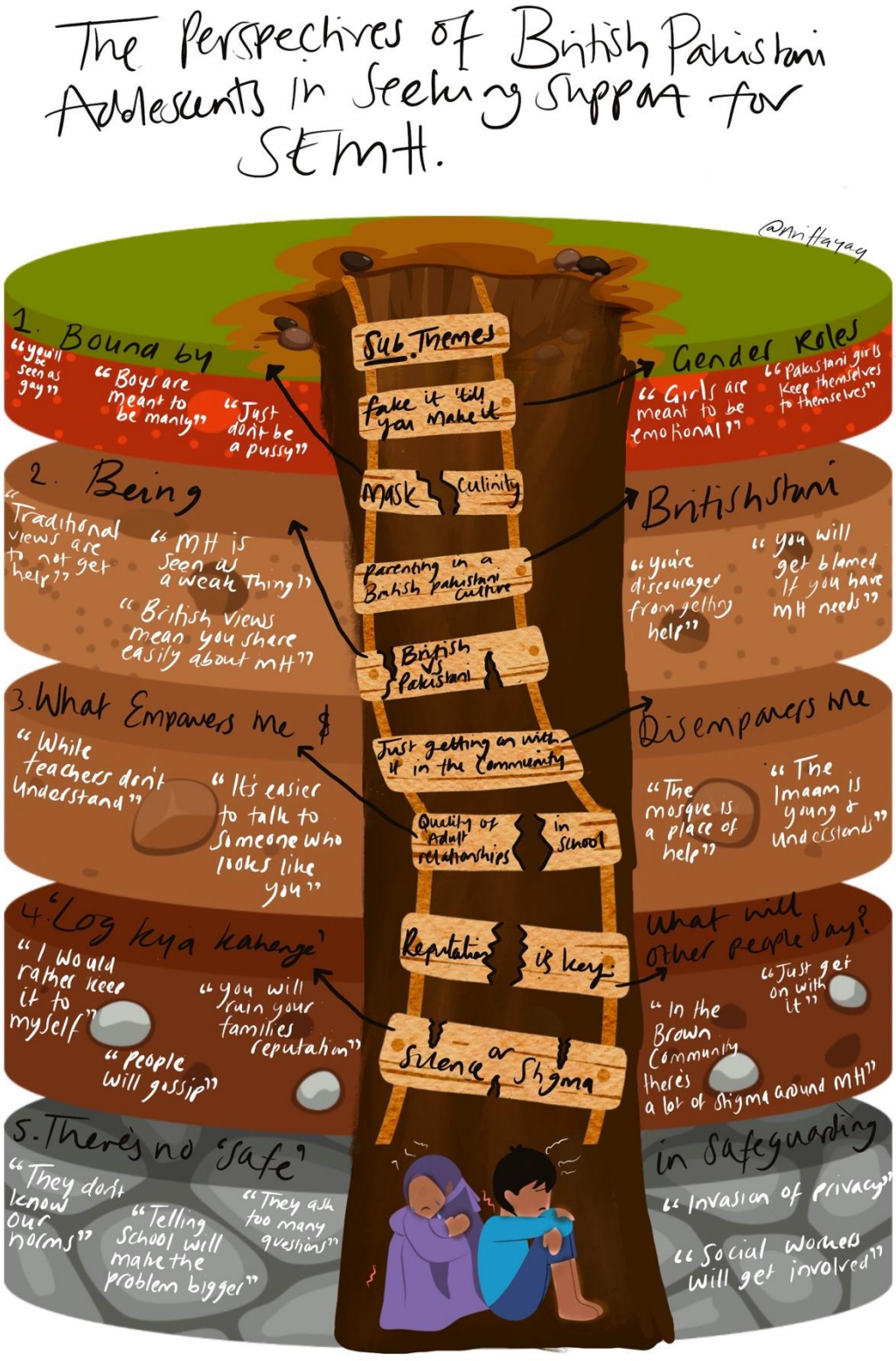
conforming to societal expectations and the impact it can have on individuals' well-being, as they grapple with the internal conflict of wanting to preserve their reputation while also facing their struggles in isolation.

4.7 The Overall Story of the Data

In line with Braun and Clarke's 'the story of the data' (Braun & Clarke, 2006), the story of the data subheading was used as one of the key considerations of reflexive thematic analysis (RTA) is whether the themes tell a coherent and compelling story of the data that address the research questions. The illustration below (see figure 3) depicts the researchers' visualisation of what was shared by participants. The main themes appear to represent more barriers than facilitators, interpreted as layers that prevented participants from seeking help or, in some cases, deterred them as their internal beliefs made them feel that the consequences of seeking help were far greater than dealing with problems by themselves.

Figure 3

Illustration of themes and subthemes.



In conclusion, the research findings shed light on the complex dynamics surrounding help-seeking behaviours for SEMH issues among secondary-aged students of British Pakistani background.

While there was lack of trust in systems (safeguarding), and access to the 'right' kind of person at school, the study revealed deep-seated cultural norms and expectations that act as significant barriers to seeking support. Participants expressed fears of judgment, stigma, and the importance of upholding community and family reputation over addressing mental health concerns. Gender stereotypes also played a role, with societal pressures dictating how males and females should express emotions and seek help. The pervasive theme of silence, stigma, and the perception of mental health as a taboo subject within the community emerged as key challenges. By addressing these barriers and leveraging these facilitators, schools and communities can work together to create a more supportive environment for students grappling with SEMH issues.

Following on from these findings, the next chapter will discuss them with respect to the research questions posed in the research, as well as links to literature, theory and implications.

Chapter 5: Discussion

5.0 Chapter Overview

In this chapter the findings of the study will be discussed in connection to the research goals and literature relevant to British Pakistani adolescents seeking support for social, emotional, and mental health needs. The chapter starts with an overview of the findings, discussing all six themes in the context of existing literature. Next, a critical assessment of the study's strengths and limitations is provided, followed by an exploration of the study's implications for educational psychologists, school staff, and other professionals working with young British Pakistanis. Lastly, the researcher reflects on the overall research process.

5.1 Aims and Overview of Findings

In the literature review it was identified that there was limited research around social-emotional wellbeing is the specific group of British Pakistani adolescents, particularly from a male perspective. In addition, given the challenges of cultural context, it was noted that there may be barriers towards help-seeking for aspects related to mental health. The literature review uncovered several themes, including insights into the prevalence and unique experiences of minority ethnic communities among both adults and children/young people. It also highlighted the significant role of beliefs and religious figures in the context of mental health. Various factors influencing help-seeking behaviour for mental health issues were identified, encompassing socio-economic, language, and educational elements. Additionally, important sub-themes emerged, such as the impact of culture on professional relationships, practices and pressures, gender roles, and mixed cultural identities. As such the aims of the research was to explore the research question: What are the perspectives of adolescents of British Pakistani background in seeking support for Social, Emotional & Mental Health (SEMH) needs?

Following on from this and in line with the literature review, two sub questions were posed:

1a. What role does culture play in shaping British Pakistani adolescents' experiences of help-seeking for mental health needs?

1b. What role does gender play in shaping British Pakistani adolescents' experiences of help-seeking for mental health needs?

As outlined in the results chapter, the study's findings reveal how young British Pakistanis perceived both barriers and facilitators when seeking support for social, emotional, and mental health (SEMH) issues. Five themes and eight subthemes emerged in relation to the research question, providing insight into the participants' knowledge and understanding of the influence of culture and gender on the process of seeking support. These themes and subthemes were specifically:

- There is no ‘safe’ in Safeguarding;
- “Log kya kahenge” - What will other people say?
  - Reputation is Key
  - Silence or Stigma;
- 3.What empowers and disempowers me in School and the community
  - Quality of Adult Relationships in School
  - Just Getting on With it in The Community;
- 4.Being ‘Britishstani
  - British Vs Pakistani Culture
  -Parenting in a British Pakistani Culture’;
- 5. Bound by Gender Roles
  -Mask-Culinity
  -Fake it ‘till you make it.

The findings are discussed below alongside previous literature, highlighting both the similarities and differences with the current study.

5.2 The Role of Culture in Shaping British Pakistani Adolescents' Experiences of Help Seeking?

A number of barriers and facilitators linked to culture are discussed below in the context of help-seeking for social-emotional and mental health issues. Notable barriers include the importance of maintaining reputation and the fear of inviting judgement. However, other aspects such as generational influences and religion's impact indicate variable positive and negative impact on help-seeking. Adults with cultural insight were recognised as important facilitators of seeking support.

5.2.1 The Importance of Maintaining Reputation

The importance of standing and reputation is noted to be a key umbrella finding throughout a number of themes. Reputation is a significant factor within Pakistani culture and participants in this current study expressed in many ways how reputation was a way in which parents and the community used to essentially 'control' what was shared and what was not. These narratives were apparent amongst participants within this research (Themes: *Log kya kahenge, What empowers and disempowers me in school and the Community; Being Britishstan*i) and emphasised how cultural factors influence the importance of family reputation within this particular ethnic group. This was done through messages about not speaking to others outside the family about any problems as this would lead to an impact on the family's reputation and others gossiping about them. Participants also shared concerns around potential repercussions of disclosing SEMH concerns, including fear of damaging reputation, facing ostracisms or experiencing reduced marriage prospects due to the perceived impact on the family honour and shame as highlighted in the subtheme '*Reputation is key'*. Therefore a number of themes highlight that the family reputation is highly regarded and maintaining standing within the community is one of the most important things to strive for. As such, the importance of reputation can be seen as a key barrier within the research as emphasised in

the theme '*Log Kya Kahenge- What will Other People Say'* to help seeking within the community. This is in line with finding by Moller et al. (2016) who noted that the stigma attached to mental health concerns within the British South Asian community, such as being perceived as "crazy or depressed", could negatively impact their reputation within the community.

The potential reputational damage, highlights that the fear of a breach in confidentiality and the possibility of personal information becoming public knowledge, also contributes to the reluctance in seeking help. As highlighted in the theme '*There is no 'safe' in Safeguarding'* Participants stated that they felt unsafe sharing information to school staff or other professionals out of fear that the information would somehow still get out to either their families or the wider school/ Pakistani community. The lack of control around who and what information is passed on to those in safeguarding positions played a dominant and prevalent role in the narratives within the participants perceptions or experience in seeking support within the school.

5.2.2 The Fear of Inviting Judgement

Further to the importance of maintaining a positive reputation, participants in the current study (in the theme '*Log kya kahenge – What will other people say*), also emphasised the importance of avoiding sharing information as this will lead to specific negative judgements or opinions around themselves and their family. A study conducted by Husain (2018) looked at barriers to seeking psychological help in Pakistan, with social defame highlighted barrier to seeking help. This referred to the fear or concern individuals may have about how their mental health struggles will be perceived by others in their community. This fear of social judgement or negative consequences can act as a significant deterrent to seeking professional help.

A number of themes (*Log Kya Kahenge – What will Other people say; What empowers me and disempowers me in the community and in school*) in the current research indicated that shame and honour play a crucial cultural role in regulating adolescent behaviour within the British Pakistani/Pakistani community. Research by Sangar and Howe (2021) indicates that the concept of shame is tied to adhering to societal norms, and any deviation from these norms can bring shame upon the family, damaging their social reputation. This societal pressure to maintain honour and avoid shame leads individuals to modify their behaviour to meet community expectations. 'Izzat,' which translates to the preservation of honour in the South Asian community, is paramount, and an individual's actions are seen as a reflection of their entire family. Shame and honour are interconnected, with shame serving as a tool to protect honour. Actions perceived as bringing shame to the family can result in social ostracism or even honour-based violence. Consequently, individuals may adjust their behaviour to prevent bringing shame to their families and community, thereby contributing to the internal regulation of behaviour within the community (Sangar & Howe, 2021).

As highlighted in the sub-theme '*Silence or Stigma'*, participants reported hearing stigmatising views from the British Pakistani / Pakistani community regarding social, emotional and Mental Health problems. Common narratives included beliefs that mental health issues were a sign of weakness, indicative of being 'crazy' or the attachment of a negative label. These negative perceptions further reinforced the fear of disclosing SEMH needs. Causier et al. (2024) identified stigma as a significant barrier to help-seeking for severe mental health problems among young Pakistani women, with cultural influences playing a crucial role in shaping perceptions and experiences, the study highlighted how cultural norms and societal expectations within the Pakistani community perpetuated stigma around SEMH.

5.2.3 Generational influences

The findings highlighted the intricate interaction between Pakistani and British cultures in shaping attitudes toward mental health and seeking help. Participants noted generational shifts toward less stigmatising views of mental illness, suggesting evolving perspectives among younger and older generations of Pakistani immigrants as highlighted in the theme '*Being Britishstani*'. Participants explored how their parents or those older may hold very negative views around accessing support for SEMH but participants were eater to excuse this generation by explaining the lack of education around these topics especially if they were from Pakistan (and not born in the Britain). The findings highlighted generational differences in awareness and education about mental health, particularly between parents born in Pakistan and those born and raised in the UK. Participants observed that parents who immigrated from Pakistan often grew up without education or exposure to mental health discussions. Consequently, these parents might lack understanding or awareness of mental health issues and may not prioritise such discussions within the family. In contrast, parents born and raised in the UK were more likely to have encountered mental health education, potentially through schools or other resources. This generational gap in awareness and education was seen as a key factor contributing to the reluctance or avoidance of discussing social, emotional, and mental health needs within some families.

Participants expressed empathy and understanding towards their parents, acknowledging the cultural and generational limitations that influenced their perspectives. Rather than blaming their parents for their lack of knowledge or reluctance to discuss SEMH needs, participants attributed these attitudes to the historical context and cultural norms of their parents' upbringing. This nuanced understanding fostered a more compassionate view of their parents' perspectives on mental health, recognizing that these attitudes were shaped by different contextual factors.

Several studies have investigated the generational shifts in attitudes toward mental health within the South Asian community in the UK. These studies highlight notable differences, with younger generations demonstrating greater openness to discussing mental health issues compared to older generations, who often regard mental health as a taboo topic due to cultural norms and lack of awareness (Corin & Bibeau, 2006; Daker-White et al., 2002).

For instance, a comprehensive review examined the experiences of South Asian mental health service users in the UK, revealing significant generational differences. Younger South Asians are generally more willing to engage in discussions about mental health, while older generations often view these issues with stigma and shame, a perspective shaped by their upbringing in countries where mental health is less openly addressed (Fenton & Sadiq, 1996; Mukadam et al., 2011).

Another study focusing on South Asian women in England found that cultural sensitivity in mental health services greatly influenced their experiences. Younger South Asian women, who are more integrated into British society, tend to have a better understanding of mental health issues compared to their older counterparts, who may have had less exposure to mental health education and awareness campaigns (Phillips & Andriopoulou, 2022).

Pilkington et al. (2012) found that higher levels of education and acculturation positively influenced the intention to seek psychological help, whereas higher levels of shame/izzat (family honour) and biological beliefs about mental health had a negative association. For migrant individuals, the number of years spent in Britain and shame/izzat significantly predicted their intention, with higher levels of shame/izzat leading to lower intentions to seek help. This can be linked to the findings of this research where it was shared by participants that parents born in the UK were more inclined to support them or have an understanding about SEMH compared to those parents who were not. Similarly, it felt that participants were struggling between there dual culture

of wanting to express emotions but being held back by internalised norms related to Pakistani culture.

5.2.4 Impact of Religion

In existing literature, religion emerged as a significant cultural factor that could either support or obstruct help-seeking, depending on individual beliefs and practices (Causier et al., 2024) A systematic review by Edge and Mackian (2024) revealed that religion can play a dual role in mental health help-seeking among South Asians. The study indicated that while some individuals derive comfort and support from their religious beliefs and communities, others encounter significant barriers due to stigma and misconceptions about mental health prevalent in their religious contexts. This dual influence of religion was also observed in research on help-seeking behaviour among South Asian survivors of sexual violence, where religious and cultural factors significantly impacted their willingness to seek help (Ahmed et al., 2022). Additionally, a study focusing on perinatal mental health services found that South Asian women often face barriers stemming from cultural and religious stigma, affecting their engagement with mental health services (Bicknell et al., 2023).

When exploring the theme, '*What Empowers and Disempowers me'*, Participants spoke about how religious leaders within the community could hinder or help with accessing support for SEMH concerns. One participant shared how sometimes the lack of connection religiously was stated as a reason why the individual would be experiencing SEMH concerns instead of religious leaders allowing you to talk about your concerns e.g., "*They blame you for being mentally unwell because you don't pray (*Saira, L45). This was something also said by parents to participants and a belief that the community would blame you personally for having any SEMH problems. Seeking religious support can serve as a powerful facilitator for support, particularly in addressing social, emotional, and mental health needs. It provides spiritual guidance, purpose, and a supportive community that shares common values and beliefs. Engaging in prayer, meditation, and religious teachings enables

individuals to cultivate inner resilience, seek comfort in faith during challenging times, and develop virtues that enhance their emotional and spiritual well-being. Religious leaders and fellow believers offer encouragement, compassionate counsel, and a network of caring relationships, fostering personal growth and providing a sense of belonging that is crucial for navigating SEMH concerns with faith-based perspectives. However in this instance the participant was highlighting how religion could be a barrier for getting access to the correct support as parents may assume your SEMH needs are due to your lack of connection with God and overlook any other factors therefore dismissing other avenues such as; counselling or mental health support.

Ayub and Macaulay (2023) conducted a study exploring the perceptions of mental health within the British Pakistani Muslim community, revealing barriers to seeking help such as stigma, fear of public opinion, and societal expectations. They noted that while religion can act as a protective factor in managing mental health issues through religious practices, there is also a fear of judgment and blame for perceived lack of religiosity. The study emphasised the importance of addressing stigma, promoting open discussions about mental health within religious and cultural contexts, and integrating religious beliefs into mental health support services to better serve the needs of the community.

Cultural and religious pressures within the British Pakistani Muslim community significantly influence attitudes toward mental health and help-seeking behaviours. These pressures often centre on maintaining a certain image or meeting specific community expectations. Individuals may feel obligated to follow cultural norms and religious practices that shape perceptions and responses to mental health issues. The fear of judgment or stigma for seeking mental health help can arise from cultural expectations that emphasise strength, resilience, and adherence to traditional gender roles.. These cultural pressures are likely to create barriers to accessing mental health services and contribute to the stigma surrounding mental health within the British Pakistani Muslim community.

Addressing these pressures through education, awareness campaigns, and culturally sensitive support services is essential for promoting mental well-being and encouraging help-seeking behaviours (Ayub & Macaulay, 2023).

The intersection of religion and culture was explored within both subthemes of what empowers and disempowers me. Alharbi et al. (2023) conducted a systematic review and thematic synthesis to investigate beliefs and attitudes toward mental health problems in Muslim communities and the acceptability of Cognitive Behavioural Therapy (CBT) as a treatment. The study aimed to identify barriers that prevent Muslims from accessing CBT and explored variations across different countries. The findings emphasised the significant influence of religious beliefs and Islamic teachings on attitudes toward mental health difficulties among Muslims. The study highlighted the importance of considering cultural and religious factors to address help-seeking barriers in mental health services for Muslim individuals.

The belief in Jinn among Muslims can significantly influence their access to support for mental health difficulties (Khalifa et al., 2011). This belief often leads individuals to prioritise seeking help from religious healers or engaging in rituals aimed at addressing Jinn-related issues, potentially delaying or dissuading them from seeking formal mental health services (Khalifa et al., 2011. Moreover, linking mental health challenges to supernatural causes like Jinn possession can contribute to stigma and shame within Muslim communities, creating obstacles to seeking professional support (Khalifa et al; Memon et al., 2016). Interpreting symptoms through a cultural and religious lens may lead individuals to attribute their struggles solely to spiritual causes, overlooking psychological or medical explanations (Khalifa et al., 2011; Iqbal et al., 2012). Some individuals may choose a dual approach to treatment, combining religious practices with professional mental health support, which can affect their engagement with evidence-based therapies. Mental health professionals must possess cultural competence and sensitivity to these beliefs to establish

trust and facilitate access to appropriate support for individuals grappling with mental health challenges within Muslim communities (Alharbi, Farrand and Laidlaw, 2023). This specific belief around supernatural beliefs impacting mental health was not explicitly shared by participants of this research study. But it was noted that participants did share that professionals who did not share the same ethnicity as them would not understand the norms within the culture. As those from the Pakistani community are predominantly Muslim it could be assumed that the intersection of cultural and religious norms is so entangled that they seem one.

5.2.5 Adults with Insight

Participants highlighted the importance of building positive relationships with adults whether this be within the community or in school (What *empowers and disempowers me*) and how this was a positive factor in enabling them to access support for SEMH. There was a shared view that the local Imaam in a particular area was someone accessible to participants as he was young, spoke English and had much more of a social understanding in comparison to other adults in their lives, such as parents or older siblings.

Another factor highlighted by Participants was around the understanding of culture and cultural norms and how this influenced them sharing. Participants in the current study expressed a preference for culturally sensitive services that take their cultural background and experiences into account. Some participants were hesitant to share personal information with specifically White counsellors, perceiving them as ignorant about their cultural background and less likely to understand their experiences. In the theme 'What empowers me and disempowers me' and the theme 'There is no 'safe' in safeguarding', participants stated how it would be easier to share with those who either had cultural awareness or shared the same ethnicity as them. This is aspect was further highlighted by participants in the theme '*There is no 'safe' in safeguarding'*. Here participants shared that speaking with staff who do not understand or share the same culture as them may flag

information to safeguarding and create a bigger problem, not just for them but their families due to the staff member not understanding what is seen as a common practice within the culture.

Therefore, participants shared how it is easier to share with those who share the same culture as them to avoid this happening. This finding aligns with other studies indicating that individuals from minority ethnic groups often feel misunderstood by practitioners due to cultural differences (Moller et al., 2016; Sanger & Howe, 2021; Bailey & Tribe, 2021). Moller et al. (2016) found that participants felt more comfortable sharing personal information with counsellors who shared their ethnicity and religion. They preferred South Asian counsellors with the same religious background, believing these counsellors would better understand their cultural values and beliefs. This preference fostered a sense of comfort and trust in the counselling process.

However, controversially, some participants did express that it was much easier to share to White professionals as they felt less judged and not held against cultural norms. According to Moller et al (2016), participants in the study indicated a preference for White counsellors because they perceived them as less judgmental. This belief stemmed from the perception that White counsellors, being less connected to South Asian culture, could provide a more impartial and unbiased perspective. Consequently, participants thought that White counsellors would focus more on their individual concerns rather than cultural or ethnic aspects, thereby fostering a sense of comfort and reducing feelings of being judged when sharing personal information (Moller et al., 2016).

In the subtheme '*Just getting on with it in the community*' participants shared how they were more likely to share with family members than others outside of the family unit, this was done for many reasons such as: not allowing information to be spread amongst the community, not impacting the families' reputation and avoiding creating a bigger problem if other external agencies are then involved. Similarly, Bailey and Tribe (2021) explored the attitudes of Black Caribbean adults

in the UK toward seeking support for depression. The study found that participants generally preferred seeking help from informal sources like family and friends who shared their cultural experiences, rather than from healthcare professionals. The study by Perera, Owen, and Johnstone (1991) found that fewer South Asians, compared to Caucasians and Afro-Caribbeans, came to psychiatric attention via the police, suggesting that strong family ties may help manage mental illness within the home. This indicates a tendency within South Asian communities to rely on family support and networks to address mental health issues rather than seeking external professional help. The close-knit nature of South Asian families likely contributes to containing mental health challenges within the family unit. Furthermore, Birchwood et al. (1992) examined a group of patients, including South Asians, Afro-Caribbeans, and Caucasians, and found that more South Asians were married and nearly all lived with their relatives. The relapse and readmission rates were lowest for South Asians, which seemed to be associated with family living, suggesting a protective effect of family support on mental health outcomes.

These findings highlight the significant role of strong family ties in managing mental illness within South Asian families. Although this is seen as a positive way to manage mental illness within the South Asian community, research by Causier et al (2024) would suggest it is a way of the family within the South Asian community to prevent gossip and a negative reputation being built about them within the wider community, therefore sharing within the family is better. This was also highlighted in the theme '*What empowers me and disempowers me'* in the sub theme, '*Just getting on with it in the community*'*.*

5.3 Support Structures in School

General school support structures appeared to be missing from the discussion with participants. While participants were aware of safeguarding measures and mentoring schemes

available in school, they noted that these were often targeted at younger students rather than those in sixth form.

Emotional Literacy Support Assistants (ELSAs) and Educational Mental Health Practitioners (EMHPs) play vital roles in supporting the mental health and emotional well-being of students in the UK (Ellins et al., 2023). Despite their potential significance, there was no mention of ELSAs and EMHPs by the participants within this research, potentially highlighting the lack of these roles within the schools or the lack of knowledge around what is available to students. Recent research conducted by Ellins et al, (2023) the necessity for culturally adapted mental health interventions. EMHPs have encountered challenges in delivering appropriate mental health support to ethnic minority students due to cultural and language barriers. The standardised approaches, frequently based on Western frameworks such as CBT may not always be effectively applicable across diverse cultural contexts. Though EMHPs were not specifically mentioned in the research conducted in this thesis, the want and need for culturally competent/ curious professionals was highlighted by participants in the themes *What empowers me and disempowers me in school and in the community.*

Participants frequently mentioned safeguarding, perceiving it as a potentially harmful rather than helpful route. They expressed concerns that attempting to access safeguarding could cause more harm than good (see theme *'There is no 'safe' in safeguarding'*). Chaudhry (2019) discovered significant concerns among British Pakistani students regarding the effectiveness and cultural sensitivity of safeguarding practices in multi-ethnic secondary schools. The study revealed a pervasive lack of trust in safeguarding professionals, largely stemming from past experiences of discrimination and cultural misunderstandings. Students felt that these professionals often lacked the necessary cultural competence to address their specific needs, leading to a perception that seeking help could result in further harm rather than protection. This mistrust was compounded by a notable gap between the safeguarding policies outlined by the schools and their practical

implementation, leaving students feeling excluded and unsafe within the school environment (Chaudhry, 2019). These findings align with this research as participants expressed the lack of trust in staff especially when it came to safeguarding alerts and how this was a huge factor in deterring them from seeking help from school staff (See theme *There's no 'safe' in safeguarding').*

Engaging with the British Pakistani community and involving parents and community leaders in discussions about safeguarding is crucial for bridging the gap between school policies and community expectations. Schools can facilitate this by organising regular meetings and workshops with community representatives. Such initiatives foster mutual understanding and cooperation, helping to alleviate fears of stigma and discrimination. By doing so, students and their families are likely to feel more comfortable with the idea of seeking help, knowing that their cultural context is respected and understood (Chaudhry, 2019; NSPCC, 2020)

5.3 The Role Gender Plays in Shaping British Pakistani Adolescents Experiences of Help Seeking?

The study also explored how gender roles and the stereotypes perceived by participants influenced help seeking behaviours. Three overarching themes in relation to how gender plays a role in shaping British Pakistani adolescent's experiences of help seeking were; Reputation, Shame and Honour, although these did not look identical for both genders. Both women and men in Pakistani culture are perceived through the lens of honour and societal expectations, albeit in different ways. Women are seen as the custodians of family honour, while men are viewed as the providers and protectors of that honour. These roles create significant pressures on both genders, influencing their behaviours, decisions, and mental health help-seeking practices. The fear of societal judgment and the consequences of tarnishing family honour act as significant barriers for both women and men in accessing support for their mental well-being.

An interesting finding was that when discussing the impact of gender, female participants seemed to focus more on males' difficulties with sharing emotions in the British Pakistani

community. This emphasis might serve to deflect from their own feelings and needs, suggesting that they are coping completely fine and implying that women don't have mental health issues. Alternatively, it could be a strategy to avoid discussing their own thoughts and feelings about why they can or cannot share SEMH concerns.

5.3.1 Female Perspectives

In the sub theme '*Fake it 'Till You Make it'*,, participants highlighted the challenges faced by the British Pakistani community regarding shame and stigma surrounding mental health issues. While women are expected to be expressive emotionally, making it seemingly more acceptable for them to share their feelings, there remains a reluctance to discuss deeper emotional and mental health concerns openly within the community. This suggests that although emotional expression is somewhat tolerated for females, significant barriers still exist to openly addressing more serious mental health issues.

Furthermore, there is a poignant observation about the societal pressure on females within the community to prioritise marriage preparation and meet familial expectations over their personal emotional growth. This emphasis on adhering to traditional gender roles and cultural norms disregards the comprehensive development of individuals. Women may feel compelled to uphold their families' reputation and honour by embodying idealized qualities of virtue and stability. This pressure often leads to hiding their struggles and prioritising projecting an image of success and stability, even at the expense of their mental health and emotional authenticity.

In Pakistani communities, the concepts of honour and shame are deeply embedded in societal norms, influencing the roles and behaviours of both women and men in significant ways. Women are seen as the primary guardians of family honour, with their actions directly impacting the reputation of the entire family (Talnbani et al, 2000; Weaver,2017; Sangar & Howe, 2023). Based on

this literature, they are expected to embody traits such as purity, modesty, and adherence to social expectations. This societal construction places considerable pressure on women to conform to these ideals to avoid bringing shame to their families.

The regulation and surveillance of women's behaviour are common practices aimed at preserving family honour and reputation. In the current study, although shame was not explicitly mentioned as a mechanism just for females, it was interesting to note that the concept of shame was spoken about more by the female participants. In particular, they expressed that if you were to seek help it would bring shame on the family and the stigma attached to it as a female would impact the family's reputation negatively. Sangar & Howe (2021) investigated the influence of shame and mental health discourses on help-seeking behaviours among British-born South Asian females.

Existing research on SA youth has predominantly centred on females, with a key thematic focus on shame and honour. The study highlighted the gendered nature of shame, noting that SA females perceive shame differently compared to their male counterparts. Shame appears to serve as a mechanism for monitoring and regulating behaviour within the SA community, with individuals weighing the potential shame brought upon their family or community against the perceived risk of deviating from societal norms. This dynamic often poses a significant barrier to help-seeking within the SA community.

The importance of maintaining honour is further underscored by its association with marriage prospects. Mental health issues, if perceived as affecting a woman's suitability for marriage, can be stigmatised and viewed as potential threats to family honour. This societal pressure may often deters women from seeking help for mental health concerns due to the fear of bringing shame to their families (Talnbani et al, 2000; Weaver,2017; Sangar & Howe, 2023). Although participants in the current study recognised that females 'are meant to be more emotional' and 'allowed' to be

emotional (See sub theme '*Fake it till you make it'*) there still was a belief amongst participants that sharing about emotions and seeking support for SEMH concerns would create a negative label on them. There was a perception that British Pakistani females need to look mentally stable to ensure suitors and family of suitors see them as positive potential future wife.

5.3.2 Male Perspectives

In the sub theme of 'Mask-Culinity,' participants emphasized that males in the British Pakistani community encounter societal pressures and stereotypes that discourage them from expressing emotions or seeking help for mental health issues. There is an expectation for males to uphold traditional gender norms of strength and composure, which often results in hesitancy to display vulnerability or seek support. The stigma surrounding mental health and the belief that seeking professional help signifies weakness contribute to a culture of shame and secrecy among males in this community. Many fear judgment or being labeled as weak if they were to discuss their struggles openly, leading to a cycle of silence and emotional repression. Cultural stereotypes and family expectations significantly influence how males are expected to behave within British Pakistani households.

The pressure to adhere to traditional gender roles, reinforced by male family members and societal norms, creates obstacles for males to openly express their emotions and seek necessary support. These points underscore the challenges faced by males in the British Pakistani community concerning shame, stigma, and the impact of societal expectations on their mental health and emotional well-being. Pakistani men are subject to societal expectations that emphasise control and dominance, particularly as the main breadwinners and protectors of family honour. In a predominantly patriarchal society, the self-esteem and self-image of the entire family are often seen as dependent on the male members (Niaz & Hassan, 2006). Men are expected to assume a dominant and controlling position, maintaining control over their emotions and actions.

The sub theme ‘Mask-Culinity’, highlighted how boys will be seen as weak if they were to share emotions. Many studies have looked into male stereotypes and how this prevents men from seeking support for help for emotional wellbeing. Miller (2009) examined the notion of "toxic jock" behaviours and their impact on male identity and help-seeking tendencies. The research investigated how specific sport-related identities, marked by hypermasculine traits, can lead to feelings of shame and reluctance to display vulnerability or emotionality among teenage boys. These toxic jock behaviours could hinder efforts to seek assistance for mental health concerns, as individuals might view seeking help as a display of weakness or as falling short of adhering to conventional masculine standards.

Real (2001) conducted a study examining how societal beliefs and gender norms influence the perception and expression of emotions among males. The research underscored how traditional masculine standards frequently discourage men from openly discussing their emotional difficulties or seeking assistance for mental health concerns. Real (2001) observed that societal expectations compel men to project strength, stoicism, and emotional control, resulting in a hesitation to admit vulnerability or seek support when confronting emotional hurdles. Though this did not look specifically at any ethnic group, these findings do align with the participants within this research study. In the subtheme ‘*Mask-Culinity’*, participants expressed how cultural masculine standards discouraged males from sharing about emotions. With one participant highlighting it can be seen as ‘gay’ within the Pakistani community if he was to share about emotions. Other participants highlighted that sharing emotions as male made you look weak and as a male you should just be getting on with it.

Schofield et al. (2000) propose a gender-relations approach to understanding men's health, recognizing that the interactions between men and women, and the contexts in which these interactions occur, can have both positive and negative health outcomes. Consequently, the health-related beliefs and behaviours of men and women are ways of expressing their femininities and

masculinities (Courtenay, 2000). Courtenay (2000) theorised that men who conform to socially prescribed masculinity (in Western culture) tend to adopt unhealthy beliefs and behaviours, such as embracing risk and physical discomfort, while actively rejecting behaviours perceived as 'feminine', such as seeking help.

Another factor highlighted within this theme (*'Mask-culinity')* was the role of the father and other significant male role models within the family. Participants highlighted that fathers help a more responsible role than an emotional one, they were to provide for the family financially therefore this was the blueprint for boys as they grow up, that they do not need to speak on emotional side of stuff and should keep worries to themselves. Galdas (2006) conducted a study examining how masculinity affects the decisions of White and South Asian men regarding seeking medical help for acute chest pain. The research focused on understanding the decision-making process among men who experienced chest pain, investigating the influence of masculinity on help-seeking decisions among White men of various demographics, and exploring the same influence among South Asian men of Indian, Pakistani, and Bangladeshi backgrounds The study revealed distinct differences in help-seeking behaviours between White and South Asian men. White men tended to exhibit behaviours aligned with traditional masculine norms, such as minimizing symptoms and delaying seeking medical aid. Conversely, South Asian men were more inclined to adopt a "wait and see" approach before seeking help The difference between "delaying seeking medical aid" and a "wait and see" approach lies in their respective attitudes towards addressing health concerns. Delaying seeking medical aid involves actively putting off seeking professional help even when symptoms are present, often due to factors like fear, cost concerns, or underestimating the severity of symptoms. In contrast, a wait and see approach entails monitoring symptoms temporarily to see if they improve or worsen before deciding to seek medical assistance. This approach typically involves initial self-care measures and a willingness to seek help if symptoms persist or worsen, reflecting a more cautious and responsive attitude towards health management.

These disparities underscore the significant role of cultural factors in shaping men's attitudes toward seeking medical assistance, emphasising the importance of considering ethnicity and masculinity in healthcare planning and delivery. In South Asian cultures, traditional ideals of masculinity might dissuade men from showing vulnerability or seeking assistance for health issues. Men may feel pressured to uphold ideals of strength and self-sufficiency, which could impede their inclination to seek medical help for chest pain. Additionally, cultural stigma surrounding illness or seeking medical aid in South Asian communities may contribute to this reluctance. Men might fear judgment or a decline in social standing within their community if they are perceived as weak or in need of medical intervention, further deterring them from seeking assistance for chest pain.

In conclusion, gender emerged as a recurring theme in the highlighted studies. Specifically, females were found to bear a higher burden of shame and honour compared to males. Additionally, males in SA communities displayed more negative attitudes toward mental health compared to females (Sangar & Howe, 2021; Soorkia et al., 2011). The current study therefore similarly underscored the differential treatment experienced by males and females within SA communities and indicate that irrespective of gender, this factor provides notable barriers for accessing support..

5.4 Support Structures in School

General school support structures appeared to be missing from the discussion with participants. While participants were aware of safeguarding measures and mentoring schemes available in school, they noted that these were often targeted at younger students rather than those in sixth form.

Emotional Literacy Support Assistants (ELSAs) and Educational Mental Health Practitioners (EMHPs) play vital roles in supporting the mental health and emotional well-being of students in the UK (Ellins et al., 2023). Despite their potential significance, there was no mention of ELSAs and EMHPs by the participants within this research, potentially highlighting the lack of these roles within the schools or the lack of knowledge around what is available to students. Recent research conducted by Ellins et al, (2023) the necessity for culturally adapted mental health interventions. EMHPs have encountered challenges in delivering appropriate mental health support to ethnic minority students due to cultural and language barriers. The standardised approaches, frequently based on Western frameworks such as CBT may not always be effectively applicable across diverse cultural contexts. Though EMHPs were not specifically mentioned in the research conducted in this thesis, the want and need for culturally competent/ curious professionals was highlighted by participants in the themes *What empowers me and disempowers me in school and in the community.*

Participants frequently mentioned safeguarding, perceiving it as a potentially harmful rather than helpful route. They expressed concerns that attempting to access safeguarding could cause more harm than good (see theme *'There is no 'safe' in safeguarding'*). Chaudhry (2019) discovered significant concerns among British Pakistani students regarding the effectiveness and cultural sensitivity of safeguarding practices in multi-ethnic secondary schools. The study revealed a pervasive lack of trust in safeguarding professionals, largely stemming from past experiences of discrimination and cultural misunderstandings. Students felt that these professionals often lacked the necessary cultural competence to address their specific needs, leading to a perception that seeking help could result in further harm rather than protection. This mistrust was compounded by a notable gap between the safeguarding policies outlined by the schools and their practical implementation, leaving students feeling excluded and unsafe within the school environment (Chaudhry, 2019). These findings align with this research as participants expressed the lack of trust in

staff especially when it came to safeguarding alerts and how this was a huge factor in deterring them from seeking help from school staff (See theme *There's no 'safe' in safeguarding').*

Engaging with the British Pakistani community and involving parents and community leaders in discussions about safeguarding is crucial for bridging the gap between school policies and community expectations. Schools can facilitate this by organising regular meetings and workshops with community representatives. Such initiatives foster mutual understanding and cooperation, helping to alleviate fears of stigma and discrimination. By doing so, students and their families are likely to feel more comfortable with the idea of seeking help, knowing that their cultural context is respected and understood (Chaudhry, 2019; NSPCC, 2020)

Participants expressed the need for a wider range of trusted adults they can turn to, reflecting their varied preferences and comfort levels. Some students felt more comfortable talking to White adults, while others prefer brown adults. Without this variety, many students may not seek the help they need. Therefore, it is crucial to implement a more inclusive support system that acknowledges and respects these differences, providing students with the appropriate space and trusted individuals to have important conversations about their mental health and well-being.

5.5 Contribution of Findings to Existing Theories

Rickwood et al.(2005) describe help-seeking as the act of actively engaging with and using social relationships, whether formal (such as professional assistance) or informal (such as support from peers and family), in response to personal problems or distressing experiences. These issues can extend beyond psychological concerns. In this research, "help-seeking" broadly encompasses the thoughts, feelings, and behaviours that prompt individuals to seek both formal and informal support for a range of psychological and non-psychological difficulties. The discussion above has centred on

exploring possible barriers and enablers from a cultural and gender perspective based on adolescent participants who identify as British Pakistani.

The Social Behaviour Model (Anderson &Newman, 1973) seeks to explain why individuals, especially older adults, use health and social services. According to this model, service utilisation is influenced by three primary factors:

1. Predisposing Factors: These are personal characteristics present before the need for a service arises, including demographic factors like age and gender, as well as social structure characteristics such as marital status and education.

2. Enabling Factors: These factors either facilitate or hinder the use of a service. They encompass elements like access to transportation, income level, awareness of available services, and other resources that enable individuals to seek assistance.

3. Need Factors: This pertains to the perceived necessity for a service, which can be based on an individual's subjective assessment or a professional evaluation of their needs.

This model indicates factors which are quite objective, such as age, gender, income level, access to transport etc. However, this is limiting in terms of understanding nuances and intersectional element of culture, religion and gender. In the context of help seeking behaviours in relation to SEMH for British Pakistani adolescents, The Social Behaviour Model could be adapted to understand why individuals may seek or avoid services.

Predisposing factors for British Pakistani adolescents may include cultural beliefs surrounding mental health, stigma related to seeking help for psychological concerns and perceptions of mental health services or other services such as social services as culturally insensitive. Generational differences may also be at play with differences in acculturation levels between parents and adolescents which may impact attitudes towards seeking help for SEMH. Gender and expectations

regarding traditional gender roles within the British Pakistani community may influence help seeking with males and females facing different expectations and barriers.

Enabling factors may include limited proficiency in English among the older generation which could hinder both access and understanding of the services available, and as such lead to an absence of modelling of utilisation of these services to younger generations. The lack of cultural competency/ curiosity within services that cater to SEMH as well as school staff and professionals is seen as a barrier to seeking help for SEMH. An enabling factor participants mentioned in the results sections indicated that they were most likely to seek support from family and friends over school staff. However they were more inclined to share with staff when there was a shared cultures, or when staff were felt to be approachable and culturally sensitive.

In terms of 'Need factors', there is growing evidence of an increase in mental health needs in the adolescent age range, irrespective of culture, gender and religion. There is therefore a need to share, demonstrate and embed coping strategies and social support which may be taken up by adolescents within this demographic to manage there SEMH needs. Research indicates that Pakistanis are more likely to consult their General Practitioners (GPs) compared to their White counterparts; however, their mental health issues are often inaccurately diagnosed or undetected (Bhui et al., 2001). One possible explanation is a mismatch between Pakistanis' explanatory models of illness (Bhui & Bhugra, 2002) and those of their GPs. This perspective suggests that different ethnic groups may have varying models or explanations for their symptoms and illnesses, including perceived causes, severity, prognosis, and treatment preferences (Kleinman, 1980).

While the model emphasises the importance of awareness, need, and access in predicting service utilisation, it has limitations in fully explaining help-seeking behaviours in specific populations. For instance, it may not sufficiently consider cultural barriers, individual perceptions of

stigma, or the impact of social norms on service use. A key limitation of the Social Behaviour Model is its focus on demographic and structural factors to predict service utilisation, potentially overlooking the influence of psychosocial variables like self-reliance, embarrassment, and social comparisons on help-seeking behaviours. Additionally, the model's emphasis on awareness and need as primary predictors of service use may not fully capture the complexities of decision-making processes related to seeking assistance. Cultural beliefs, stigma, and community gossip, particularly among UKME groups, can significantly affect individuals' perceptions of self-esteem and their willingness to seek help, aspects that the model does not fully address.

The Threats-to-Self-Esteem Model, described by Fisher et al. (1983) suggests that individuals' decisions to seek help are influenced by whether they perceive the characteristics of receiving aid as self-threatening or self-supporting. When individuals see assistance as mainly self-threatening, their response is generally negative, leading to lower help-seeking behaviour. In contrast, if they view the aid as primarily self-supportive, their response is positive, resulting in higher help-seeking tendencies. This model emphasises the importance of considering how individuals' self-esteem and perceptions of assistance affect their willingness to seek help.

Adapting the Threats-to-Self-Esteem Model to understand help-seeking behaviours among British Pakistani adolescents involves considering various factors that can impact their perceptions of self-esteem and willingness to seek assistance. Gender norms play a significant role, with traditional expectations dictating different attitudes towards help-seeking for males and females. Males may feel pressure to maintain a facade of strength and self-reliance, while females may face restrictions on seeking help due to societal norms and gender roles within the community. These gender dynamics can create barriers to seeking mental health support and influence adolescents' self-perceptions in relation to help-seeking.

Moreover, stigma and cultural beliefs surrounding mental health within the British Pakistani community can contribute to feelings of shame or embarrassment associated with seeking assistance. Adolescents may internalise negative stereotypes about mental health issues, leading to concerns about being judged or ostracised if they were to seek help. Additionally, worries about marriage suitability and the fear of being perceived as mentally unstable or weak can further impact adolescents' self-esteem when considering reaching out for support.

Furthermore, the fear of community gossip and the potential repercussions on one's reputation can act as a significant deterrent to seeking help for mental health concerns. The pervasive nature of community gossip within tight-knit British Pakistani communities can create a sense of self-threat, as adolescents may fear the social consequences and judgment that could arise from seeking mental health assistance. These external pressures and societal expectations can significantly influence adolescents' perceptions of self-esteem and their decision-making regarding help-seeking behaviours.

The Seeking Mental Health Care model by McLaren et al. (2021) is a comprehensive framework designed to predict help-seeking behaviour for depressive symptoms by considering a range of attitudinal and cognitive variables such as stigma, treatment experiences, continuum and causal beliefs, depression literacy, and self-efficacy. This model offers a validated conceptual framework for understanding the help-seeking process, focusing on internal influences in decision-making. In the context of British Pakistani adolescents, as explored in this research, the model's factors can be linked to cultural and gender-specific barriers and facilitators that influence help-seeking behaviours.

The research highlights significant cultural barriers, such as the stigma surrounding mental health, the importance of maintaining family honour, and gender-specific expectations, which inhibit

open discussions about mental health and seeking professional support. Female participants showed a relatively higher inclination towards seeking help compared to their male counterparts, who often faced cultural pressures to conform to traditional masculine norms. These findings underscore the need for culturally sensitive interventions and greater mental health literacy within the British Pakistani community, suggesting that the model must account for these cultural nuances. However, the model's limitations include its potential underestimation of the profound impact of cultural and religious beliefs on help-seeking behaviour and the necessity for further adaptation to fully address the specific experiences of adolescents from diverse cultural backgrounds.

The findings of this study can be interpreted using the lenses of visibility theory and intersectionality, providing a deeper understanding of the barriers faced by British Pakistani adolescents in seeking help for the SEMH needs. These frameworks offer valuable insight into how socio-cultural and systemic factors intersect to shape the lived experiences of marginalised groups.

Visibility theory (Brighenti, 2007) explores the role of visibility in shaping social dynamics, focusing on how individuals or groups are made visible or invisible within a societal context. Visibility is not merely about being seen but also about how being seen carries different implications, such as empowerment, stigma, or control (Goffman, 1963). The theory posits that invisibility can marginalise individuals by erasing their challenges, while visibility, if handled appropriately, can empower them by drawing attention to their needs (Brighenti, 2007).

In the context of the research, visibility theory sheds light on how mental health challenges of British Pakistani adolescents are often rendered invisible within their communities. Cultural norms that prioritise family honour (Izzat) discourage open discussions about mental health, perpetuating stigma and shame (Pilgrim,2019). Adolescents, particularly girls, may feel the need to hide their struggles to avoid social repercussions. Similarly, the invisibility extends to systemic barriers, where mental health services lack cultural competence or curiosity, further alienating these adolescents (Patel & Fatimilehin, 1999).

Applying Visibility theory to these findings suggest that increasing the visibility of culturally sensitive mental health resources and normalising discussions about mental health within the British Pakistani communities could help reduce stigma. For example, public awareness campaigns led by trusted community figures or faith leaders could promote visibility in a manner that respects cultural values while addressing mental health issues. Making these challenges visible in a way that promotes understanding rather than judgement could empower adolescents to seek the support they need (Kimayer & Pedersen, 2014).

Intersectionality, introduced by Crenshaw (1989) examines how overlapping social identities – such as race, gender. ethnicity and age interact to create a unique experience of oppression or privilege. This framework challenges the notion of a single- axis approach to discrimination, arguing that intersecting identities produce distinct vulnerabilities and barriers (Collins, 2000).

The research findings reveal how British Pakistani adolescents face complex challenges shaped by intersecting identities. Girls, for instance, navigate the dual pressure of cultural expectations tied to gender roles and the stigma surrounding mental health. These expectations may place a heavier burden on girls to conform to the ideas of modesty and family loyalty, making it harder to seek help without the risk of judgement and gossip. Boys, on the other hand, contend with societal norms that discourage emotional openness, forcing them to mask vulnerabilities and "just get on with it" (Ahmad & Bradby, 2007). These intersecting barriers shape distinct help-seeking behaviours and contribute to disparities in access to mental health resources (Pilgrim,2019).

By applying intersectionality, these findings underscore the need for tailored interventions that consider the unique challenges posed by the overlapping identities. For instance, mental health campaigns targeting boys could address the cultural stigma of emotional expression, while initiatives aimed at girls might focus on creating a safe, confidential space for discussion (Crenshaw, 1989). Intersectionality also highlights the importance of addressing systemic biases in mental health

services, such as the lack of representation and cultural understanding among practitioners, which further alienates marginalised adolescents (Kirmayer & Pedersen, 2014).

5.6 Implications

5.6.1 Implications for EPs and School Staff

Educational Psychologists (EPs) are expected to work with children and young people of various ages and backgrounds. According to the British Psychological Society (BPS, 2023) and the Health and Care Professions Council (HCPC, 2023) proficiencies, EPs must demonstrate an understanding of cultural influences on development and knowledge of evidence-based strategies to promote mental health (BPS 1.5). Additionally, they must be able to apply knowledge of diversity and cultural differences (BPS 3). However, there is limited research conducted by EPs on supporting individuals from the British Pakistani community. Given the multicultural nature of UK society, it is crucial for EPs to enhance their cultural competency and awareness of sensitive topics to ensure they effectively support those who may feel marginalised.

Accessing training to become an EP presents significant challenges for those from ethnic minority backgrounds, including South Asians, due to a range of systemic barriers. These barriers include financial constraints, a lack of awareness about the profession, and the competitive nature of the training programs, which often require strong academic backgrounds that may not be equally accessible to all ethnic groups. Research highlights that ethnic minority students face numerous obstacles in higher education, including disparities in academic attainment and the financial burdens associated with postgraduate training (David, 2012; Gorard, 2008) In recent years, there have been efforts to increase the number of ethnic minority trainees in educational psychology. For example, initiatives such as open evenings hosted by institutions like the Tavistock and Portman Clinic

specifically aim to recruit individuals from historically underrepresented backgrounds. These efforts are part of a broader push to make the profession more multicultural and inclusive, though significant work remains to achieve full representation.

With the EP role broadening to include young people aged up to 25 years, EPs are in the best position to offer support. Given their specialist knowledge in mental health, education, and transitions, EPs are uniquely positioned to provide direct support to British Pakistani students in regard to SEMH concerns. With EP training incorporating more anti racist practice and training around cultural competencies and curiosity, EPs are able to utilise their knowledge not only with direct work with children and young people, but also through training school staff and other professionals around barriers to help seeking specifically within the British Pakistani community but also broaden this out to other minoritised groups that share some of the same stigmas and barriers in line with this research.

EPs are ideally placed to conduct systemic work in schools (Atfield et al, 2023), leveraging their expertise in practice frameworks and organisational change models. Systemic work could include training on topics such as Cultural Awareness specific to the British Pakistani community, building positive relations with schools and the community and developing the schools' policies around anti racism and cultural awareness.

Therapeutic support can also be provided by EPs for children and young people from British Pakistani backgrounds. This offer could be extended within the community at local mosques or holding coffee mornings for parents within the British Pakistani community. Community psychology emphasises the importance of understanding and addressing social issues within specific cultural contexts, promoting community well-being, and empowering individuals within their communities (McMillan & Chavis, 1986).

For example, holding coffee mornings or events at local mosques can provide a culturally sensitive and accessible platform for parents to engage with educational and psychological services. This approach aligns with community psychology principles by enhancing community involvement in addressing educational and social needs, thereby promoting community resilience and empowerment (Jason et al., 2019).

These methods could be utilise for EPs to provide psychoeducation to British Pakistani parents about SEMH but also to young people about Safeguarding procedures as a key barrier was a worry that safeguarding may mean that bigger problems may arise for them.

5.6.2 Implications for Community

Educational psychologists play a crucial role in facilitating and implementing strategies to enhance support and positive role modelling within the British Pakistani community and families.

Educational psychologists can collaborate with community leaders, mosques, and local organizations to organise culturally sensitive events and workshops. They can contribute by designing workshops that address SEMH as well as the systems in schools and the community that can provide support such as; CAMHS, Safeguarding and other local offers that may be available to them. By leveraging their understanding of Educational Psychological principles and cultural dynamics, educational psychologists help create spaces where community members feel comfortable discussing sensitive topics and accessing valuable information about mental health.

Educational psychologists can facilitate the establishment of peer support groups within the community. They can provide training and guidance to peer leaders on group facilitation skills, active listening, and creating a supportive environment. Educational psychologists can also offer ongoing support and supervision to peer leaders to address any challenges that may arise within the groups. They can facilitate discussions on coping strategies, problem-solving techniques, and navigating

cultural barriers to mental health support. By promoting peer support as a valuable resource for emotional well-being, educational psychologists empower community members to share their experiences and provide mutual encouragement in managing mental health challenges.

Educational psychologists can collaborate with family support networks within the British Pakistani community to promote mental health awareness and effective communication practices within families. They can conduct workshops or training sessions for parents on topics such as parenting styles, positive discipline, and fostering resilience in children. Educational psychologists can provide strategies for promoting open communication about SEMH and reducing stigma within family settings.

In summary, educational psychologists leverage their expertise in psychology and education to facilitate community engagement, design psychoeducation programs, support peer-led initiatives, and strengthen family networks within the British Pakistani community. Through collaborative efforts with community stakeholders, these professionals promote mental health awareness, resilience, and well-being among individuals and families, thereby fostering a supportive environment conducive to positive development.

5.7 Strengths and Limitations of Research

The primary strength of this research was the extensive and rich data gathered during the interview process, with all participants providing comprehensive responses to all questions on the interview schedule. The participants were enthusiastic and engaged. The semi-structured interview schedule effectively structured the discussions while also allowing participants the flexibility to explore topics of interest in greater depth (Powney and Watts, 1987). The qualitative design allowed for in-depth exploration of complex social, emotional, and mental health concerns. It captures the lived experiences and personal narratives of the participants. Reflexive thematic analysis was well-

suited for identifying patterns and themes within qualitative data, allowing for a thorough and reflective analysis of the participants' help-seeking behaviours.

Sharing the same culture and religious background as participants likely enhanced the researcher's ability to build rapport with participants allowing them to be more open leading to richer and more authentic data. This also meant that the researcher had insight into cultural norms, values and believes and could provide a nuanced interpretation of participants experiences and perspectives that may have otherwise possibly been overlooked if the researcher did not share these same qualities on the downside this could have had negative implications whereby the participants may have felt a sense of discomfort sharing with someone who looks like them as they might feel more judged against cultural expectations. However, sharing the same cultural background with participants, while providing this insider perspective, can introduce unconscious biases in interpreting the data. While this insider perspective can be advantageous in understanding nuances and context, it also carries the risk of influencing how data is perceived and analysed. Researchers may inadvertently project their own cultural beliefs, values, and assumptions onto the data, potentially skewing interpretations or overlooking important perspectives that differ from their own. This limitation underscores the importance of reflexivity and employing rigorous methods to mitigate bias, such as triangulation of data sources and involving diverse perspectives in the analysis process. Discussion during supervision also enabled reflection of the impact of researcher bias as a result of this factor. There were also discussions about the implications of how the findings from this research may be received in the community.

The sample size is a critical aspect of research design that can significantly impact the validity and generalizability of study findings. In the research on mental health concerns in British Pakistani adolescents, the sample size limitation is a key consideration that warrants further exploration.

The research included a sample size of 12 participants, with an equal number of males and females. The number of participants is in line with the analysis approach (RTA). Furthermore, having representation from males and females felt like an important achievement in terms of accessing perspectives from different genders. While qualitative research often involves smaller sample sizes to facilitate in-depth exploration of individual experiences, the limited number of participants in this study may raise concerns about the representativeness of the findings. A small sample size can restrict the variability of perspectives and experiences captured, potentially limiting the richness and diversity of data collected.

Focusing solely on British Pakistani adolescents from a similar cultural and religious background might overlook variations within the community, such as differences in socioeconomic status, education levels, and degree of acculturation. Identities such as special educational needs, class, ability, age, religion, gender, sexuality, and other protected characteristics under the Equality Act (2010), along with those in Burnham's (2012) Social GRACES, were not considered. Exploring the overlapping identities that shape individual experiences may have been necessary. This concept, known as intersectionality, views categories like special educational needs, class, ability, age, religion, gender, race, and ethnicity as interconnected factors that influence human experiences and their social world within various structures of power (Hankivsky, 2014).

5.8 Researchers' Reflections

5.8.1 Personal Reflections

Braun and Clarke (2019) emphasise the importance of researchers continuously reflecting on their assumptions and positions throughout the research process. This reflection helps determine whether initial assumptions were validated and how they may have influenced the research process

and findings. Reflections were undertaken through use of a reflective diary (see Appendix 11) and the utilisation of research supervision (See Appendix 12). I recognised that I was able to access a group of young people who may have otherwise found it uncomfortable to share with someone who may not have understood or had a shared understanding of cultural norms or what it is like growing up as a British Pakistani person. Having a cultural understanding allowed me to provide a deeper insight into the specific cultural norms being shared by participants. I was also familiar with the linguistic nuances and cultural communication styles that helped improve the quality of the interactions with participants enhancing trust and the authenticity of their responses.

Before enrolling in the Educational Psychology course, my experience as a teacher working with staff and professionals from diverse backgrounds and religions made me keenly aware of the prevalent cultural and religious ignorance among some individuals. When participants in this research mentioned that teachers often lack understanding of cultural norms, it reminded me of an incident from my teaching days. A colleague expressed concerns about a student who was sharing and writing positively about his religion, viewing it as a red flag that warranted intervention. This highlighted the significant need for greater cultural and religious awareness in educational settings.

As a member of the British Pakistani community, I have an inside perspective allowing me to understand cultural nuances, social norms and community dynamics. I felt I was more attuned to unspoken rules, values and beliefs that govern the community. This insider status allowed me to build positive rapport with participants allowing them to feel more comfortable opening up and communicating with me. Some of the comments shared by participants took me back to my own childhood for example, the fear of school calling home and sharing anything I had told them or creating a bigger problem by calling home and sharing anything with my parents was something I greatly feared whilst growing up.

However, despite my shared cultural background with the participants, my role as researcher positioned me as an outsider to some extent. This dual role/ perspective provided me with critical distance allowing me to analyse and interpret data objectively. However, it is essential to remain aware of how my position influenced my interaction with participants and my interpretation of their responses.

Prior to conducting the research, it is important to acknowledge the pre- conceived notions and biases I had about help-seeking behaviours within the British Pakistani community based on my own experiences. Assumptions I had prior to conducting this research were around the following topics: what would prevent British Pakistani's seeking help were around; the influence of cultural stigma; the impact on reputation and a high focus on what would be said within the community and finally, around the reputation of females around honour and shame relating to marriage suitability. While the other aspects were noted by participants, I was surprised by how few participants mentioned marriage suitability, as this was something that I had experienced a lot growing up within the community. This made me wonder if there may be a slight shift in beliefs from my own experiences versus the views of Pakistani parents nowadays. There is possibly a shift away from female marriage suitability and towards parents focusing more on education and ensuring children have a successful career.

I also had a belief that participants would exclusively want to seek support from professionals who shared the same ethnicity and religion as them. However, the perspectives on this point more ambiguous. Some participants expressed that they were seeking and longing for professionals that had a cultural/ religious understanding, but on the other hand felt that they may be judged, and therefore said they would prefer a non-Pakistani professional. However, the concern that a lack of cultural understanding would always mean they could not fully get the help and understanding they were longing for may counter this perspective. As such some participants felt as

if they could only share certain aspects of their needs to certain professionals for example, sharing to a White professional may mean that they avoid talking about stuff related to cultural norms whereas when talking to a British Pakistani professional they may avoid discussing parts they feel will be judged.

One significant reflection for me was the role of shame and honour within the Pakistani community, impacting both males and females albeit in distinct ways. Participants indirectly indicated that expressing emotional vulnerability could tarnish the reputation of males, portraying them as weak, while females might be perceived as unstable. These societal perceptions cast negative stigmas on both genders and reflect deeply on their families. This observation highlighted the overarching importance placed on preserving familial reputation, often at the expense of addressing personal struggles. It was not surprising to find that prioritizing the community's perceptions over one's own well-being was a prevailing norm, underscoring the societal pressure to suppress individual issues for the collective honour.

5.8.2 Professional Reflections

In terms of the actual undertaking of research, and perceptions of being a researcher. Undertaking research has been a transformative journey that goes beyond acquiring knowledge. Through this process, I've developed critical thinking, problem-solving, time management, and communication skills. These skills have helped me navigate challenges such as synthesising extensive literature, overcoming data collection hurdles, and addressing analytical complexities.

Personally, research has deepened my self-awareness, revealing my strengths and areas for improvement. Through conducting this research and building a positive relationship with my

research supervisor this allowed me to engage in reflective questioning that allowed me to dig deeper in my own personal experiences as a British Pakistani Female and allowed me to look at data through a deeper lens.

Furthermore, in terms of future as an EP, doing this research made me want to continue my work further and develop stronger ties with the British Pakistani community to help enable change for future generations.

5.10 Disseminating Data

It is hoped that the study will be shared with schools initially within the locality of where the research was conducted, with then a hope to share amongst community organisations specifically supporting the British Pakistani community. The study will also be shared on the Tavistock repository and findings will be shared at the team's day where the research was conducted. It is hoped that this data can be shared directly to the community through contacting local organisations specifically for the Pakistani community. There may be some challenges in relation to the topic of SEMH and stigma around this in the community, but it is hoped that once organisations have a better understanding of the research and how it can help promote SEMH within the community and support younger people that this will allow for positive relationships to be built.

Participants will be approached to ask whether they would like to remove anonymity and co present training to school and community organisations to share their experiences. Finally, with the support of my research supervisor it is hoped that this research will be published.

5.11 Conclusion

This research has delved into the intricate dynamics of seeking help for social, emotional and mental health concerns within the British Pakistani community, with a specific focus on adolescents. By exploring the multifaceted aspects of help-seeking behaviours and the impact of cultural and gender norms, significant insights have been gleaned into the challenges and experiences faced by young individuals in accessing mental health support.

The findings of this study underscore the critical role that culture plays in shaping attitudes towards mental health and help-seeking behaviours among British Pakistani adolescents. Participants highlighted the significance of reputation within Pakistani culture, indicating how familial and societal expectations can influence the disclosure of mental health issues. The emphasis on maintaining family honour and status emerged as a prominent barrier to seeking support, reflecting the deeply ingrained cultural values that impact individuals' willingness to open up about their mental health struggles. Understanding these cultural nuances is essential in developing effective interventions and support systems that resonate with the lived experiences of British Pakistani youth.

Moreover, the intersectionality of culture and gender was a recurring theme in the research findings. Participants shared insights into how gender norms and expectations shape their experiences of seeking help for mental health concerns. For instance, the influence of traditional ‘western’ gender roles on greater freedom in expressing emotions and seeking support was evident in the narratives of female participants. The research highlighted the need to consider these intersecting identities when designing mental health interventions tailored to the needs of British Pakistani adolescents.

The implications of this research extend beyond academic discourse to practical applications in educational and mental health settings. By raising awareness of the cultural barriers and facilitators to help-seeking behaviours, educators, mental health professionals, and policymakers can

better support the mental well-being of British Pakistani youth. Culturally sensitive approaches to mental health promotion and intervention are essential in creating inclusive and supportive environments where young individuals feel empowered to seek help without fear of judgment or stigma.

Recommendations stemming from this research emphasize the importance of collaboration between schools, mental health services, and community organizations to address the unique mental health needs of British Pakistani adolescents. Providing culturally competent training for educators and mental health professionals can enhance their understanding of the cultural factors influencing help-seeking behaviours and enable them to provide more effective support to young individuals from diverse backgrounds. Additionally, promoting mental health literacy within the British Pakistani community through targeted outreach programs and awareness campaigns can help reduce stigma and encourage open conversations about mental well-being.

Looking ahead, there are several avenues for future research to build upon the findings of this study and further advance our understanding of mental health in the British Pakistani community. Longitudinal studies tracking the mental health trajectories of British Pakistani adolescents over time can provide valuable insights into the factors that contribute to resilience and vulnerability in this population. Exploring the role of family dynamics, social support networks, and acculturation processes in shaping mental health outcomes among British Pakistani youth can offer a more comprehensive understanding of the complexities at play.

In conclusion, this research contributes to the growing body of knowledge on mental health in ethnic minority communities, emphasising the need for culturally informed approaches to support the mental well-being of British Pakistani adolescents. By amplifying the voices and experiences of

young individuals within this community, we can work towards creating a more inclusive and equitable mental health landscape where all individuals feel empowered to seek help and thrive.

Reference list

Ahmad, W. I. U., & Bradby, H. (2007). Locating ethnicity and health: Exploring concepts and contexts. *Sociology of Health & Illness, 29*(6), 793–811. https://doi.org/10.1111/j.1467-9566.2007.01051.x

Ahmed, S. (2017). Cultural differences in help-seeking in South Asian populations. *Cultural differences in help-seeking in South Asian populations.*

Ahmed, S., Rahman, S., & Patel, V. (2022). Help-seeking and mental health outcomes among South Asian young adult survivors of sexual violence in the New York State Region. *BMC Public Health.*

Alemdar, M., & Anılan, H. (2020). The development and validation of the emotional literacy skills scale. *International Journal of Contemporary Educational Research*, 7(2), 258–270.

Ali, N., McLachlan, N., Kanwar, S., & Randhawa, G. (2017). Pakistani young people's views on barriers to accessing mental health services. *International Journal of Culture and Mental Health*, 10(1), 33-43.

American Psychiatric Association. (2015). *Understanding Mental Disorders: Your Guide to DSM-5®.** www.DSM5.org.

Archer, M. S., Bhaskar, R., Collier, A., Lawson, T., & Norrie, A. (1998). *Critical realism: Essential readings.*Routledge.

Atfield, G., Baldauf, B., Owen, D., Davey, C., & Monk, L. (2023). Educational psychology services: Workforce insights and school perspectives on impact (Research report). *Warwick Institute of Employment Research and Ecorys.*

Ayub, R., & Macaulay, P. J. R. (2023). Perceptions from the British Pakistani Muslim community towards mental health. *Mental Health, Religion & Culture.* Advance online publication.

Bains, S., & Gutman, L. M. (2021). Mental health in ethnic minority populations in the UK: Developmental trajectories from early childhood to mid-adolescence. *Journal of Youth and* Adolescence, 50(11), 2151-2165.

Baron-Cohen, S. (2000). Is Asperger syndrome/high-functioning autism necessarily a disability? *Development and Psychopathology*, 12(3), 489–500.

Bebbington, P. E., Cooper, C., Minot, S., Brugha, T. S., Jenkins, R., Meltzer, H., & Dennis, M. (2009). Suicide attempts, gender, and sexual abuse: Data from the 2000 British psychiatric morbidity survey. *American Journal of Psychiatry*, 166(10), 1135–1140.

Bhikha, A. G., Farooq, S., Chaudhry, N., Naeem, F., & Husain, N. (2015). Explanatory models of psychosis amongst British South Asians. *Asian Journal of Psychiatry*, 16, 48–54.

Bhui, K., & Bhugra, D. (2002). Mental illness in Black and Asian ethnic minorities: Pathways to care and outcomes. *Advances in Psychiatric Treatment,* 8,26-33.

Bhui, K., Bhugra, D., Goldberg, D., Dunn, G., & Desai, M. (2001). Cultural influences on the prevalence of common mental disorders, general practitioners' assessments and help-seeking among Punjabi and English people visiting their general practitioner. *Psychological Medicine*, 31, 815-825.

Bhui, K., King, M., Dein, S., & O'Connor, W. (2008). Ethnicity and religious coping with mental distress. *Journal of Mental Health*, 17(2), 141-151.

Bhui, K., Stansfeld, S., Hull, S., Priebe, S., Mole, F., & Feder, G. (2003). Ethnic variations in pathways to and use of specialist mental health services in the UK: Systematic review. *British Journal of Psychiatry,* 182(2), 105–116.

Bicknell, S., Janković, J., Packer, K. C., Jovanovic, N., Conneely, M., & Bains, K. (2023). Exploring Black and South Asian women's experiences of help-seeking and engagement in perinatal mental health services in the UK. *Frontiers in Psychiatry.*

Bignall, T. (2015). Violence and violence prevention for children, young people and families. *Race Equality Foundation*

Birchwood, M., Cochrane, R., MacMillan, F., Copestake, S., Kucharska, J., & Cariis, M. (1992). The influence of ethnicity and family structure on relapse in first-episode schizophrenia. *British Journal of Psychiatry,* 161,783-790.

Bradby, H., Green, G., Davison, C., & Krause, K. (2017). Is superdiversity a useful concept in European medical sociology? *Frontiers in Sociology*, 1, 17.

Branney, P., & White, A. (2008). Big boys don't cry: Depression and men. *Advances in Psychiatric Treatment,* 14(4), 256-262.

Brighenti, A. M. (2007). Visibility: A category for the social sciences. *Current Sociology, 55*(3), 323–342

Bryman, A. (2012). *Social research methods* (4th ed.). Oxford University Press.

Causier, C., Waite, F., & Team. (2024). Experiences of help-seeking for severe mental health problems in young Pakistani women: A preliminary study. J*ournal of Cross-Cultural* Psychology, 55(4), 439-443.

Chaudhry, J. (2019). British Pakistani students' experiences in multi-ethnic secondary schools in England. *University of Bedfordshire*.

Ciftci, A., Jones, N., & Corrigan, P. W. (2013). Mental health stigma in the Muslim community. *Journal of Muslim Mental Health*, 7(1), 17-32.

Coleman-Fountain, E., Buckley, C., & Beresford, B. (2020). Improving mental health in autistic young adults: A qualitative study exploring help-seeking barriers in UK primary care. *The British Journal of General Practice,* 70(694), e356.

Collins, P. H. (2000). *Black feminist thought: Knowledge, consciousness, and the politics of empowerment*. Routledge

Collins, P. H., & Bilge, S. (2016). *Intersectionality.* Polity Press.

Connor, C., Greenfield, S., Lester, H., Channa, S., Palmer, C., Barker, C., Lavis, A., & Birchwood, M. (2016). Seeking help for first-episode psychosis: A family narrative. *Early Intervention in Psychiatry*, 10, 334–345.

Corin, E., & Bibeau, G. (2006). Speaking about culture in multiple voices. *Transcultural Psychiatry,* 43(1), 106–125.

Courtenay, W. H. (2000). Constructions of masculinity and their influence on men's well-being: A theory of gender and health. *Social Science and Medicine*, 50, 1385-1401.

Cowburn, M., Gill, A. K., & Harrison, K. (2015). Speaking about sexual abuse in British South Asian communities: Offenders, victims and the challenges of shame and reintegration.

Creswell, J. W. (2013). *Qualitative inquiry and research design: Choosing among five approaches* (3rd ed.). SAGE Publications.

Crenshaw, K. (1989). Demarginalising the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *University of Chicago Legal Forum*, 1989(1), 139-167.

Cho, S., Crenshaw, K. W., & McCall, L. (2013). Toward a field of intersectionality studies: Theory, applications, and praxis. *Signs: Journal of Women in Culture and Society, 38*(4), 785-810.

Cybulski, L., Ashcroft, D. M., Carr, M. J., Garg, S., Chew-Graham, C. A., Kapur, N., & Webb, R. T. (2021). Temporal trends in annual incidence rates for psychiatric disorders and self-harm among children and adolescents in the UK, 2003–2018. *BMC Psychiatry*, 21(1), 1–12.

Daker-White, G., Beattie, A., Gilliard, J., & Means, R. (2002). Minority ethnic groups in dementia care: A review of service needs, service provision and models of good practice*. Aging & Mental Health*, 6(2), 101–108.

David, M. (2012). Changing policy discourses on equity and diversity in UK higher education: What is the evidence? In T. Hinton-Smith (Ed.), *Widening participation in higher education: Casting the net wide* (pp. 9-27). Palgrave Macmillan.

Dein, S., & Sembhi, S. (2001). The use of traditional healing in South Asian psychiatric patients in the U.K.: Interactions between professional and folk psychiatries. *Transcultural Psychiatry,* 38, 243–257.

Department of Health and Social Care. (2021). *Reforming the Mental Health Act* (White Paper). Crown Copyright.

DfE, & DoH. (2015). *Special Educational Needs and Disability Code of Practice: 0 to 25 years* (revised). London.

DfE, & DoH. (2015). *Future in mind: Promoting, protecting and improving our children and young people's mental health and wellbeing* London: DoH.

DoH, & DfE. (2017). *Transforming children and young people's mental health provision: A green paper.* London: DoH & DfE.

DfE, & DoH. (2015). *Special educational needs and disability code of practice: 0 to 25 years* (revised). London.

Edge, D., & MacKian, S. C. (2010). Ethnicity and mental health encounters in primary care: Help-seeking and help-giving for perinatal depression among black Caribbean women in the UK. *Ethnicity & Health, 15*(2), 93–111

Edge, D., & Mackian, S. (2024). Accessing mental health services: A systematic review and meta-ethnography of the experiences of South Asian service users in the UK. *Journal of Racial and Ethnic Health Disparities.*

Ellins, J., Hocking, L., Al-Haboubi, M., Newbould, J., Fenton, S.-J., Daniel, K., Stockwell, S., Leach, B., Sidhu, M., Bousfield, J., McKenna, G., Saunders, C., O'Neill, S., & Mays, N. (2023). Implementing mental health support teams in schools and colleges: The perspectives of programme implementers and service providers. *Journal of Mental Health*

Fenton, S., & Sadiq, A. (1996). Asian women speak out. In T. Heller, J. Reynolds, R. Gomm, R. Muston, & S. Pattison (Eds.), *Mental health matters: A reader* (pp. 252–259). Macmillan Education UK.

Gill, P., Stewart, K., Treasure, E., & Chadwick, B. (2008). Methods of data collection in qualitative research: Interviews and focus groups. *British Dental Journal,* 204(6), 291-295.

Gillborn, D. (2015). Intersectionality, critical race theory, and the primacy of racism: Race, class, gender, and disability in education. *Qualitative Inquiry,* 21(3), 277-287.

Goffman, E. (1963). *Stigma: Notes on the management of spoiled identity*. Prentice Hall

Gorard, S. (2008). Who is missing from education? *Cambridge Journal of Education*, 38(3), 421–437.

Gov UK. (2014). Adults experiencing common mental disorders: By ethnicity and sex.

Gough, D., Oliver, S., & Thomas, J. (2017). *An introduction to systematic reviews*. SAGE Publications.

Grimm, F., Alcock, B., Butler, J., Fernandez Crespo, R., Davies, A., Peytrignet, S., Piroddi, R., Thorlby, R., & Tallack, C. (2022). Improving children and young people's mental health services: Local data insights from England, Scotland and Wales. *The Health Foundation.*

Gunasinghe, C., Hatch, S. L., & Lawrence, J. (2019). Young Muslim Pakistani women's lived experiences of izzat, mental health, and well-being. *Qualitative Health Research,* 29(5), 747-757.

Hamblin, E. (2016). *Gender and children and young people's emotional and mental health:* Manifestations and responses: A rapid review of the evidence.

Haque, A., Tubbs, C. Y., & Kahloon, R. (2015). Cultural adaptation of mental health services: A case study of Asian Muslims in the USA. *International Journal of Culture and Mental Health*, 8(1), 34-48.

Health Foundation. (2021). Latest data highlights a growing mental health crisis in the UK. Retrieved from *Health Foundation.*

Henderson, R. C., Williams, P., Gabbidon, J., Farrelly, S., Schauman, O., Hatch, S., et al. (2018). Mistrust of mental health services: Ethnicity, hospital admission and unfair treatment. (2015): 258–265.

Higgins, J. P., Thomas, J., Chandler, J., Cumpston, M., Li, T., Page, M. J., & Welch, V. A. (Eds.). (2019). *Cochrane handbook for systematic reviews of interventions.* John Wiley & Sons.

Holland, J., Ramazanoglu, C., Sharpe, S., & Thomson, R. (1998). *The male in the head: Young people, heterosexuality, and power*. Tufnell Press.

Hossain, M. M., & Purohit, N. (2019). Improving child and adolescent mental health in India: Status, services, policies, and way forward. *Indian Journal of Psychiatry*.

Howitt, D. (2016). *Introduction to qualitative methods in psychology* (4th ed.). Pearson Education Limited.

Husain, W. (2019). Barriers in seeking psychological help: Public perception in Pakistan. *Community Mental Health Journal, 56*(1), 75-78.

Iqbal, G., Gumber, A., Johnson, M. R. D., Szczepura, A., Wilson, S., & Dunn, J. A. (2012). Improving ethnicity data collection for health statistics in the UK: The South Asian perspective. *BMC Public Health,* 12,243.

Islam, Z., Rabiee, F., & Singh, S. P. (2015). Black and minority ethnic groups' perception and experience of early intervention in psychosis services in the United Kingdom. *Journal of Cross-Cultural Psychology*, 46(5), 737–753.

Jason, L. A., Stevens, E., & Ram, D. (2019). *Community psychology: Foundations for practice. *American Psychological Association.*

Keating, F., & Robertson, D. (2004). Fear, black people and mental illness: A vicious circle? *Health and Social Care Community,* 12(5), 439–447.

Khalifa, N., Hardie, T., Latif, S., Jamil, I., & Walker, D. M. (2011). Beliefs about Jinn, black magic and evil eye among Muslims: Age, gender and first language influences. *International Journal of Culture and Mental Health*, 4(1), 68-77.

Khan, R. (2007). Attitudes towards mental health services in the Pakistani community. *Mental Health Review Journal*, 12(3), 24-36.

Kirmayer, L. J., & Pedersen, D. (2014). Toward a new architecture for global mental health. *Transcultural Psychiatry, 51*(6), 759–776

King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. SAGE Publications.

Kincheloe, J. L., & McLaren, P. (2011). Rethinking critical theory and qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), *The SAGE handbook of qualitative research* (pp. 303-342). SAGE Publications.

Knifton, L. (2012). Understanding and addressing the stigma of mental illness with ethnic minority communities. *Health Sociology Review*, 21(3), 287–298.

Kushal, S., & Manickam, E. (2014). (Dis)honourable paradigms: A critical reading of Provoked, Shame and Daughters of Shame.

Lawrence, V., Murray, J., Samsi, K., & Banerjee, S. (2008). Attitudes and support needs of Black Caribbean, South Asian and White British carers of people with dementia in the UK. *British Journal of Psychiatry,* 193 (3), 240–246.

Lin, E., & Parikh, S. V. (1999). Sociodemographic, clinical, and attitudinal characteristics of the untreated depressed in Ontario. *Journal of Affective Disorders, 53*(2), 153-162.

Lynch, L., Moorhead, A., Long, M., et al. (2022). The role of informal sources of help in young people's access to, engagement with, and maintenance in professional mental health care—A scoping review. *Journal of Child and Family Studies.*

MacLellan, J., Dixon, S., Bi, S., Toye, F., & McNiven, A. (2023). Perimenopause and/or menopause help-seeking among females from ethnic minorities: A qualitative study of primary care practitioners' experiences. *British Journal of General Practice*, 73(732).

McKenzie, S. K., Oliffe, J. L., Black, A., & Collings, S. (2022). Men's experiences of mental illness stigma across the lifespan: A scoping review. *American Journal of Men's Health,* 16(1), 1–16.

McLaughlin, E. (2012). *What is critical realism?* Routledge.

McLaren, T., Peter, L.-J.,(2021) The Seeking Mental Health Care Model Research Team. Seeking mental health care for depressive symptoms: Prediction by stigma and mental illness representations. *BMC Public Health*, 23(69).

McMillan, D. W., & Chavis, D. M. (1986). Sense of community: A definition and theory. *Journal of Community Psychology,* 14(1), 6-23.

Memon, A., Taylor, K., Mohebati, L. M., Sundin, J., Cooper, M., Scanlon, T., & de Visser, R. (2016). Perceived barriers to accessing mental health services among black and minority ethnic (BME) communities: A qualitative study in Southeast England. *BMJ Open, 6*(11), e012337.

Miller, K. E. (2009). Sport-related identities and the "toxic jock". *Journal of Sport Behaviour, 32* (1), 69.

Moller, N., Burgess, V., & Jogiyat, Z. (2016). Barriers to counselling experienced by British South Asian women: A thematic analysis exploration. *Counselling and Psychotherapy Researc*h, 16(3), 201–210.

Mukadam, N., Cooper, C., & Livingston, G. (2011). A systematic review of ethnicity and pathways to care in dementia. *International Journal of Geriatric Psychiatry,* 26(1), 12–20.

Murray, C. E., et al. (2012). The role of beliefs about depression and its treatment in familial communication about depression. *Journal of Family Issues, 33*(10), 1293-1317.

Nazroo, J. Y., Fenton, S., Karlsen, S., & O'Connor, W. (2002). Context, cause and meaning: Qualitative insights. In K. Sproston & J. Nazroo (Eds.), *Ethnic minority psychiatric illness rates in the community (EMPIRIC)* (pp. 178–210). National Centre for Social Research.

NHS Digital. (2022). *Mental health of children and young people in England 2022*. NHS Digital.

Niaz, U., & Hassan, S. (2006). Culture and mental health of women in South-East Asia. *World Psychiatry, 5*, 118-120.

Nice, N. (2016*). Mental health problems in people with learning disabilities: Prevention, assessment and management.*

NSPCC. (2020). *Safeguarding children from Black, Asian and minoritised ethnic communities.*

Patel, N., & Fatimilehin, I. A. (1999). Racism and mental health: The prejudice against prejudice. In C. Newnes, G. Holmes, & C. Dunn (Eds.), *This is madness: A critical look at psychiatry and the future of mental health services* (pp. 140–157). PCCS Books

Perera, R., Owen, D., & Johnstone, E. (1991). Ethnic differences in pathways to psychiatric care. *International Journal of Social Psychiatry,* 37(4), 264-273.

Phillips, L., & Andriopoulou, P. (2022). An exploratory study of South Asian women's experiences of mental health services in England: A thematic analysis of cultural sensitivity. *Mental Health Review Journal,* 27(4), 437–454.

Phillips, K. A., Morrison, K. R., Andersen, R., & Aday, L. A. (1998). Understanding the context of healthcare utilization: Assessing environmental and provider-related variables in the behavioural model of utilisation. *Health Services Research,* 33(3), 571-596.

Pilkington, A., Msetfi, R. M., & Watson, R. (2012). Factors affecting intention to access psychological services amongst British Muslims of South Asian origin. *Mental Health, Religion & Culture, 15*(1), 1-22.

Pilgrim, D. (2019). *Key concepts in mental health* (3rd ed.). SAGE Publications.

Powney, J., & Watts, M. (1987). *Interviewing in educational research.* Routledge & Kegan Paul.

Purcell, R., Kelly, C., & Woods, K. (2023). Exploring secondary school pupils' views regarding the skills and outcomes they gain whilst undertaking the Emotional Literacy Support Assistant (ELSA) intervention. *Pastoral Care in Education*. Advance online publication.

Race Equality Foundation. (2015). MHPF and Race Equality Foundation Project Team.

Real, T. (2001). The mask of masculinity: Male stereotypes and the social construction of masculinity. *Journal of Men's Studies*, 9(3), 255-282.

Rickwood, D., Deane, F. P., Wilson, C., & Ciarrochi, J. (2005). Young people's help-seeking for mental health problems. *Advances in Mental Health*, 4.

Sadler, K., Vizard, T., Ford, T., Goodman, A., Goodman, R., & McManus, S. (2018). Mental health of children and young people in England, 2017 summary of key findings*. Health and Social Information Centre: National Health Service Digital.*

Sangar, M., & Howe, J. (2021). How discourses of sharam (shame) and mental health influence the help-seeking behaviours of British born girls of South Asian heritage. *Educational Psychology in Practice,* 37(4), 343–361.

Schofield, T., Connell, R. W., Walker, L., Wood, J., & Butland, D. L. (2000). Understanding men's health and illness: A gender-relations approach to policy, research, and practice. *Journal of American College Health*, 48, 247-256.

Shah, R. (2010). Mental health literacy in a sample of UK Pakistani community. *Journal of Public Mental Health*, 9(3), 20-33.

Shefer, G., Rose, D., Nellums, L., Thornicroft, G., Henderson, C., & Evans-Lacko, S. (2013). "Our community is the worst": The influence of cultural beliefs on stigma, relationships with family and help-seeking in three ethnic communities in London. *International Journal of Social Psychiatry*, 59(6), 535–544.

Smith, J. A., & Osborn, M. (2008). Interpretative phenomenological analysis. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 53-80). SAGE Publications.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research.* SAGE Publications.

Soorkia, R., Snelgar, R., & Swami, V. (2011). Factors influencing attitudes towards seeking professional psychological help among South Asian students in Britain*. Mental Health, Religion & Culture*, 14(6), 613–623.

Swaile, C. (2017). Child and adolescent mental health: Access for Black, Asian and minority ethnic children and young people. *Haringey Clinical Commissioning Group.*

Talbani, A., & Hasanali, P. (2000). Gender, culture, and power: Barriers to help-seeking in South Asian women. *Journal of Mental Health*, 28(3), 245-259.

Tabassum, R., Macaskill, A., & Ahmad, I. (2000). Attitudes towards mental health in an urban Pakistani community in the United Kingdom. I*nternational Journal of Social Psychiatry*, 46, 170-181.

Thara, R., & Padmavati, R. (2013). Community mental health care in South Asia. *World Psychiatry.*

Trivedi, J. K., Goel, D., Kallivayalil, R. A., Isaac, M., Shrestha, D. M., & Gambheera, H. C. (2007). Regional cooperation in South Asia in the field of mental health. *World Psychiatry*, 6, 57–59.

Virdee, G., Frederick, T., Tarasoff, L. A., McKenzie, K., Davidson, L., & Kidd, S. A. (2017). Community participation within the context of recovery: Multiple perspectives on South Asians with schizophrenia. *International Journal of Culture and Mental Health*, 10 (2), 150–163.

Vogel, D. L., Heimerdinger-Edwards, S. R., Hammer, J. H., & Hubbard, A. (2011). "Boys don't cry": Examination of the links between endorsement of masculine norms, self-stigma, and help-seeking attitudes for men from diverse backgrounds. *Journal of Counselling Psychology,* 58(3), 368.

Weatherhead, S., & Daiches, A. (2010). Muslim views on mental health and psychotherapy. *Psychology and Psychotherapy: Theory, Research and Practice,* 83(1), 75–89.

Weaver, A. (2017). South Asian women and mental health: An exploration of the stereotypes and realities. *Journal of South Asian Studies*, 42(3), 315-328.

Weich, S., McBride, O., Twigg, L., Duncan, C., Keown, P., Crepaz-Keay, D., Cyhlarova, E., Parsons, H., Scott, J., & Bhui, K. (2017). Variation in compulsory psychiatric inpatient admission in England: A cross-classified, multilevel analysis. *Lancet Psychiatry,* 4(8), 619-626.

Weich, S., Nazroo, J., Sproston, K., McManus, S., Blanchard, M., Erens, B., Karlsen, S., King, M., Lloyd, K., Stansfeld, S., & Tyrer, P. (2004). Common mental disorders and ethnicity in England: The EMPIRIC study. *Psychological Medicine, 34*(8), 1543-1551.

Wilkinson, S. (1998). Focus groups in feminist research: Power, interaction, and the co-construction of meaning. *Women's Studies International Forum, 21*(1), 111-125.

Willig, C. (2013). *Introducing qualitative research in psychology* (3rd ed.). McGraw-Hill Education.

Yardley, L. (2008). Demonstrating validity in qualitative psychology. In J. A. Smith (Ed.), *Qualitative psychology: A practical guide to research methods* (pp. 235-251). Sage Publications.

Yardley, L. (2017). Demonstrating the validity of qualitative research. *The Journal of Positive Psychology*, 12(3), 295-296.

Yousaf, O., Grunfeld, E. A., & Hunter, M. S. (2015). A systematic review of the factors associated with delays in medical and psychological help-seeking among men. *Health Psychology Review*, 9(2), 264-276.

Zins, J., Bloodworth, M., Weissberg, R., & Walberg, H. (2004). The scientific base linking social and emotional learning to school success. In J. Zins, R. Weissberg, M. Wang, & H. Walberg (Eds.), *Building*

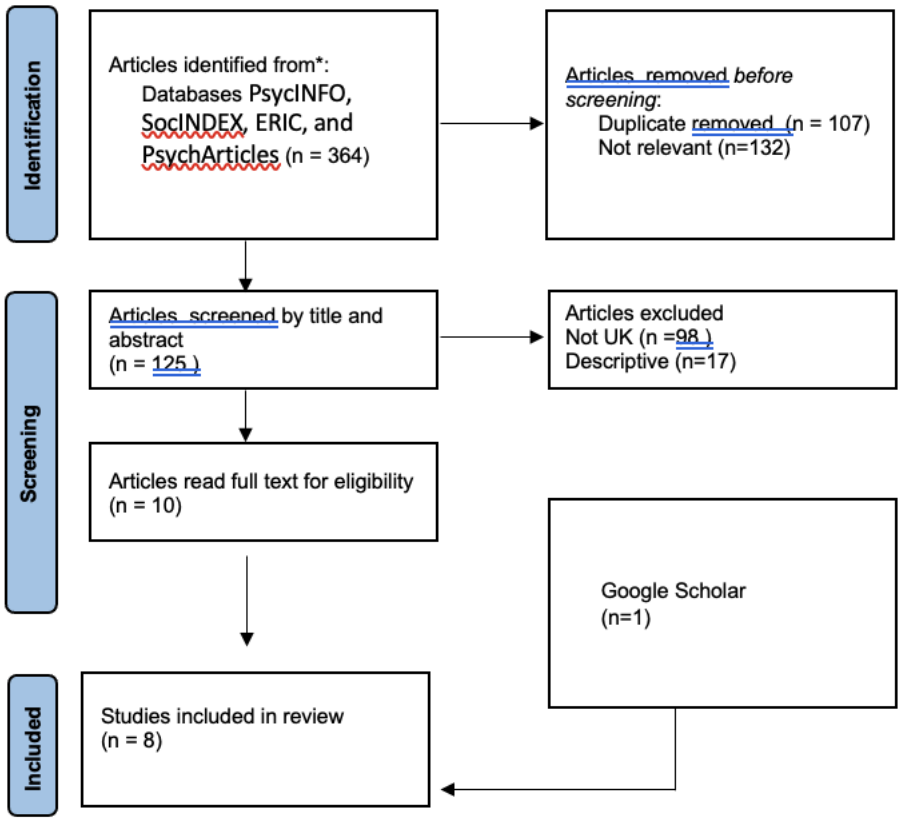
academic success on social and emotional learning: What does the research say? (pp. 1-22). Teachers Press Columbia University.

Zohrabi, M. (2013). Mixed method research: Instruments, validity, reliability and reporting findings. *Theory & Practice in Language Studies,* 3(2).

Appendices

Appendix 1

Flowchart of literature search



Appendix 1a

Summary of Studies included in literature review

Author/Date/Title	Study Design & Methodology	Participants and relevant demographics	Findings relevant to factors around seeking help for mental health

Ali, Mclachlan & Randwhawa (2016): Pakistani young people's views on barriers to accessing mental health services	A qualitative approach utilised Focus Groups to collect data	33 Participants aged 11-19 from Peterborough, British Pakistani 17 Male (Aged (11 – 19) 16 Female (Aged 12-18 Years)	The study on Pakistani youth's access to mental health services found limited awareness beyond GPs, emphasising a need for broader education on treatment options like CBT. Cultural barriers and reliance on GPs were major obstacles, highlighting the need for culturally sensitive care. The study explored gender differences and stressed the importance of culturally competent approaches to improve accessibility for Pakistani youth.
Bains & Gutman (2021): Mental Health in Ethnic Minority Populations in the UK: Developmental Trajectories from Early Childhood to Mid Adolescence	The research used a longitudinal cohort study over a period of 11 years. Interviews and self-completed questionnaires were conducted at different ages (3,5,7,11 & 14 years).	18,521 Participants 49% Female UKME background 3-14 years	The study finds significant ethnic disparities in the development of mental health problems among children in the UK. Ethnic minority children, particularly Pakistani, Bangladeshi, and Black Caribbean, exhibit more internalising and externalising problems compared to White children, with these issues persisting into adolescence for some groups. Despite socioeconomic and maternal factors influencing these

			outcomes, they do not fully account for the observed ethnic differences. Additionally, Black Caribbean children are underrepresented in mental health services, indicating unmet needs, partly due to cultural stigma, lack of cultural awareness among practitioners, and systemic barriers
Ineichen (2012). Mental illness and suicide in British South Asian Adults	Lit Review The study's methodology included a systematic literature review, gathering data from diverse sources, qualitatively analysing findings, conducting comparative analyses, and interpreting results.	N/A	The study highlighted the diverse characteristics within the South Asian population, noting differences based on generation, country of origin, religion, class, wealth, and geography, which affect mental health outcomes. It found that older South Asian women faced more mental health challenges than younger South Asians and White peers. The research also explored the impact of religion on suicide and how socioeconomic factors influence mental illness rates.
Khalifa, Hardie, Latif, Jamil, & Walker (2011) Belief about jinns, Black magic and the evil eye	The study utilised a cross-sectional design and employed a self-report questionnaire	111 Participants, 52 Female 59 Male Aged between 18 and 30 Years old	Participants had diverse views on treatment approaches: some advocated for religious figures, others

among Muslims: age, gender and first language influences			for medical doctors, and a significant portion supported using both religious and medical authorities.
Memon, Taylor, Mohebati Sundin , Cooper , Scanlon , De Visser (2016) Percieved barriers to accessing mental health services among BME communities: a qualitative study in Southeast England	The study utilised a qualitative approach which consisted of 2 focus groups and data collected was analysed using thematic analysis.	Participants were recruited from UKME backgrounds from Southeast England and over 18 years. 26 Participants Focus group 1 – 14 Participants (9 Females, 5 Males) Focus group 2- 12 Participants (4 Females, 8 Males)	Participants noted barriers to seeking help, including difficulty recognising mental health issues, social stigma, cultural identity impact, and financial constraints. The study identified challenges in relationships between service users and healthcare providers, including communication barriers, power dynamics, and cultural insensitivity. It emphasised the complexity of barriers for UKME communities, stressing the need to address cultural beliefs, improve communication, and enhance cultural competence in mental health services for equitable access.
Moller, Burgess & Jogiyat, (2016) Barriers to counselling experienced by British South Asian Women: A thematic analysis	Researchers used qualitative surveys which were analysed using Thematic analysis.	82 Participants British South Asian Women aged 18-40	The findings highlighted "Stereotyping," as a central theme, which encompassed perceptions and beliefs about counselling among second-generation South Asian women in Britain. Participants

			commonly held stereotypes about White counsellors being culturally ignorant and unable to comprehend Asian culture, creating a hindrance to seeking help. The study found the pressing need to address these stereotypes and barriers to enhance the accessibility of psychological services for this population.
Pilkington, Msetfi & Watson (2012) Factors affecting intention to access psychological services amongst British Muslims of South Asian origin	A mixed method design was used. Quant component- Survey Questionnaires Qual- Semi-structured interviews	94 Participants British Muslim girls of South Asian heritage 48 Female 46 Male (Mean age of PPs 31 years)	Acculturation emerged as a substantial predictor of the intention to access psychological services, particularly among individuals born in Britain. This could be attributed to higher levels of education and familiarity with Westernised mental health beliefs. Conversely, the study did not find religiosity to be a significant predictor, potentially influenced by a recruitment method bias towards religious participants. The research showed the importance of taking into account factors such as shame/izzat, beliefs regarding the causes of mental health challenges,

			and acculturation to comprehend help-seeking behaviours in this population.
Sangar & Howe (2021) How discourses of shame and mental health influence the help-seeking behaviours of British born girls of south Asian heritage.	The study employed an exploratory and flexible qualitative research design. Semi-structured interviews were conducted. The data collected from these interviews were analysed using a version of Foucauldian discourse analysis.	7 Participants – British South Asian Girls aged 13-14 years.	Findings revealed complex and contradictory narratives about shame and mental health in this group. Shame was seen as both a regulatory and oppressive force, as well as protective, affecting help-seeking behaviour. Cultural constructs like shame and honour were significant barriers to mental health assistance for British South Asian girls. The study emphasised the need for culturally competent practices and community engagement, highlighting the importance of considering young people's voices to create accessible, ethical, and culturally sensitive services. It underscored the unique challenges these girls face in balancing their cultural values with Western society.
Soorkia, Snelgar & Swami (2011). Factors	The study employed a cross-sectional design,	The study involved 148 university	The findings showed that women had more positive attitudes towards

influencing attitudes towards seeking professional psychological help among south Asian students in Britain	gathering data at a singular point in time to evaluate the connections between attitudes toward seeking psychological help and cultural factors among South Asian students in Britain.	students of South Asian heritage in Britain, comprising 81 women and 67 men.	seeking help compared to men, highlighting gender differences. Indian participants had higher scores than those of Pakistani and other South Asian backgrounds. Ethnic identity, cultural mistrust, and adherence to Asian values were key predictors of attitudes towards professional psychological help. These predictors remained significant even after considering sex and ethnicity, emphasizing the crucial role of cultural factors in shaping attitudes towards mental health support among South Asian students in Britain.

Appendix 2: CASP review

Critical Appraisal Skills Programme (CASP)								
Question	**Pilkington, A., Msetfi, R. M., & Watson, R. (2012).**	**Soorkia, R., Snelgar, R., & Swami, V. (2011).**	**Khalifa, N., Hardie, T., Latif, S., Jamil, I., & Walker, D. M. (2011)**	**Sangar & Howe (2021)**	**Memon A, Taylor K, Mohebati LM, Sundin J, Cooper M, Scanlon T, de Visser R, (2016)**	**Moller, N., Burgess, V., & Jogiyat, Z. (2016).**	**Bains S, Gutman (2021)**	**Ali, N., McLachlan, N., Kanwar, S., & Randhawa, G. (2017).**
Was there a clear statement of the								

aims of the research?								
Is a qualitative method appropriate?								
Was the research design appropriate to address the aims of the research?								

Was the recruitment strategy appropriate to the aims of the research?								
Was the data collected in a way that addressed the research issues?								
Has the relationship between								

researcher and participants been adequately considered?								
Have ethical issues been taken into consideration?								
Was the data analysis sufficiently rigorous?								

Is there clear statements of findings?								
How valuable is the research?								

Critical Appraisal Skills Programme (CASP)	**Study Author: Ineichen, B. (2012).** **Key: YES NO CAN'T TELL**
Did thereview address a clearly focused question?	
Did the authors look for the right type of papers?	
do you think all the important, relevant studies were included?	
Did the review's authors do enough to assess quality of the included studies?	
If the results of the review have been combined,	

was it reasonable to do so?	
What are the overall results of the review?	
How precise are the results?	
Can the results be applied to the local population?	
Were all important outcomes considered?	
Are the benefits worth the harms and costs?	

Appendix 3: TREC Application

Tavistock and Portman Trust Research Ethics Committee (TREC)

APPLICATION FOR ETHICAL REVIEW OF STUDENT RESEARCH PROJECTS

This application should be submitted alongside copies of any supporting documentation which will be handed to participants, including a participant information sheet, consent form, self-completion survey or questionnaire.

Where a form is submitted and sections are incomplete, the form will not be considered by TREC and will be returned to the applicant for completion.

For further guidance please contact [redacted]

FOR ALL APPLICANTS

If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters. You need only complete sections of the TREC form which are NOT covered in your existing approval

Is your project considered as 'research' according to the HRA tool? (http://www.hra-decisiontools.org.uk/research/index.html)	Yes
Will your project involve participants who are under 18 or who are classed as vulnerable? (see section 7)	Yes
Will your project include data collection outside of the UK?	No

SECTION A: PROJECT DETAILS

Project title	What are the Perspectives of adolescents students of British Pakistani background in seeking support for Social, Emotional & Mental Health?		
Proposed project start date	09/2023	**Anticipated project end date**	**09/2024**
Principle Investigator (normally your Research Supervisor): [redacted]			
Please note: TREC approval will only be given for the length of the project as stated above up to a maximum of 6 years. Projects exceeding these timeframes will need additional ethical approval			
Has NHS or other approval been sought for this research including through submission via Research Application System (IRAS) or to the Health Research Authority (HRA)?	**YES (NRES approval)** ☐ **YES (HRA approval)** ☐ **Other** ☐ **NO** ☒		

If you already have ethical approval from another body (including HRA/IRAS) please submit the application form and outcome letters.

SECTION B: APPLICANT DETAILS

Name of Researcher	
Programme of Study and Target Award	M4 – Child, Community and Educational Psychology
Email address	
Contact telephone number	0

SECTION C: CONFLICTS OF INTEREST

Will any of the researchers or their institutions receive any other benefits or incentives for taking part in this research over and above their normal salary package or the costs of undertaking the research? **YES** ☐ **NO** ☒ If **YES**, please detail below:
Is there any further possibility for conflict of interest? YES ☐ **NO** ☒

Are you proposing to conduct this work in a location where you work or have a placement? **YES** ☒ **NO** ☐ If **YES**, please detail below outline how you will avoid issues arising around colleagues being involved in this project:
Participants will be offered face to face interviews that will take place in meeting rooms in the local authority office, The interviews will be conducted in quiet meetings rooms away from colleagues and other professionals. This has been agreed by the principle educational psychologist at BucksCC (Letter has been attached)

Is your project being commissioned by and/or carried out on behalf of a body external to the Trust? (for example; commissioned by a local authority, school, care home, other NHS Trust or other organisation). *Please note that 'external' is defined as an organisation which is external to the Tavistock and Portman NHS Foundation Trust (Trust)	**YES** ☐ **NO** ☒
If **YES**, please add details here:	
Will you be required to get further ethical approval after receiving TREC approval? If **YES**, please supply details of the ethical approval bodies below AND include any letters of approval from the ethical approval	**YES** ☐ **NO** ☒

bodies (letters received after receiving TREC approval should be submitted to complete your record):	
A letter from the Principal Educational Psychologist (PEP) is included which confirms I will not be needing further ethical approval from the council, This letter also includes that they are happy and willing to support me completing my research in the local authority	
If your project is being undertaken with one or more clinical services or organisations external to the Trust, please provide details of these:	
If you still need to agree these arrangements or if you can only approach organisations after you have ethical approval, please identify the types of organisations (eg. schools or clinical services) you wish to approach:	
Secondary Schools – Once ethical approval has been agreed, relevant secondary schools and post 16 educational provisions will be approached. An initial scoping email has been drafted for sending out in preparation for this (Draft email has been attached)	
Do you have approval from the organisations detailed above? (this includes R&D approval where relevant) Please attach approval letters to this application. Any approval letters received after TREC approval has been granted MUST be submitted to be appended to your record	**YES** ☐ **NO** ☐ **NA** ☒

SECTION D: SIGNATURES AND DECLARATIONS

APPLICANT DECLARATION

I confirm that:

- The information contained in this application is, to the best of my knowledge, correct and up to date.
- I have attempted to identify all risks related to the research.
- I acknowledge my obligations and commitment to upholding ethical principles and to keep my supervisor updated with the progress of my research
- I am aware that for cases of proven misconduct, it may result in formal disciplinary proceedings and/or the cancellation of the proposed research.
- I understand that if my project design, methodology or method of data collection changes I must seek an amendment to my ethical approvals as failure to do so, may result in a report of academic and/or research misconduct.

Applicant (print name)	[redacted]
Signed	[redacted] .
Date	04/10/2023

FOR RESEARCH DEGREE STUDENT APPLICANTS ONLY

Name of Supervisor/Principal Investigator	[redacted]

Supervisor –

- Does the student have the necessary skills to carry out the research?

  YES ☒ **NO** ☐

- Is the participant information sheet, consent form and any other documentation appropriate?

  YES ☒ **NO** ☐

- Are the procedures for recruitment of participants and obtaining informed consent suitable and sufficient?

  YES ☒ **NO** ☐

- Where required, does the researcher have current Disclosure and Barring Service (DBS) clearance?

  YES ☒ **NO** ☐

Signed	[redacted]
Date	04.10.23

COURSE LEAD/RESEARCH LEAD

Does the proposed research as detailed herein have your support to proceed? YES ☐ NO ☐

Signed	[redacted]
Date	

SECTION E: DETAILS OF THE PROPOSED RESEARCH

1. **Provide a brief description of the proposed research, including the requirements of participants. This must be in lay terms and free from technical or discipline specific terminology or jargon. If such terms are required, please ensure they are adequately explained (Do not exceed 500 words)**
The purpose of the proposed research is to explore the perspectives of Pakistani-British adolescents with regard to Social Emotional Mental Health (SEMH) and help-seeking behaviours. Help-seeking will be defined as seeking help for one's well- being by actively reaching out to healthcare services or trustworthy individuals within the community (Rickwood et & Thomas, 2015)[2].This includes seeking understanding, guidance, treatment, and overall support during times of distress or when facing stressful situations (Rickwood & Thomas, 2015). The proposed research is exploratory since it aims to generate better understanding and new knowledge in the field since there is limited if any research in the UK which has looked at this population's perspectives on SEMH and related help-seeking behaviours. It is also hoped that the research will elicit views on how gender and cultural norms may influence their help seeking behaviours in relation to SEMH. Participants in this research will include young people (males and females) in Secondary School/Post 16 Education in one specific local authority. They will be recruited through gatekeepers (e.g., head teachers; SENCos/INCOs). Participants will need to: - be between the ages of 16-18 years old. - attending sixth form in secondary schools or colleges - self-identify as British Pakistani

[2] Rickwood D &Thomas K. (2012). Conceptual measurement framework for help-seeking for mental health problems. *Psychol Res Behav Manag.,*5:173–183. doi: 10.2147/PRBM.S3870

-Participants will have a perspective on SEMH and the support available, but not necessarily have experienced seeking support for SEMH issues.

Recruitment

- A scoping email will be sent and subsequent conversation will be held with the SENCo and/or Headteacher to gauge their interest in being part of this research
- If SENCo/ Headteacher is interested, an email will be sent out to SENCO and/or Headteachers with relevant information as well as the research poster (once ethical approval has been gained). The research poster will be shared with them in agreement that they will then share this with relevant students.
- Once potential participants have been identified at school by the SENCo and/or Headteacher, The school staff will share the recruitment poster to the young person, for them to get in contact with me to express their interest in taking part in the study. The recruitment poster has a QR code, where students will be able to complete their information for me to get in contact with them or alternatively my email address is available on the poster for them to directly email that they are interested in taking part.
- Once potential participants have made contact with the researcher, they will be offered a phone call/ teams meeting if they wish to get further information on the study before making an informed decision to take part in the study. The researcher will re-iterate that they are under no obligation to take part in the study following the initial meeting. The researcher will use professional judgement to ascertain potential participants suitability with regards to vulnerabilities and mental capacities (See below for how this will be done) . The researcher will also ensure potential participants are aware of what is required in terms of their participation, so that they can judge for themselves if they are suitable.

- Potential participants will have up to one week to make a decision if they would like to take part in the study after gaining more information. The research will contact them after a week, if they have not heard from them just to confirm their decision.
- The consent form will be sent out once the participant has verbally agreed to take part in the study and an interview date has been set (Consent form will be sent ahead of the interview date)
- If the participant withs to participate in an online interview an online version (Microsoft teams) consent form will be sent prior to the interview. (Click to see Microsoft form)
- The participants will be invited to take part in a semi-structured interview which will last approximately one hour. The open-ended questions will explore their perspectives on SEMH and access to support for SEMH as related to their age group, gender and culture. The qualitative data from the interviews will be analysed using Reflexive Thematic Analysis to identify relevant themes.

2. Provide a statement on the aims and significance of the proposed research, including potential impact to knowledge and understanding in the field (where appropriate, indicate the associated hypothesis which will be tested). This should be a clear justification of the proposed research, why it should proceed and a statement on any anticipated benefits to the community. (Do not exceed 700 words)

According to statistics from the Department for Education, the United Kingdom (UK) is witnessing a continuous rise in SEMH needs since 2020, which were already notably high. In fact, SEMH needs rank as the third most common primary need for pupils in the UK.

NHS data[3] from 2017 indicates that one in eight children between the ages of 5 and 19 had at least one diagnosable mental health condition (though not necessarily formally diagnosed, they met the threshold for diagnosis) (NHS, 2017). This highlights the high and continuously rising prevalence of SEMH needs among Children and Young People (CYP) in the UK.

Importantly, there is a distinct lack of statistics regarding the Mental Health (MH) issues in CYP from South Asian (SA) backgrounds living in Britain. It should be noted that often statistics or research for SA population previously fell under the Black and Minority Ethnic (BAME) category which further camouflages specific details within this community. The term BAME is now no longer since it homogenised ethnicities under one category (Laux & Nisar, 2022)[4].

Based on data referred to by Ahmad et al. (2022)[5], reducing mental health disparities and improving access to mental healthcare has become a major public health concern in the UK over the past two decades. However, there is still limited evidence about the extent of these disparities especially for ethnic minority and migrant individuals. It is felt that these groups face higher risks of facing unfavourable or intimidating pathways to mental healthcare and tend to experience poorer outcomes from psychological services (Ahmad et al., 2022). Mental health (MH) problems in South Asian local communities appear to be influenced by various factors, including age and gender, with access to support impacted by weak mental health infrastructure, limited availability of mental health practitioners, and unsupportive cultural and religious beliefs. There is therefore a lack of reliable data on mental health prevalence in these communities in their country of origin. Similarly, there

[3] NHS (2017). *Mental Health of Children and Young People in England 2022* . NHS Digital

[4] Laux, R., & Nisar, S. (2022). *Why we've stopped using the term 'BAME' in government - Civil Service*

[5] Ahmed, S. (2017). *CULTURAL DIFFERENCES IN HELP-SEEKING IN SOUTH ASIAN POPULATIONS*. Cultural differences in help seeking in south asian populations.

has been very limited research conducted in the UK in relation to the British South Asian community and MH needs, with the small number of existing studies mainly focusing on adults within the British SA community (Race Equality Foundation, 2015) [6]. The Office for National Statistics (2020)[7] provides statistics show that older SA females are an at-risk group for suicide. Statistics show that men are more likely to die by suicide than female and that suicide in young men is on the rise. However, it is not possible to explore the full picture in terms of ethnicity and suicide due to ethnicity not being on the death certificates (Office for National Statistics, 2020).

Therefore, in summary, this research aims to address the following gaps in this area:

1. There are no current studies within the UK looking at mental health, cultural norms and help seeking behaviours in British born Pakistani male adolescents, and only a few that focus on adolescent females. This existing research focuses on the experiences of SA females as a group (not specifically to British Pakistani background) and how shame and honour is seen as a barrier to accessing support for MH needs.
2. Studies have reported the underrepresentation of ethnic minorities within the MH service (Malek & Joughin, 2004) despite there being a recognised need in this area.
3. It has been argued that CAMHS currently do not meet the needs of those from Ethnic Minority (EM) backgrounds (Fatimilehin, 2007) [8].

The proposed research will aim to explore the following research question:

[6] ONS. (2022). *Ethnic group, England and Wales: Census 2021*.
[7] ONS (2020). Suicides in England and Wales – Office for National Statistics
[8] Fatimilehin, I. (2007). Building Bridges in Liverpool: Delivering CAMHS to Black and Minority Ethnic Children and their Families. *Journal of Integrated Care*, *15*(3), 7–16.

"What are the perspectives of adolescents of British Pakistani background in seeking support for Social, Emotional & Mental Health (SEMH) needs?". Alongside this main question, the research will explore two subsidiary questions:

- What role does culture play in shaping British Pakistani adolescents' views in seeking support for SEMH?
- What role does gender play in shaping British Pakistani adolescent views in seeking support for SEMH?

The proposed research is highly relevant to the Educational Psychology (EP) profession. Educational Psychologists (EPs) are expected to work with a range of different Children and young people of different ages and from different backgrounds. In line with this, the BPS (2021)[9] and HCPC (2023)[10] proficiencies EPs must show that they are able to demonstrate understandings of cultural influences on development and knowledge of evidence informed strategies to promote MH (BPS 1.5) and that they must be able to demonstrate application of diversity and cultural differences (BPS 3). There is limited research generated by EPs in this field about how to support those from the SA community. Given that the UK is a multi-cultural society, it is important that EPs increase cultural competency and awareness around sensitive topics to ensure that the profession is a helping those that may feel marginalised.

3. Provide an outline of the methodology for the proposed research, including proposed method of data collection, *tasks* assigned to participants of the research and the proposed method and duration of data analysis. If the

[9] British Psychological Society. (2021). *BPS Code of Human Research Ethics*
[10] Health & Care Professions Council. (2023). *Standards of proficiency*

proposed research makes use of pre-established and generally accepted techniques, please make this clear. (Do not exceed 500 words)

This research will adopt critical realism (Bhaskar, 1978)[11] as its underlying ontology. Critical realism, as a philosophical perspective, posits the existence of multiple domains of reality (Bhaskar & Danermark, 2006)[12]. According to this view, there is an independent and external reality that exists beyond the limitations of our understanding and perceptions. The epistemological stance taken in this study will be a Social Constructionist position. Constructionists suggest that knowledge is constructed through language (Tolentino & Andrews, 2012)[13]. Constructionist suggests that language used within populations create the norms, behaviours and values.

A qualitative methodology will be used in this research, with the chosen method of data collection for this research being semi- structured interviews. Semi-structured interviews will allow for specific information shared on participants perspective on support seeking for emotional wellbeing to be gathered, whilst still allowing space for broader information to be shared (Fylan, 2005)[14]. Semi-structured interviews allow for more free-flowing conversation, allowing data to be pushed to broader areas than the researcher initially anticipates (Howitt, 2016)[15].

Data analysis will be conducted over 2 months to allow for the process of transcribing and analysis through various lenses.

[11] Bhaskar, R. (1978). On the Possibility of Social Scientific Knowledge and the Limits of Naturalism. *Journal for the Theory of Social Behaviour*, *8*(1), 1–28.
[12] Bhaskar, R., & Danermark, B. (2006). Metatheory, interdisciplinarity and disability research: A critical realist perspective. *Scandinavian Journal of Disability Research*, *8*(4), 278–297.
[13] Tolentino, C., & Andrews, T. (2012). *What is Social Constructionism What is Social Constructionism?*
[14] Fylan, F. (2005). Semi-structured interviewing. *A handbook of research methods for clinical and health psychology*, *5*(2), 65-78.
[15] Howitt, D. (2016). *Introduction to Qualitative Research Methods in Psychology: Putting Theory*. Pearson Education

Semi-structured interviews will be conducted with a minimum of 4 participants and a maximum 8 participants (Smith et al., 2009)[16]. Semi-structured interviews will be used as they are non- directive and open-ended, thus the interviewee can respond in their own way providing rich qualitative data that can be analysed for meanings, constructions, and interpretations (Braun & Clarke, 2019). A draft set of proposed semi-structured questions are included in this application. They will explore the perspectives of adolescents of British Pakistani heritage in relation to seeking support for SEMH.

Interviews will be audio recorded, transcribed, and analysed. Interviews will be either held online using my Tavistock zoom account or completed face to face using meeting rooms in the local authority council building (As I am currently on placement in the local authority, I have access to meeting rooms, which are a neutral space to meet with interviewees and ensures others are in the building during the interviews).
The reason for having the option of both online and in person it allows flexibility for the interviewees to choose what they feel best comfortable with.

The information gathered through the semi-structured interviews will undergo analysis using Reflexive Thematic Analysis (RTA). This analysis is proposed to take about 2 month. This methodology was developed by Braun and Clarke (2019) based on their original 2006 model for thematic analysis. RTA involves a six-phase process: 1. Data familiarisation, 2 Data coding, 3. Developing and reviewing themes, 5 Refining defining and naming themes and 6. Write up that enables the identification and development of common themes in the data. It also considers individual viewpoints and experiences, which corresponds with the researcher's rationale for utilising semi-structured interviews.

[16] Braun, V., & Clarke, V. (2019). Reflecting on reflexive thematic analysis. In *Qualitative Research in Sport, Exercise and Health* (Vol. 11, Issue 4, pp. 589–597). Routledge

Additionally, RTA acknowledges that the researcher has their own biases and subjectivity. After data is categorised, practicing reflexivity prompts the researcher to examine whether their personal judgments or beliefs have influenced the analysis.

SECTION F: PARTICIPANT DETAILS

4. Provide an explanation detailing how you will identify, approach and recruit the participants for the proposed research, including clarification on sample size and location. Please provide justification for the exclusion/inclusion criteria for this study (i.e. who will be allowed to / not allowed to participate) and explain briefly, in lay terms, why these criteria are in place. (Do not exceed 500 words)

The researcher will use a purposive sampling approach. The study aims to recruit 6-8 participants (male and female) to partake in semi structured interviews. This number of participants is deemed appropriate for this research as it allows for the rich, individual data to be valued, whilst also accounting for feasibility of transcribing and analysing the data within a certain timeframe (Fugard & Potts, 2015)[17].

With current research heavily focused on adults within this particular group, it feels necessary to explore the views of adolescents from British Pakistani backgrounds. Inclusion criteria will therefore include:

- Participants will be between the ages of 16-18 years old. (up to 21 years old if needing to extend age range)
- Speak English fluently
- Participants will self-identify as British Pakistani (Born in Britain with Pakistani heritage)
- Participants will currently be attending an educational setting.

[17] Fugard, A. J. B., & Potts, H. W. W. (2015). Supporting thinking on sample sizes for thematic analyses: a quantitative tool.

Recruitment of participants will involve several strategies. The researcher aims to recruit by:

1. Contacting schools where the researcher is involved as part of her role as a Trainee EP to share information about the study. The researcher intends to initially contact SENCOs from local schools in the local authority ([redacted] where the researcher is placed. The reason SENCOs will be contacted first is because they are the point of contact for EPs within the placement Local Authority. The researcher will request the SENCO to ensure Head Teacher/Senior Leadership are in agreement with research objectives and the information being shared with potential participants. The researcher will offer to meet with relevant senior leaders to describe the research further if required. They will be asked to share (research poster) with sixth form students (above the age of 16) and ask whether students would be interested in taking part. A Participant Information and Consent Form will be shared with them at this stage and through this, potential participants will have information to contact the researcher to get further information and/or request to take part. All participants will be required to sign consent forms prior to interviews taking place.
2. If the above source of recruitment does not lead to enough participants, the researcher will make use of her established links in the Pakistani local community to directly share relevant research posters and research information forms with young people and their parents. If further recruitment is required, the researcher will approach community centres specific for Pakistanis or local mosques to use a snowball sampling technique, whereby the community centre/ mosque would select a single individual participant and ask them if they are able to share the poster and information sheet with those who might be willing to participate in the study.
3. If it is not possible to recruit enough participants between 16-18, the age group will be increased to 21 years-old and recruitment will be extended to further college and university settings.

The researcher having a shared cultural and ethnic background as the participants intended for this study can be seen as an advantage to hopefully reduce barriers to recruitment. It is intended that through

community links, schools and colleges will be approached and asked whether they are able to ask sixth form students if they are particularly interested in taking part in the study.

5. Please state the location(s) of the proposed research including the location of any interviews. Please provide a Risk Assessment if required. Consideration should be given to lone working, visiting private residences, conducting research outside working hours or any other non-standard arrangements.

If any data collection is to be done online, please identify the platforms to be used.

Participants will be attending educational settings in [redacted]. Interviews will either take place online or face to face.

Face to face interviews. Will take place in quiet, confidential meeting rooms at the local authority council building away from other professionals and the public.

Online interviews will be held via the researcher's Tavistock Zoom account.

The researcher will conduct the interviews from a private room and confidentiality of the interviews will be further protected by the researcher using headphones if conducted online. The participants will be advised to organise a private room for themselves whilst taking part in the interview online to protect their own information.

If participants choose to engage in online interviews, this will take place using their own equipment from a location they feel is confidential and private (whether this is home or within school) – Interviews will not be conducted if the participant is engaging from a public place such as a library or café.

6. Will the participants be from any of the following groups?*(Tick as appropriate)*

☐ Students or Staff of the Trust or Partner delivering your programme.

☐ Adults (over the age of 18 years with mental capacity to give consent to participate in the research).

☒ Children or legal minors (anyone under the age of 16 years)[1]

☐ Adults who are unconscious, severely ill or have a terminal illness.

☐ Adults who may lose mental capacity to consent during the course of the research.

☐ Adults in emergency situations.

☐ Adults[2] with mental illness - particularly those detained under the Mental Health Act (1983 & 2007).

☐ Participants who may lack capacity to consent to participate in the research under the research requirements of the Mental Capacity Act (2005).

☐ Prisoners, where ethical approval may be required from the National Offender Management Service (NOMS).

☐ Young Offenders, where ethical approval may be required from the National Offender Management Service (NOMS).

☐ Healthy volunteers (in high risk intervention studies).

☐ Participants who may be considered to have a pre-existing and potentially dependent[3] relationship with the investigator (e.g. those in care homes, students, colleagues, service-users, patients).

☐ Other vulnerable groups (see Question 6).

☐ Adults who are in custody, custodial care, or for whom a court has assumed responsibility.

☐ Participants who are members of the Armed Forces.

[1]If the proposed research involves children or adults who meet the Police Act (1997) definition of vulnerability[3], any researchers who will have contact with participants must have current Disclosure and Barring Service (DBS) clearance.

[2] 'Adults with a learning or physical disability, a physical or mental illness, or a reduction in physical or mental capacity, and living in a care home or home for people with learning difficulties or receiving care in their own home, or receiving hospital or social care services.' (Police Act, 1997)

[3] Proposed research involving participants with whom the investigator or researcher(s) shares a dependent or unequal relationships (e.g. teacher/student, clinical therapist/service-user) may

compromise the ability to give informed consent which is free from any form of pressure (real or implied) arising from this relationship. TREC recommends that, wherever practicable, investigators choose participants with whom they have no dependent relationship. Following due scrutiny, if the investigator is confident that the research involving participants in dependent relationships is vital and defensible, TREC will require additional information setting out the case and detailing how risks inherent in the dependent relationship will be managed. TREC will also need to be reassured that refusal to participate will not result in any discrimination or penalty.

7. Will the study involve participants who are vulnerable? YES ☐ NO ☒

For the purposes of research, 'vulnerable' participants may be adults whose ability to protect their own interests are impaired or reduced in comparison to that of the broader population. Vulnerability may arise from:

- the participant's personal characteristics (e.g. mental or physical impairment)
- their social environment, context and/or disadvantage (e.g. socio-economic mobility, educational attainment, resources, substance dependence, displacement or homelessness).
- where prospective participants are at high risk of consenting under duress, or as a result of manipulation or coercion, they must also be considered as vulnerable
- children are automatically presumed to be vulnerable.

7.1. If YES, what special arrangements are in place to protect vulnerable participants' interests?

While the participants are not defined as 'children' as they are above the age of 16, there may be an element of risk, as participants are school aged students (16-18) who may or may not have experienced SEMH difficulties. In line with the BPS (2021) guidelines, it is not necessary to gain parental consent from those aged 16, as under the Mental Capacity Act they are defined as an adult. The researcher will ensure that the chosen participants do not have any additional vulnerabilities and will only seek

participants that can give informed consent in line with the Mental Capacity Act. However, Participants are expected to discuss sensitive topics around their culture, cultural norms in relation to mental health and how this could cause barriers to seeking help. There is potential for participants to experience some stress, worries or anxieties when talking about these topics.

For mental capacity: the researcher will establish Mental Capacity in the following way: confirm that the participant: has received and understood the information given to them about the research, check their understanding of that information and clarify any areas which the potential participant has concerns or questions about; ensure that the potential participant has in writing (consent form) and verbally at the start of the interview communicated and confirmed their understanding.

For additional vulnerabilities: the researcher will use their professional judgement to ascertain during the pre-meeting with potential participants as well at the start of the interview, whether the participant has: cognitive or communicative vulnerability – this will be established with respect to their ability to comprehend questions posed by the researcher and their understanding of the research requirements, as well as questions asked, or responses shared by the potential participant.
Social vulnerability – this will be established by the researcher by identifying if the potential participants involvement in this research might make them feel that they are a target for discrimination since the research specifically focuses on their ethnic group.
Emotional vulnerability – this will be established by the researcher by identifying through conversation with the participants at the pre-meeting or start of the interview if involvement in this research (in particular, talking about aspects of emotional wellbeing and mental health) is likely to result in them feeling emotionally dysregulated. The researcher will reinforce safeguarding processes to be considered , and will ensure that participants are aware of the support they can access - pre and post the interviews. (these have been covered in other parts of the TREC).

When sharing information with the SENCO/Headteacher the researcher will ask that they use there professional judgement regarding an individual's vulnerability and therefore not necessarily share with individuals they feel are extremely vulnerable with respect to the above considerations.

The questions in the semi- structured interview will focus on their understanding of mental health in their age group; opportunities for accessing support available to them, as well as their thoughts on barriers and facilitators for accessing these. In addition, it hoped that participants will discuss how cultural norms and views of mental health may impact help seeking behaviours. The aim of the study is therefore not to look specifically at their own personal experiences of mental health (unless highlighted by them). While the conversation during the interview may go towards those participants discussing their own experiences, it is not the intention to seek that information for the purpose of this study. If a concerning disclosure is made, then the safeguarding lead will be notified as well as taking it to my supervisor.

Participants will be provided with full information about the research as well as a consent form to review and sign. Participants will be made aware that they are able to withdraw from the study at any point up until data analysis. Participants will be provided with a date to allow them to know the exact date they are able to withdraw from (BPS, 2021).

The researcher will provide information prior to and after the semi-structured interview about where to seek support should they experience any adverse effects before, during or after the interview. The researcher will monitor the participant's emotional state throughout the interview and will verbally check-in and ask if the participant wants to pause or end the interview should any emotional discomfort be noticed. The participant will be reminded that they can choose to end the interview at any stage without any repercussions.

It will be important to protect participant anonymity. Pseudonyms will be used, and information will be deidentified. Confidentiality during interviews will be ensured by careful planning of the interview environment. In the write up, careful consideration will be taken to ensure information about the schools and other local community places are deidentified. All collected data will be stored securely, and participants will be informed about the data retention period (Data Protection Act, 2018).

If YES, a Disclosure and Barring Service (DBS) check **within the last three years** is required.

Please provide details of the "clear disclosure":

Date of disclosure: 07/08/2021
Type of disclosure: Enhanced
Organisation that requested disclosure: Tavistock and Portman NHS Trust
DBS certificate number: [redacted]

*(NOTE: information concerning activities which require DBS checks can be found via https://www.gov.uk/government/publications/dbs-check-eligible-positions-guidance). Please **do not** include a copy of your DBS certificate with your application*

8. **Do you propose to make any form of payment or incentive available to participants of the research? YES ☐ NO ☒**

If **YES**, please provide details taking into account that any payment or incentive should be representative of reasonable remuneration for participation and may not be of a value that could be coercive or exerting undue influence on potential participants' decision to take part in the research.

Wherever possible, remuneration in a monetary form should be avoided and substituted with vouchers, coupons or equivalent. Any payment made to research participants may have benefit or HMRC implications and participants should be alerted to this in the participant information sheet as they may wish to choose to decline payment.

9. What special arrangements are in place for eliciting informed consent from participants who may not adequately understand verbal explanations or written information provided in English; where participants have special communication needs; where participants have limited literacy; or where children are involved in the research? (Do not exceed 200 words)

The Criteria for participants to be: Sixth form students or students currently attending a post-16 educational setting who are fluent English speakers (this will ensure that participants are able to read and have capacity to participate and consent in the research).

The Information sheet and Consent form will be designed to ensure accessibility and will be trialled with young people of similar age and background to ensure it is accessible.

Participants can request a copy of proposed questions to be shared with them prior to the interview.

During the interview, the researcher will clarify any terms or questions which the participant seems confused by.

SECTION F: RISK ASSESSMENT AND RISK MANAGEMENT

10. Does the proposed research involve any of the following? *(Tick as appropriate)*

☐ use of a questionnaire, self-completion survey or data-collection instrument (attach copy)

☒ use of emails or the internet as a means of data collection

☐ use of written or computerised tests

☒ interviews (attach interview questions)

☐ diaries (attach diary record form)

☐ participant observation

☐ participant observation (in a non-public place) without their knowledge / covert research

☒ audio-recording interviewees or events

☒ video-recording interviewees or events

☐ access to personal and/or sensitive data (i.e. student, patient, client or service-user data) without the participant's informed consent for use of these data for research purposes

☐ administration of any questions, tasks, investigations, procedures or stimuli which may be experienced by participants as physically or mentally painful, stressful or unpleasant during or after the research process

☐ performance of any acts which might diminish the self-esteem of participants or cause them to experience discomfiture, regret or any other adverse emotional or psychological reaction

☐ Themes around extremism or radicalisation

☐ investigation of participants involved in illegal or illicit activities (e.g. use of illegal drugs)

☐ procedures that involve the deception of participants

☐ administration of any substance or agent

☐ use of non-treatment of placebo control conditions

☐ participation in a clinical trial

☐ research undertaken at an off-campus location (risk assessment attached)

☐ research overseas (please ensure Section G is complete)

11. Does the proposed research involve any specific or anticipated risks (e.g. physical, psychological, social, legal or economic) to participants that are greater than those encountered in everyday life?

YES ☒ **NO** ☐

If **YES**, please describe below including details of precautionary measures.

There may be an element of risk, as participants are school aged students (16-18) who may or may not have experienced difficulties. Participants are expected to discuss sensitive topics around their culture, cultural norms in relation to mental health and how this could cause barriers to seeking help. There is potential for participants to experience some stress, worries or anxieties when talking about these topics.

The questions in the semi- structured interview will focus on their views on mental health in their age group; opportunities for accessing support available to them, as well as their thoughts on barriers and facilitators for accessing these. In addition, it hoped that participants will discuss how cultural norms and views of mental health may impact help seeking behaviours. The aim of the study is therefore not to look specifically at their own personal experiences of mental health (unless highlighted by them). While the conversation during the interview may go towards those participants discussing their own experiences, it is not the intention to seek that information for the purpose of this study. If a concerning disclosure is made, then the safeguarding lead will be notified as well as taking it to my supervisor.

The researcher will provide information prior to and after the semi-structured interview about where to seek support should they experience any adverse effects before, during or after the interview. The researcher will monitor the participant's emotional state throughout the interview and will verbally check-in and ask if the participant wants to pause or end the interview should any emotional discomfort be noticed. The participant will be reminded that they can choose to end the interview at any stage without any repercussions.

It will be important to protect participant anonymity. Pseudonyms will be used, and information will be deidentified. Confidentiality during interviews will be ensured by careful planning of the interview environment. In the write up, careful consideration will be taken to ensure information about the schools and other local community places are deidentified. All collected data will be stored securely, and participants will be informed about the data retention period (Data Protection Act, 2018).

12. Where the procedures involve potential hazards and/or discomfort or distress for participants, please state what previous experience the investigator or researcher(s) have had in conducting this type of research.

The researcher has had safeguarding training, previous experience as a teacher has allowed me to understand procedures in place to keep young people safe from harm and know who the appropriate professionals to inform if there is potential harm to young people I am working with.

Having worked in pupil referral units the researcher has had training on SEMH and further training on SEMH within my doctoral training.

The researcher has regular access to supervision both on the course and at placement.

The researcher will draw on professional psychological knowledge and skills, particularly knowledge and experience of working with Secondary students of Pakistani heritage. The researcher feels the participants may feel more comfortable being open with her seeing that she is a British Pakistani herself and therefore having a shared culture.

13. Provide an explanation of any potential benefits to participants. Please ensure this is framed within the overall contribution of the proposed research to knowledge or practice. (Do not exceed 400 words)

NOTE: Where the proposed research involves students , they should be assured that accepting the offer to participate or choosing to decline will have no impact on their assessments or learning experience. Similarly, it should be made clear to participants who are patients, service-users and/or receiving any form of treatment or medication that they are not invited to participate in the belief that participation in the research will result in some relief or improvement in their condition.

It is hoped that the participants in this research will benefit from having space to discuss their perspectives on SEMH and what support is available, and possibly their experiences in seeking help for these issues. Participants may also feel the benefit of 'feeling involved',

being ‘listened to’ and gaining their views in a piece of research which could potentially have future impact on peers, particularly from their own cultural background.

From a community point of view, it is hoped that this research will allow the community to see different viewpoints on accessing help and help reduce the stigma around SEMH and seeking help.

This research is highly relevant to the EP practice for a range of reasons. Firstly, those from ethnic minority backgrounds are less likely to be referred to EPs or CAMHs teams compared to their White counterparts (Edbrooke-Childs & Patalay, 2019) [18]. As such, being aware of potential reasons for this will be useful for address provision in and out of schools. Secondly, there is limited research in this field and EPs could make a difference within this area if they understood South Asian (SA) culture and how it impacts young SA males and females. this research could also equip school staff to further explore behaviours with SA males and females to avoid exclusions and to challenge stereotypes.

In terms of practice, EPs would be able to make informed suggestions for schools in relation to helping male and females within SA communities and help schools understand protentional barriers, social norms within the culture and culturally sensitive ways of practice. EPs could also recognise the need for including relevant questions during consultation and challenge discourses made about those from SA communities. They might also be able to identify questions which may reveal needs from the SA community that are currently not being met, where help- seeking behaviours may be repressed by cultural factors (Sangar & Howe, 2021)[19]. EPs can use consultation to discuss and

[18] Edbrooke-Childs, J., & Patalay, P. (2019). Ethnic Differences in Referral Routes to Youth Mental Health Services. *Journal of the American Academy of Child & Adolescent Psychiatry*, *58*, 368-375.e1.

[19] Sangar, M., & Howe, J. (2021). How discourses of sharam (shame) and mental health influence the help-seeking behaviours of British born girls of South Asian heritage. *Educational Psychology in Practice*, *37*(4), 343–361.

question schools' approach to certain behaviours when working with those from SA backgrounds to ensure they are able to access the correct support.

Importantly, cultural awareness is necessary to ensure negative discourses surrounding families and communities are challenged. This research will be looking to emphasise the importance of understanding cultural differences around MH and offer awareness to those working with ethnic minorities. Linked to this, the growing practice around anti racist work within organisations could also be one of the key reasons as to why this research is important. When speaking on anti-racist practice it can become very binary and not all races are considered when discussing the barriers faced by those in marginalised groups in relation to race and ethnicity.

Finally, it is hoped that this research can allow for systemic work in schools, such a whole school approaches that could possibly encourage safe spaces, same us of language around mental health, remove stigma around MH needs and uncover myths around metal health needs and the systems involved with helping those with MH needs.

14. Provide an outline of any measures you have in place in the event of adverse or unexpected outcomes and the potential impact this may have on participants involved in the proposed research. (Do not exceed 300 words)

The researcher will ensure that all adverse or unforeseen problems arising from the research project are reported in a timely fashion to the Tavistock Ethics Committees.

The researcher will be aware of relevant Pastoral and Safeguarding leads in each of the schools where the participants attend. The participant will be made aware at the start of the interview that this person is available for them should they wish to contact them after the interview process. If a participant becomes distressed during the course of the interview, the researcher will end the interview immediately and request that contact is

made with the identified key person. The researcher will offer to talk with the participant and the key person to ensure that the young person is supported. In the event of an interview being terminated due to participant's distress, the researcher will contact the key Pastoral lead at the school the following day to monitor the participants' wellbeing. The researcher will also contact the school after one week to monitor the participant's wellbeing. If concerns with regards to the participant's distress continue the researcher will signpost to an appropriate service
e.g., CAMHS.

The researcher will leave a contact e-mail address with the key person in school and with participants over the age of 16. If a young person continues to be distressed as a result of taking part in the interview, the researcher will offer a further meeting with the young person and familiar adult to discuss. All young people who take part in the study will receive an information sheet with the researcher's contact details and other support services that they can access.

The safeguarding/disclosure procedures are as follows:

a) The Researcher will stop the young person and explain that she is concerned about what they are telling her and we will need to raise this with someone who is able to help at their school.

b) The researcher will listen to the young person's disclosure and ensure that they record as much information as they can.

c) Researcher will not offer any advice to the young person involved but will take a sympathetic and understanding stance.

d) The school safeguarding lead will be informed of the disclosure; the disclosure will be recorded both at school and in project records.

e) School safeguarding leads will be expected to take appropriate action.

The Researcher working with young people has had a full DBS check.
In the debrief stage, the researcher will ensure that participants are aware that support for any sensitive issues covered during the interview is available if needed and will direct them towards these resources. The resources include helplines to contact when a participant needs more urgent or personalised advice and support, alongside signposting to online resources for more generalised advice on a topic.

See answer to question 12 for additional safeguarding measures in place.

15. Provide an outline of your debriefing, support and feedback protocol for participants involved in the proposed research. This should include, for example, where participants may feel the need to discuss thoughts or feelings brought about following their participation in the research. This may involve referral to an external support or counseling service, where participation in the research has caused specific issues for participants.

Participants will be debriefed after the interviews and will have the opportunity to ask the researcher any questions they may have.

Participants will be informed with regards to confidentiality and anonymity. The semi structured questions used in the interview will not directly ask young people to disclose information about home-life or concerns for their wellbeing. The participant information sheet clearly explains that all the information that the young people share with researcher is strictly confidential and private unless they disclose anything of concern, in which case we will need to act on this.

In the debrief stage, the researcher will ensure that participants are aware that support for any sensitive issues covered during the interview is available if needed and will direct them towards these resources. The resources include helplines to contact when a participant needs more urgent or personalised advice and support, alongside signposting to online resources for more generalised advice on a topic.

In line with good practice guidelines following the interview, each participant will receive an information sheet with an e-mail address to contact the researcher and the contact details of supporting services will be given to participants at the end of each interview (see appendix).

A summary of the main findings of the research will be offered to participants after the research is completed.

16. Please provide the names and nature of any external support or counselling organisations that will be suggested to participants if participation in the research has potential to raise specific issues for participants.

The following signposting information will be included and relayed in the debrief to participants:

<u>Helplines and support</u>

1 in 4 people will experience difficulties with their mental health or wellbeing at some point during their life. Sometimes we may need a little help or support to help us through more difficult times.

Below are the contact details of some places where you can find information and support should you feel you need some help.

For immediate support please contact one of the following 24 hour services:

SAMARITANS: 116 123 / www.samaritans.org

CHILDLINE: 0800 1111 / www.childline.org.uk

Shout 85258 a free, confidential, 24/7 text messaging support service for anyone who is struggling to cope

To find services local to you, visit:

[redacted]

Information will also be included for the Pastoral Lead of the school the young person attends.

17. Where medical aftercare may be necessary, this should include details of the treatment available to participants. Debriefing may involve the disclosure of further information on the aims of the research, the participant's performance and/or the results of the research. (Do not exceed 500 words)

N/A

FOR RESEARCH UNDERTAKEN OUTSIDE THE UK

18. Does the proposed research involve travel outside of the UK?

☐ **YES** ☒ **NO**

If YES, please confirm:

☐ I have consulted the Foreign and Commonwealth Office website for guidance/travel advice? http://www.fco.gov.uk/en/travel-and-living-abroad/

☐ I have completed ta RISK Assessment covering all aspects of the project including consideration of the location of the data collection and risks to participants.

All overseas project data collection will need approval from the Deputy Director of Education and Training or their nominee. Normally this will be done based on the information provided in this form. All projects approved through the TREC process will be indemnified by the Trust against claims made by third parties.

If you have any queries regarding research outside the UK, please contact academicquality@tavi-port.nhs.uk:

Students are required to arrange their own travel and medical insurance to cover project work outside of the UK. Please indicate what insurance cover you have or will have in place.

19. Please evidence how compliance with all local research ethics and research governance requirements have been assessed for the country(ies) in which the research is taking place. Please also clarify how the requirements will be met:

SECTION G: PARTICIPANT CONSENT AND WITHDRAWAL

20. Have you attached a copy of your participant information sheet (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. **YES ☒ NO ☐** If **NO**, please indicate what alternative arrangements are in place below:
21. Have you attached a copy of your participant consent form (this should be in *plain English*)? Where the research involves non-English speaking participants, please include translated materials. **YES ☒ NO ☐** If **NO**, please indicate what alternative arrangements are in place below:
22. The following is a participant information sheet checklist covering the various points that should be included in this document.

☒ Clear identification of the Trust as the sponsor for the research, the project title, the Researcher and Principal Investigator (your Research Supervisor) and other researchers along with relevant contact details.

☒ Details of what involvement in the proposed research will require (e.g., participation in interviews, completion of questionnaire, audio/video-recording of events), estimated time commitment and any risks involved.

☒ A statement confirming that the research has received formal approval from TREC or other ethics body.

☒ If the sample size is small, advice to participants that this may have implications for confidentiality / anonymity.

☐ A clear statement that where participants are in a dependent relationship with any of the researchers that participation in the research will have no impact on assessment / treatment / service-use or support.

☒ Assurance that involvement in the project is voluntary and that participants are free to withdraw consent at any time, and to withdraw any unprocessed data previously supplied.

☒ Advice as to arrangements to be made to protect confidentiality of data, including that confidentiality of information provided is subject to legal limitations.

☒ A statement that the data generated in the course of the research will be retained in accordance with the Trusts ’s Data Protection and handling Policies.: https://tavistockandportman.nhs.uk/about-us/governance/policies-and-procedures/

☒ Advice that if participants have any concerns about the conduct of the investigator, researcher(s) or any other aspect of this research project, they should contact Simon Carrington, Head of Academic Governance and Quality Assurance (academicquality@tavi-port.nhs.uk)

☒ Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

23. The following is a <u>consent form</u> checklist covering the various points that should be included in this document.

☒ Trust letterhead or logo.

☒ Title of the project (with research degree projects this need not necessarily be the title of the thesis) and names of investigators.

☒ Confirmation that the research project is part of a degree

☒ Confirmation that involvement in the project is voluntary and that participants are free to withdraw at any time, or to withdraw any unprocessed data previously supplied.

☒ Confirmation of particular requirements of participants, including for example whether interviews are to be audio-/video-recorded, whether anonymised quotes will be used in publications advice of legal limitations to data confidentiality.

☒ If the sample size is small, confirmation that this may have implications for anonymity any other relevant information.

☒ The proposed method of publication or dissemination of the research findings.

☐ Details of any external contractors or partner institutions involved in the research.

☐ Details of any funding bodies or research councils supporting the research.

☒ Confirmation on any limitations in confidentiality where disclosure of imminent harm to self and/or others may occur.

SECTION H: CONFIDENTIALITY AND ANONYMITY

24. Below is a checklist covering key points relating to the confidentiality and anonymity of participants. Please indicate where relevant to the proposed research.

☐ Participants will be completely anonymised and their identity will not be known by the investigator or researcher(s) (i.e. the participants are part of an anonymous randomised sample and return responses with no form of personal identification)?

☐ The responses are anonymised or are an anonymised sample (i.e. a permanent process of coding has been carried out whereby direct and indirect identifiers have been removed from data and replaced by a code, with no record retained of how the code relates to the identifiers).

☒ The samples and data are de-identified (i.e. direct and indirect identifiers have been removed and replaced by a code. The investigator or researchers are able to link the code to the original identifiers and isolate the participant to whom the sample or data relates).

☐ Participants have the option of being identified in a publication that will arise from the research.

☒ Participants will be pseudo-anonymised in a publication that will arise from the research. (I.e. the researcher will endeavour to remove or alter details that would identify the participant.)

☐ The proposed research will make use of personal sensitive data.

☐ Participants consent to be identified in the study and subsequent dissemination of research findings and/or publication.

25. Participants must be made aware that the confidentiality of the information they provide is subject to legal limitations in data confidentiality (i.e. the data may be subject to a subpoena, a freedom of information request or mandated reporting by some professions). This only applies to named or de-identified data. If your

participants are named or de-identified, please confirm that you will specifically state these limitations.

YES ☒ **NO** ☐

If **NO**, please indicate why this is the case below:

NOTE: WHERE THE PROPOSED RESEARCH INVOLVES A SMALL SAMPLE OR FOCUS GROUP, PARTICIPANTS SHOULD BE ADVISED THAT THERE WILL BE DISTINCT LIMITATIONS IN THE LEVEL OF ANONYMITY THEY CAN BE AFFORDED.

SECTION I: DATA ACCESS, SECURITY AND MANAGEMENT

26. **Will the Researcher/Principal Investigator be responsible for the security of all data collected in connection with the proposed research? YES** ☒ **NO** ☐

If **NO**, please indicate what alternative arrangements are in place below:

27. In line with the 5th principle of the Data Protection Act (1998), which states that personal data shall not be kept for longer than is necessary for that purpose or those purposes for which it was collected; please state how long data will be retained for.

☐ 1-2 years ☐ 3-5 years ☒ 6-10 years ☐ 10> years

NOTE: In line with Research Councils UK (RCUK) guidance, doctoral project data should normally be stored for 10 years and Masters level data for up to 2 years

28. Below is a checklist which relates to the management, storage and secure destruction of data for the purposes of the proposed research. Please indicate where relevant to your proposed arrangements.

☐ Research data, codes and all identifying information to be kept in separate locked filing cabinets.

☒ Research data will only be stored in the University of Essex OneDrive system and no other cloud storage location.

☒ Access to computer files to be available to research team by password only.

☐ Access to computer files to be available to individuals outside the research team by password only (See **23.1**).

☒ Research data will be encrypted and transferred electronically within the UK.

☐ Research data will be encrypted and transferred electronically outside of the UK.

NOTE: Transfer of research data via third party commercial file sharing services, such as Google Docs and YouSendIt are not necessarily secure or permanent. These systems may also be located overseas and not covered by UK law. If the system is located outside

the European Economic Area (EEA) or territories deemed to have sufficient standards of data protection, transfer may also breach the Data Protection Act (1998).

Essex students also have access the 'Box' service for file transfer: https://www.essex.ac.uk/student/it-services/box

☒ Use of personal addresses, postcodes, faxes, e-mails or telephone numbers.

☐ Collection and storage of personal sensitive data (e.g. racial or ethnic origin, political or religious beliefs or physical or mental health or condition).

☒ Use of personal data in the form of audio or video recordings.

☒ Primary data gathered on encrypted mobile devices (i.e. laptops).

NOTE: This should be transferred to secure University of Essex OneDrive at the first opportunity.

☒ All electronic data will undergo secure disposal.

NOTE: For hard drives and magnetic storage devices (HDD or SSD), deleting files does not permanently erase the data on most systems, but only deletes the reference to the file. Files can be restored when deleted in this way. Research files must be overwritten to ensure they are completely irretrievable. Software is available for the secure erasing of files from hard drives which meet recognised standards to securely scramble sensitive data. Examples of this software are BC Wipe, Wipe File, DeleteOnClick and Eraser for Windows platforms. Mac users can use the standard 'secure empty trash' option; an alternative is Permanent eraser software.

☒ All hardcopy data will undergo secure disposal.

NOTE: For shredding research data stored in hardcopy (i.e. paper), adopting DIN 3 ensures files are cut into 2mm strips or confetti like cross-cut particles of 4x40mm. The UK government requires a minimum standard of DIN 4 for its material, which ensures cross cut particles of at least 2x15mm.

29. Please provide details of individuals outside the research team who will be given password protected access to encrypted data for the proposed research.

30. Please provide details on the regions and territories where research data will be electronically transferred that are external to the UK:

SECTION J: PUBLICATION AND DISSEMINATION OF RESEARCH FINDINGS

30. How will the results of the research be reported and disseminated? *(Select all that apply)*

- ☒ Peer reviewed journal
- ☐ Non-peer reviewed journal
- ☐ Peer reviewed books
- ☐ Publication in media, social media or website (including Podcasts and online videos)
- ☐ Conference presentation
- ☐ Internal report
- ☐ Promotional report and materials
- ☐ Reports compiled for or on behalf of external organisations
- ☒ Dissertation/Thesis
- ☐ Other publication
- ☒ Written feedback to research participants
- ☒ Presentation to participants or relevant community groups
- ☐ Other (Please specify below)

31.

SECTION K: OTHER ETHICAL ISSUES

32. Are there any other ethical issues that have not been addressed which you would wish to bring to the attention of Tavistock Research Ethics Committee (TREC)?
N/a

SECTION L: CHECKLIST FOR ATTACHED DOCUMENTS

33. Please check that the following documents are attached to your application.

- ☐ Letters of approval from any external ethical approval bodies (where relevant)
- ☒ Recruitment advertisement
- ☒ Participant information sheets (including easy-read where relevant)
- ☒ Consent forms (including easy-read where relevant)
- ☐ Assent form for children (where relevant)
- ☐ Letters of approval from locations for data collection
- ☐ Questionnaire
- ☒ Interview Schedule or topic guide
- ☐ Risk Assessment (where applicable)
- ☐ Overseas travel approval (where applicable)

35. Where it is not possible to attach the above materials, please provide an explanation below.

The Tavistock and Portman NHS
NHS Foundation Trust

Quality Assurance & Enhancement Directorate of Education & Training Tavistock Centre 120 Belsize Lane London NW3 5BA

Tel: 020 8938 2699

https://tavistockandportman.nhs.uk/

17 October 2023

Dear Ariffa,

Re: Trust Research Ethics Application

Title: 'What are the Perspectives of adolescents students of British Pakistani background in seeking support for Social, Emotional & Mental Health?'

Thank you for submitting your updated Research Ethics documentation. I am pleased to inform you that subject to formal ratification by the Trust Research Ethics Committee your application has been approved. This means you can proceed with your research.

Please be advised that any changes to the project design including changes to methodology/data collection etc, must be referred to TREC as failure to do so, may result in a report of academic and/or research misconduct.

If you have any further questions or require any clarification do not hesitate to contact me. I am copying this communication to your supervisor.

May I take this opportunity of wishing you every success with your research.

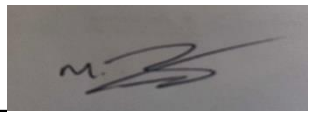
Yours sincerely,

Michael Franklyn

Academic Governance and Quality Officer T: 020 938 2699

E: academicquality@tavi-port.nhs.uk

cc. Course Lead, Supervisor, Research Lead



Appendix 4: Flyer & Email

Subject: FAO SENCO/ Headteacher

Dear

I am a year 3 Trainee Educational Psychologist placed in the [redacted] Educational Psychology Service and studying at the Tavistock and Portman clinic. As part of my Year 3 Doctoral research project I am hoping to conduct the following study:

What are the perspectives of adolescent students of British Pakistani background in seeking support for Social, Emotional & Mental Health?

Would it be possibly to set up a meeting with yourself to discuss the scope of this research and whether you will be in the future willing to share information about this study to relevant students.

Please do contact me for further information, once the research proposal has gained ethical approval from the Tavistock and Portman Ethics Committee, I will be able to share more detail information as well as information sheet and poster with you.

Kind Regards,

Ariffa Yaqoob
Trainee Educational Psychologist

Appendix 5: Information sheet & Consent form

Participant Information Sheet

The purpose of this letter is to provide you with the information that you need to decide whether to participate in this research study.

Title of the study:

Exploring the perspectives of adolescents of British Pakistani background in seeking support for Social, Emotional & Mental Health (SEMH) needs.

Who is doing the research?

My name is [redacted], and I am a Trainee Educational Psychologist. I am in my third year of studying for the Professional Doctorate in Child, Community and Educational Psychology. I am completing this research as part of my course.

The aim of the research:

What is the study about? The study is hoping to explore how British Pakistani teenagers seek support for emotional wellbeing. I am hoping to also explore the following.

- How does culture play a part in how you might ask or seek support?
- How does gender play a part in how you may ask or seek support?

Why am I doing this research? I am hoping that this research can help me and other professionals understand what may stop or encourage British Pakistani teenagers from seeking support when it comes to emotional wellbeing.

About you:

- You identify as British Pakistani
- You are between the ages of 16-18
- You are currently attending an educational provision in Sixth form or Post-16 educational provision
- You are fluent in speaking English

What does participation involve?

- Participating in an online interview of **up to one hour** with Ariffa Yaqoob on **Zoom** or **face-to-face** in a quiet meeting room at [redacted] The interview can take place in whichever council building is within your local area.

The interview will be recorded and then transcribed. The interview will involve you being asked about:

- Your views on social, emotional and mental wellbeing – what may help it or may be a barrier to it
- Your views of what help is available to support social, emotional and wellbeing needs and how useful this help is.

- Your views on the roles of culture (being British Pakistani) and gender (male or female) when it comes to seeking support for emotional wellbeing.

It is important to know that if you find responding to these areas emotionally difficult, you can stop the interview at any stage without giving an explanation.

Consent to participate in this research study:

Please take time to read the information carefully to decide whether you would like to participate. It is important that you understand the aims of the study and what it would involve for you.

If you choose to take part, you can change your mind at any time, and you do not need to explain the reasons for doing so. If you do participate, you can still withdraw from the study up to 3 weeks after the interview. After this, your data will be anonymised and analysed.

Confidentiality of the Data:

One of the aims of this research study is to share what young people have said about their views in relation to what may or may not help them to seek support for emotional wellbeing. I will be interviewing a small number of participants (6-8). I may use quotes from your interview to help describe your views in the publication of the study. For your confidentiality, what you say will be anonymised so that it cannot be linked to you. This means using a pseudonym (pretend name) when describing your views and changing any details that could identify that what was

said came from you. It is important to highlight that the sample size is small so may impact confidentiality/ anonymity if you share specific information.

Once your interview has been transcribed (written up), the audio/ video recording will be deleted, and the data will be stored as belonging to the pseudonym (pretend name), on an encrypted drive using password protection. All data collected will be stored for a minimum of 5 years and used in accordance with the UK Data Protection Act (2018) and the Tavistock and Portman's Data Protection Policy.

If you tell me something that makes me concerned about your safety or the safety of someone else, then I might have to share that information with someone else to ensure you or someone else is safe. However, I will aim to talk to you about this first where possible.

Further information:

This research has received ethical approval from the Tavistock and Portman Trust Research Ethics Committee. If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact: [redacted] pjeram@tavi-port.nhs.uk

If you have any further questions, you can contact me by email: [redacted] or my research supervisor, [redacted]

Consent form

Title of the study: Exploring the perspectives of adolescents of British Pakistani background in seeking support for Social, Emotional & Mental Health (SEMH) needs.

This research project is part of the Professional Doctorate in Child, Community and Educational Psychology degree.

Please read all the following statements (**please add initial in the box at the end of each statement)** and sign below if you agree:

- I have read and understood the research study information sheet leaflet (Version 2.0, October 2023)

- The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information.

- I understand that my data will be anonymised so that I cannot be linked to the data. I understand that the sample size is small.

- I understand that if there are concerns around my safety or safety of others, the researcher will have to share this information with relevant individuals (Safeguarding lead).

- I agree for my interview to be recorded and understand anonymised quotes from my interview may be used in publication.

- Only the researchers involved in the study will have access to the data.

- I understand the findings will be used for academic thesis and may be shared at professional conferences and in academic journal articles.

- I understand that I have the right to withdraw from the research study for up to 3 weeks after the interview, without being obliged to give any reason.

- I am willing to participate in this research

Participant's Name (BLOCK CAPITALS) .....

Participant's Signature .....

Researcher's Name (BLOCK CAPITALS) .....

Researcher's Signature .....

Date: .....

Appendix 6: Interview Schedule

Thank you for taking the time to participate in today's interview. As a reminder, we will be discussing your views on the barriers and facilitators related to seeking help for social and emotional wellbeing.

Before we begin, I'd like to confirm that I've received your consent form. Please review it and confirm that you are still willing to proceed with the interview. If at any point you wish to stop the interview or withdraw from the research, please let me know.

I will start the recording now.

1. What are your views on the state of emotional wellbeing amongst peers of your age?

2. What is available in your school/educational provision or community to help you if you had a concern about your emotional wellbeing?

2a. Sub question: have you ever accessed these?

2b. Sub question: if yes, how helpful were they?

2c. Sub question: if no, was there a reason you didn't seek these out?

2d. Sub question: what do you think might be more helpful when seeking support?

3. How would you describe your ethnic or cultural identity?

4. What role do you feel culture (that is, being of British Pakistani ethnicity) plays in seeking support for emotional wellbeing?

4a. What are your thoughts on the state of emotional wellbeing amongst your peers who share the same/different ethnicity as you?

5. What role do you feel gender plays in seeking support for emotional wellbeing?

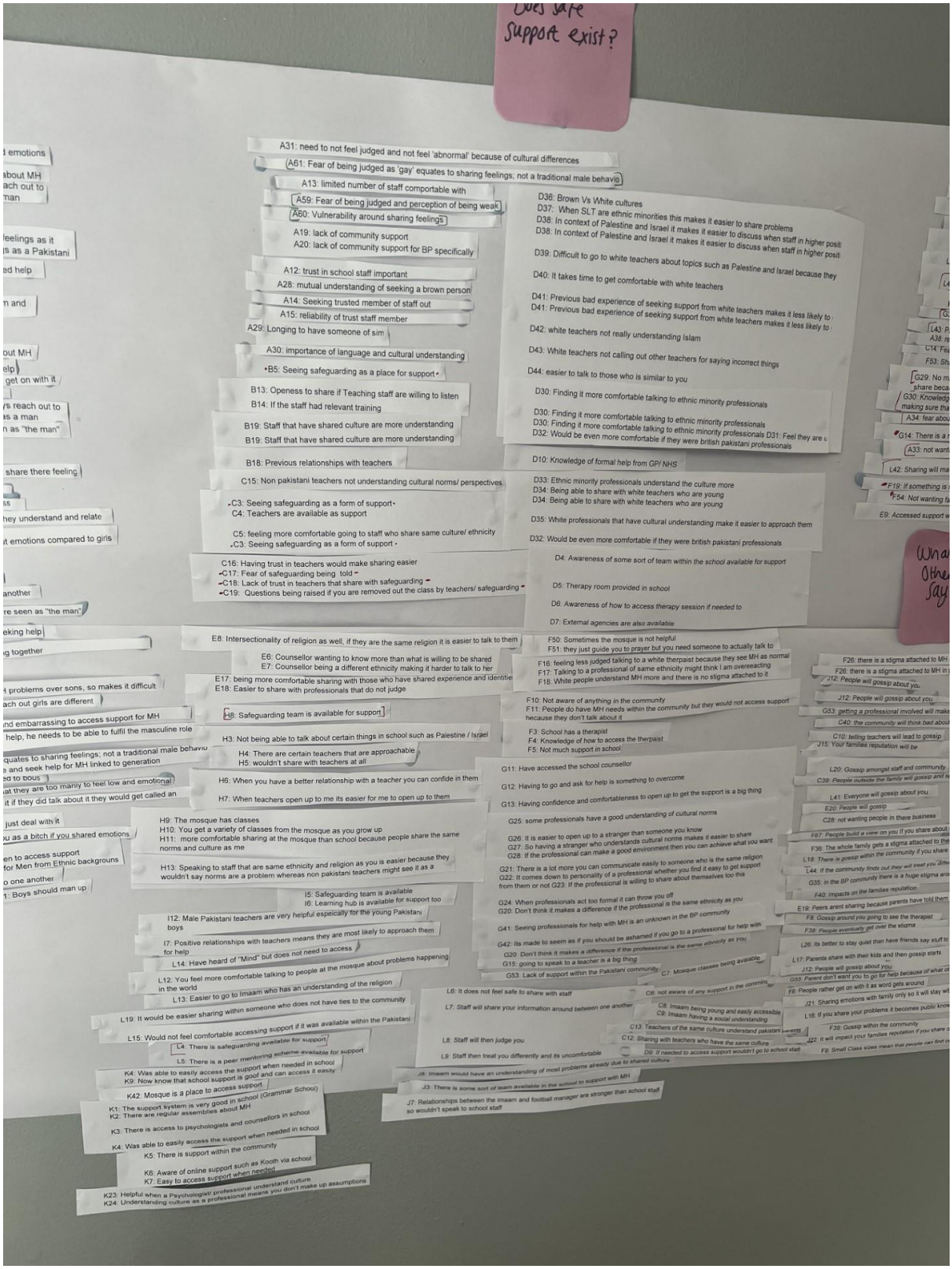
5a. What are your thoughts on the state of emotional wellbeing amongst your peers who share the same/different gender as you?

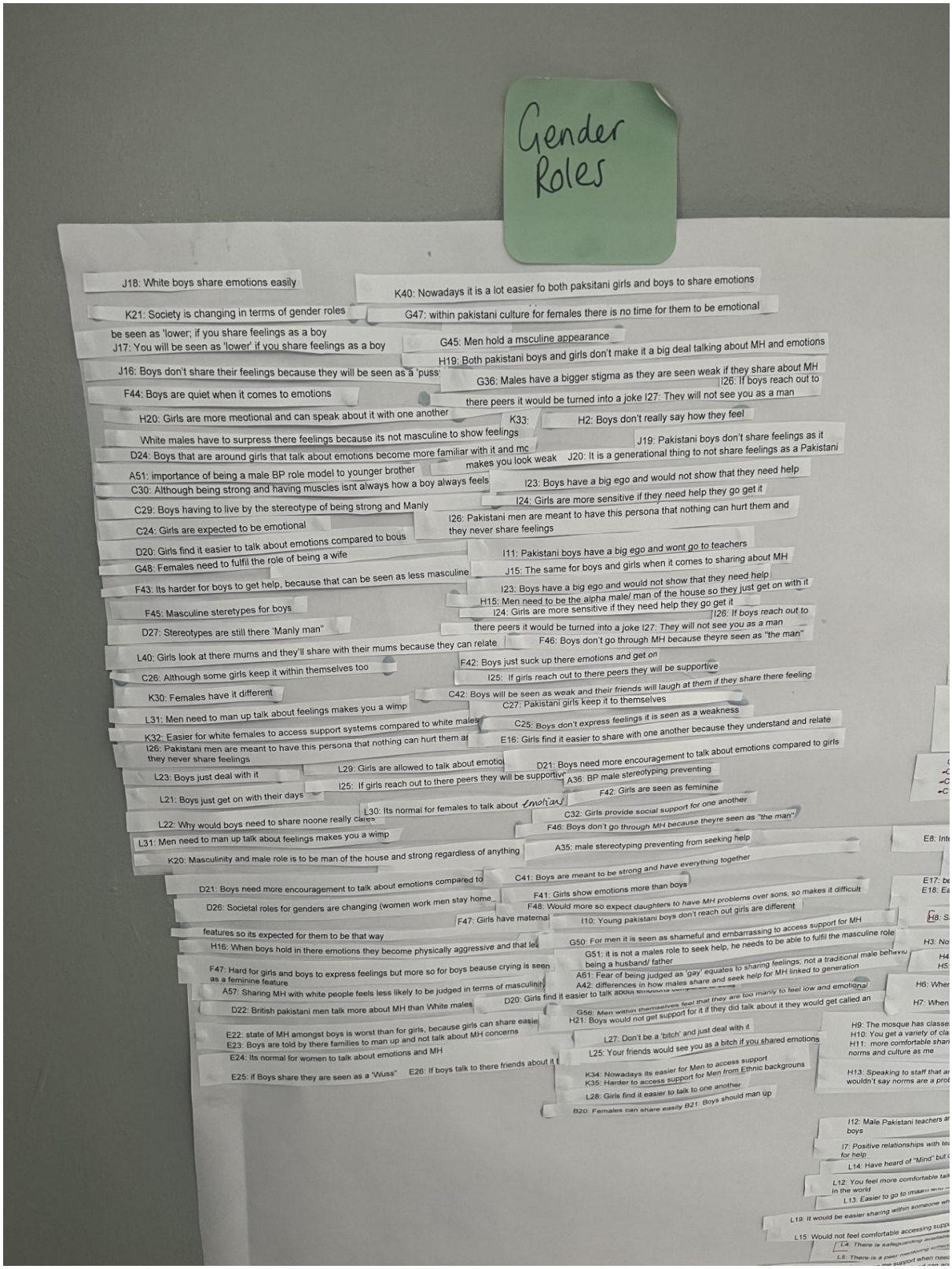
6. What role do you feel being a male/female (as applicable) as well as being of British Pakistani ethnicity has on seeking support for emotional wellbeing?

Appendix 7: Initial Coding

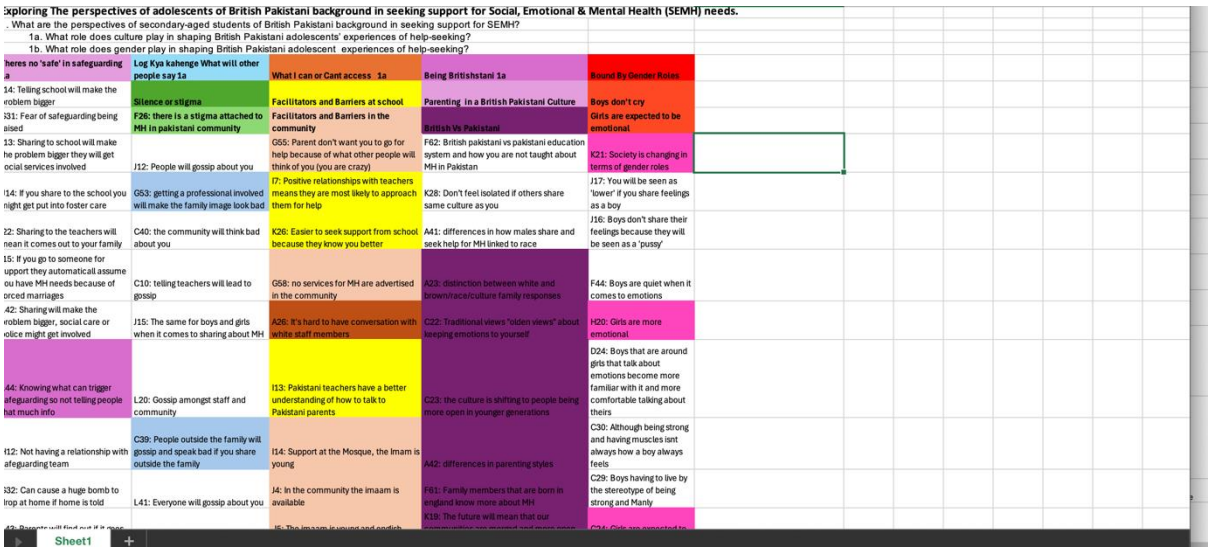
or support they utomaticall assume you ave MH needs because of orced marriages	J15: The same for boys and girls when it comes to sharing about MH	F6: Peers will begin to question why youre being pulled out of lessons	I13: Pakistani teachers have a better understanding of how to talk to Pakistani parents	K26: Easier to seek support from school because they know you better	C22: Traditional views "olden views" about keep	K36: Friends with traditional Pakistani parents find it harder to talk about emotions				
42: Sharing will make the roblem bigger, social care r police might get involved	L20: Gossip amongst staff and community	F68: Family would have a certain view on you so its better to just get and seek the advice for yourself	I14: Support at the Mosque, the Imam is young	L45: Stress doesn't last that long so its easier to just get over it	C23: the culture is shifting to people being mor	F57: Mum is from Pakistan				
44: Knowing what can rigger safeguarding so not elling people that much info	C39: People outside the family will gossip and speak bad if you share outside the family	J11: getting help from school makes you look like a 'pussy'	J4: In the community the imaam is availableg	I17: Pakistani People don't see MH as a thing, they think you are seeking attention	A42: differences in parenting styles	G40: Parents see it as an excuse to avoid work				
I12: Not having a elationship with afeguarding team	L41: Everyone will gossip about you	G17: People might see me as emoitonally unstable if they find out I am going to the counsellor	J5: The imaam is young and english speakin	L24: You just move on from your problems and get over it	F61: Family members that are born in england know more about MH	D18: Parents born in pakistan are less likely to talk about it VS Parents born in Britain				
32: Can cause a huge omb to drop at home if ome is told	E20: People will gossip	F66: I don't want people to view me any different	J6: We can speak to him about anything e.g Palestine	B3: not sharing problems/ emotions B4: Keeping it inside	K19: The future will mean that our communities are merged and more open minded	A44: father not understanding of MH problems				
43: Parents will find out if it oes to safeguarding	C28: not wanting people in there business	people will create a perception about you	E5: Counsellor is available but seen as not good	A2: keeping problems out of school /not sharing	K21: Society is changing in terms of gender roles	F27: Pakistani parents know the concept of MH				
38: reinforcing narratives bout not sharing problems	F67: People build a view on you If you share about MH		A31: need to not feel judged and not feel 'abnormal' because of cultural differences	F56: Rather get through it myself than have family know	K22: Pakistani Culture is adapting as we move to different countries	F58: Mum was educated about MH by myself and siblings				
C14: Fear of non pakistani eachers alerting afeguarding	F36: The whole family gets a stigma attached to them		B15: Teachers wanting to know more than what is wanted to be shared seen as a detterent	K27: When your school is ethnically diverse it makes it easier to go to speak to people	A47: awareness of different cultural norms (BP	F56: Pakistani paretns do not refer there children to therapist				
53: Sharing a certain mount of information to revent safeguarding	L18: There is gossip within the community if you share		G1: Emotions are hidden but we can be open with teachers if necessary	G39: there is a lot of lack of education around MH in the BP community	A46: parents raised in different countries and d	L34: Pakistani parents are supportive in terms of grades not emotions				
29: No matter how good our relationship is with a eacher there is a limit to what you share because of afeguarding potentially eing raised	L44: Knowing what can trigger safeguarding so not telling people that much info		A27: hard to approach/seek help from white staff member	K18: Can be hard for pakistanis to emigrate here due to racism	I20: Non pakistanis are more open to there families about feelings	K16: Parents from pakistan can be pressuring				
30: Knowledge of what ypes of information you hare can trigger afeguarding and making ure that you do not share hem to avoid safeguarding oncerns being raised	G35: in the BP community there is a huge stigma around MH		L11: Teachers privately ask you about stuff like grades but not about emotions	F34: Noone in the community provides support	A21: different levels of comfort based on race/c	G16: Parents were unaware of the support I was accessing from the counsellor				
34: fear about epercussions of sharing	F40: Impacts on the families reputation		H17: It easier to speak to staff that are the same ethnicity as you	B10: being a burden if you share with other people	A22: distinction between white and brown	G17: If my mum knew I was accessing the counsellor she would have felt she wasn't enou				
14: There is a risk when ou ask for help that afeguarding may be alerted	E19: Peers arent sharing because parents have told them not too because they don't want other people finding out		L19: Nothing is actually private and confidential even if you sign forms.	L33: Its better to keep quiet than to share with parents	A23: distinction between white and brown/race	A49: diminishing his problems in comparison to his father's generation				

Appendix 8: Themes


Does safe support exist?
A31: need to not feel judged and not feel 'abnormal' because of cultural differences
A61: Fear of being judged as 'gay' equates to sharing feelings; not a traditional male behavio
A13: limited number of staff comportable with
A59: Fear of being judged and perception of being weak
A60: Vulnerability around sharing feelings
A19: lack of community support
A20: lack of community support for BP specifically
A12: trust in school staff important
A28: mutual understanding of seeking a brown person
A14: Seeking trusted member of staff out
A15: reliability of trust staff member
A29: Longing to have someone of sim
A30: importance of language and cultural understanding
B5: Seeing safeguarding as a place for support
B13: Openess to share if Teaching staff are willing to listen
B14: If the staff had relevant training
B19: Staff that have shared culture are more understanding
B19: Staff that have shared culture are more understanding
B18: Previous relationships with teachers
C15: Non pakistani teachers not understanding cultural norms/ perspectives
C3: Seeing safeguarding as a form of support
C4: Teachers are available as support
C5: feeling more comfortable going to staff who share same culture/ ethnicity
C3: Seeing safeguarding as a form of support
C16: Having trust in teachers would make sharing easier
C17: Fear of safeguarding being told
C18: Lack of trust in teachers that share with safeguarding
C19: Questions being raised if you are removed out the class by teachers/ safeguarding
E8: Intersectionality of religion as well, if they are the same religion it is easier to talk to them
E6: Counsellor wanting to know more than what is willing to be shared
E7: Counsellor being a different ethnicity making it harder to talk to her
E17: being more comfortable sharing with those who have shared experience and identitie
E18: Easier to share with professionals that do not judge
H8: Safeguarding team is available for support
H3: Not being able to talk about certain things in school such as Palestine / Israel
H4: There are certain teachers that are approachable
H5: wouldn't share with teachers at all
H6: When you have a better relationship with a teacher you can confide in them
H7: When teachers open up to me its easier for me to open up to them
H9: The mosque has classes
H10: You get a variety of classes from the mosque as you grow up
H11: more comfortable sharing at the mosque than school because people share the same norms and culture as me
H13: Speaking to staff that are same ethnicity and religion as you is easier because they wouldn't say norms are a problem whereas non pakistani teachers might see it as a
I5: Safeguarding team is available
I6: Learning hub is available for support too
I12: Male Pakistani teachers are very helpful especially for the young Pakistani boys
I7: Positive relationships with teachers means they are most likely to approach them for help
L14: Have heard of "Mind" but does not need to access
L12: You feel more comfortable talking to people at the mosque about problems happening in the world
L13: Easier to go to Imaam who has an understanding of the religion
L19: It would be easier sharing within someone who does not have ties to the community
L15: Would not feel comfortable accessing support if it was available within the Pakistani
L4: There is safeguarding available for support
L5: There is a peer mentoring scheme available for support
K4: Was able to easily access the support when needed in school
K9: Now know that school support is good and can access it easily
K42: Mosque is a place to access support
K1: The support system is very good in school (Grammar School)
K2: There are regular assemblies about MH
K3: There is access to psychologists and counsellors in school
K4: Was able to easily access the support when needed in school
K5: There is support within the community
K6: Aware of online support such as Kooth via school
K7: Easy to access support when needed
K23: Helpful when a Psychologist/ professional understand culture
K24: Understanding culture as a professional means you don't make up assumptions
D36: Brown Vs White cultures
D37: When SLT are ethnic minorities this makes it easier to share problems
D38: In context of Palestine and Israel it makes it easier to discuss when staff in higher positi
D38: In context of Palestine and Israel it makes it easier to discuss when staff in higher positi
D39: Difficult to go to white teachers about topics such as Palestine and Israel because they
D40: It takes time to get comfortable with white teachers
D41: Previous bad experience of seeking support from white teachers makes it less likely to
D41: Previous bad experience of seeking support from white teachers makes it less likely to
D42: white teachers not really understanding Islam
D43: White teachers not calling out other teachers for saying incorrect things
D44: easier to talk to those who is similar to you
D30: Finding it more comfortable talking to ethnic minority professionals
D30: Finding it more comfortable talking to ethnic minority professionals
D30: Finding it more comfortable talking to ethnic minority professionals D31: Feel they are u
D32: Would be even more comfortable if they were british pakistani professionals
D10: Knowledge of formal help from GP/ NHS
D33: Ethnic minority professionals understand the culture more
D34: Being able to share with white teachers who are young
D34: Being able to share with white teachers who are young
D35: White professionals that have cultural understanding make it easier to approach them
D32: Would be even more comfortable if they were british pakistani professionals
D4: Awareness of some sort of team within the school available for support
D5: Therapy room provided in school
D6: Awareness of how to access therapy session if needed to
D7: External agencies are also available
F50: Sometimes the mosque is not helpful
F51: they just guide you to prayer but you need someone to actually talk to
F16: feeling less judged talking to a white therpaist because they see MH as normal
F17: Talking to a professional of same ethnicity might think I am overreacting
F18: White people understand MH more and there is no stigma attached to it
F10: Not aware of anything in the community
F11: People do have MH needs within the community but they would not access support because they don't talk about it
F3: School has a therapist
F4: Knowledge of how to access the therpaist
F5: Not much support in school
G11: Have accessed the school counsellor
G12: Having to go and ask for help is something to overcome
G13: Having confidence and comfortableness to open up to get the support is a big thing
G25: some professionals have a good understanding of cultural norms
G26: It is easier to open up to a stranger than someone you know
G27: So having a stranger who understands cultural norms makes it easier to share
G28: If the professional can make a good environment then you can achieve what you want
G21: There is a lot more you can communicate easily to someone who is the same religion
G22: It comes down to personality of a professional whether you find it easy to get support from them or not G23: If the professional is willing to share about themselves too this
G24: When professionals act too formal it can throw you off
G20: Don't think it makes a difference if the professional is the same ethnicity as you
G41: Seeing professionals for help with MH is an unknown in the BP community
G42: Its made to seem as if you should be ashamed if you go to a professional for help with
G20: Don't think it makes a difference if the professional is the same ethnicity as you
G15: going to speak to a teacher is a big thing
G53: Lack of support within the Pakistani community
C7: Mosque classes being available
C8: not aware of any support in the community
L6: It does not feel safe to share with staff
L7: Staff will share your information around between one another
C8: Imaam being young and easily accessible
C9: Imaam having a social understanding
C13: Teachers of the same culture understand pakistani parents
C12: Sharing with teachers who have the same culture
D9: If needed to access support wouldn't go to school staff
L8: Staff will then judge you
L9: Staff then treat you differently and its uncomfortable
J8: Imaam would have an understanding of most problems already due to shared culture
J3: There is some sort of team available in the school to support with MH
J7: Relationships between the imaam and football manager are stronger than school staff
so wouldn't speak to school staff
F26: there is a stigma attached to MH
F26: there is a stigma attached to MH in
J12: People will gossip about you
J12: People will gossip about you
G53: getting a professional involved will make
C40: the community will think bad about
C10: telling teachers will lead to gossip
J15: Your families reputation will be
L20: Gossip amongst staff and community
C39: People outside the family will gossip and
L41: Everyone will gossip about you
E20: People will gossip
C28: not wanting people in there business
F8?: People build a view on you if you share about
F36: The whole family gets a stigma attached to the
L18: There is gossip within the community if you share
L44: If the community finds out they will treat you differ
G35: In the BP community there is a huge stigma arou
F40: Impacts on the families reputation
E19: Peers arent sharing because parents have told them
F8: Gossip around you going to see the therapist
F38: People eventually get over the stigma
L26: Its better to stay quiet than have friends say stuff to
L17: Parents share with their kids and then gossip starts
J12: People will gossip about you
G55: Parent don't want you to go for help because of what o
F6: People rather get on with it as word gets around
J21: Sharing emotions with family only so it will stay wi
L16: If you share your problems it becomes public know
F39: Gossip within the community
J22: It will impact your families reputation if you share o
F9: Small Class sizes mean that people can find o
What Other Say
emotions
about MH
ach out to
man
feelings as it
ls as a Pakistani
ed help
n and
out MH
elp
get on with it
's reach out to
as a man
n as "the man"
share there feeling
ss
hey understand and relate
t emotions compared to girls
another
re seen as "the man"
eking help
g together
problems over sons, so makes it difficult
ach out girls are different
nd embarrassing to access support for MH
help, he needs to be able to fulfil the masculine role
quates to sharing feelings; not a traditional male behaviu
e and seek help for MH linked to generation
ed to bous
at they are too manly to feel low and emotional
t if they did talk about it they would get called an
just deal with it
u as a bitch if you shared emotions
en to access support
for Men from Ethnic backgrouns
o one another
1: Boys should man up


Gender Roles
J18: White boys share emotions easily
K40: Nowadays it is a lot easier fo both paksitani girls and boys to share emotions
K21: Society is changing in terms of gender roles
G47: within pakistani culture for females there is no time for them to be emotional
be seen as 'lower; if you share feelings as a boy
J17: You will be seen as 'lower' if you share feelings as a boy
G45: Men hold a msculine appearance
H19: Both pakistani boys and girls don't make it a big deal talking about MH and emotions
J16: Boys don't share their feelings because they will be seen as a 'puss'
G36: Males have a bigger stigma as they are seen weak if they share about MH
I26: If boys reach out to
F44: Boys are quiet when it comes to emotions
there peers it would be turned into a joke I27: They will not see you as a man
H20: Girls are more meotional and can speak about it with one another
K33:
H2: Boys don't really say how they feel
White males have to surpress there feelings because its not masculine to show feelings
D24: Boys that are around girls that talk about emotions become more familiar with it and mc
J19: Pakistani boys don't share feelings as it
A51: importance of being a male BP role model to younger brother
makes you look weak
J20: It is a generational thing to not share feelings as a Pakistani
C30: Although being strong and having muscles isnt always how a boy always feels
I23: Boys have a big ego and would not show that they need help
C29: Boys having to live by the stereotype of being strong and Manly
I24: Girls are more sensitive if they need help they go get it
C24: Girls are expected to be emotional
I26: Pakistani men are meant to have this persona that nothing can hurt them and they never share feelings
D20: Girls find it easier to talk about emotions compared to bous
G48: Females need to fulfil the role of being a wife
I11: Pakistani boys have a big ego and wont go to teachers
F43: Its harder for boys to get help, because that can be seen as less masculine
J15: The same for boys and girls when it comes to sharing about MH
I23: Boys have a big ego and would not show that they need help
F45: Masculine steretypes for boys
H15: Men need to be the alpha male/ man of the house so they just get on with it
I24: Girls are more sensitive if they need help they go get it
I26: If boys reach out to
D27: Stereotypes are still there 'Manly man"
there peers it would be turned into a joke I27: They will not see you as a man
L40: Girls look at there mums and they'll share with their mums because they can relate
F46: Boys don't go through MH because theyre seen as "the man"
C26: Although some girls keep it within themselves too
F42: Boys just suck up there emotions and get on
I25: If girls reach out to there peers they will be supportive
K30: Females have it different
C42: Boys will be seen as weak and their friends will laugh at them if they share there feeling
L31: Men need to man up talk about feelings makes you a wimp
C27: Pakistani girls keep it to themselves
K32: Easier for white females to access support systems compared to white males
C25: Boys don't express feelings it is seen as a weakness
I26: Pakistani men are meant to have this persona that nothing can hurt them a
E16: Girls find it easier to share with one another because they understand and relate
they never share feelings
L23: Boys just deal with it
L29: Girls are allowed to talk about emotio
D21: Boys need more encouragement to talk about emotions compared to girls
L21: Boys just get on with their days
I25: If girls reach out to there peers they will be supportive
A36: BP male stereotyping preventing
F42: Girls are seen as feminine
L22: Why would boys need to share noone really cares
L30: Its normal for females to talk about emotions
C32: Girls provide social support for one another
L31: Men need to man up talk about feelings makes you a wimp
F46: Boys don't go through MH because theyre seen as "the man"
K20: Masculinity and male role is to be man of the house and strong regardless of anything
A35: male stereotyping preventing from seeking help
D21: Boys need more encouragement to talk about emotions compared to
C41: Boys are meant to be strong and have everything together
F41: Girls show emotions more than boys
D26: Societal roles for genders are changing (women work men stay home
F48: Would more so expect daughters to have MH problems over sons, so makes it difficult
F47: Girls have maternal
I10: Young pakistani boys don't reach out girls are different
features so its expected for them to be that way
H16: When boys hold in there emotions they become physically aggressive and that lea
G50: For men it is seen as shameful and embarrassing to access support for MH
G51: it is not a males role to seek help, he needs to be able to fulfil the masculine role being a husband/ father
F47: Hard for girls and boys to express feelings but more so for boys beause crying is seen as a feminine feature
A61: Fear of being judged as 'gay' equates to sharing feelings; not a traditional male behaviu
A42: differences in how males share and seek help for MH linked to generation
A57: Sharing MH with white people feels less likely to be judged in terms of masculinity
D20: Girls find it easier to talk about emotions
G56: Men within themselves feel that they are too manly to feel low and emotional
D22: British pakistani men talk more about MH than White males
H21: Boys would not get support for it if they did talk about it they would get called an
E22: state of MH amongst boys is worst than for girls, because girls can share easie
E23: Boys are told by there families to man up and not talk about MH concerns
L27: Don't be a 'bitch' and just deal with it
L25: Your friends would see you as a bitch if you shared emotions
E24: its normal for women to talk about emotions and MH
K34: Nowadays its easier for Men to access support
K35: Harder to access support for Men from Ethnic backgrouns
E25: if Boys share they are seen as a "Wuss"
E26: If boys talk to there friends about it
L28: Girls find it easier to talk to one another
B20: Females can share easily B21: Boys should man up
H9: The mosque has classes
H10: You get a variety of cla
H11: more comfortable shar
norms and culture as me
H13: Speaking to staff that ar
wouldn't say norms are a prob
I12: Male Pakistani teachers ar
boys
I7: Positive relationships with tea
for help
L14: Have heard of "Mind" but
L12: You feel more comfortable tal
in the world
L13: Easier to go to imaam
L19: It would be easier sharing within someone
L15: Would not feel comfortable accessing
L4: There is safeguarding
L5: There is a peer mentoring

Appendix 9 – Reviewed Themes



Exploring The perspectives of adolescents of British Pakistani background in seeking support for Social, Emotional & Mental Health (SEMH) needs.
. What are the perspectives of secondary-aged students of British Pakistani background in seeking support for SEMH?
1a. What role does culture play in shaping British Pakistani adolescents' experiences of help-seeking?
1b. What role does gender play in shaping British Pakistani adolescent experiences of help-seeking?

heres no 'safe' in safeguarding a	Log Kya kahenge What will other people say 1a	What I can or Cant access 1a	Being Britishstani 1a	Bound By Gender Roles
14: Telling school will make the roblem bigger	Silence or stigma	Facilitators and Barriers at school	Parenting in a British Pakistani Culture	Boys don't cry
31: Fear of safeguarding being aised	F26: there is a stigma attached to MH in pakistani community	Facilitators and Barriers in the community	British Vs Pakistani	Girls are expected to be emotional
13: Sharing to school will make he problem bigger they will get ocial services involved	J12: People will gossip about you	G55: Parent don't want you to go for help because of what other people will think of you (you are crazy)	F62: British pakistani vs pakistani education system and how you are not taught about MH in Pakistan	K21: Society is changing in terms of gender roles
14: If you share to the school you night get put into foster care	G53: getting a professional involved will make the family image look bad	I7: Positive relationships with teachers means they are most likely to approach them for help	K28: Don't feel isolated if others share same culture as you	J17: You will be seen as 'lower' if you share feelings as a boy
22: Sharing to the teachers will nean it comes out to your family	C40: the community will think bad about you	K26: Easier to seek support from school because they know you better	A41: differences in how males share and seek help for MH linked to race	J16: Boys don't share their feelings because they will be seen as a 'pussy'
15: If you go to someone for upport they automaticall assume ou have MH needs because of orced marriages	C10: telling teachers will lead to gossip	G58: no services for MH are advertised in the community	A23: distinction between white and brown/race/culture family responses	F44: Boys are quiet when it comes to emotions
42: Sharing will make the roblem bigger, social care or olice might get involved	J15: The same for boys and girls when it comes to sharing about MH	A26: It's hard to have conversation with white staff members	C22: Traditional views "olden views" about keeping emotions to yourself	H20: Girls are more emotional
44: Knowing what can trigger afeguarding so not telling people hat much info	L20: Gossip amongst staff and community	I13: Pakistani teachers have a better understanding of how to talk to Pakistani parents	C23: the culture is shifting to people being more open in younger generations	D24: Boys that are around girls that talk about emotions become more familiar with it and more comfortable talking about theirs
12: Not having a relationship with afeguarding team	C39: People outside the family will gossip and speak bad if you share outside the family	I14: Support at the Mosque, the Imam is young	A42: differences in parenting styles	C30: Although being strong and having muscles isnt always how a boy always feels
32: Can cause a huge bomb to lrop at home if home is told	L41: Everyone will gossip about you	J4: In the community the imaam is available	F61: Family members that are born in england know more about MH	C29: Boys having to live by the stereotype of being strong and Manly
			K19: The future will mean that our	

Sheet1

Appendix 10: Supervision Note reflections

map

As youre writing think about themes and sub themes and think does it fit or can it fit somewhere else better – rename

Move Role model sub theme in to Gender roles

What will other people say 1a	People will have a certain perception about you 1a

Merge these two themes

Cultural Identity = (White Vs Brown, British Vs Paksitani Old Gen Vs New Gen)	Parenting in a British Pakistani Culture

Merge these together

- **Too white for the brown kids and too brown for the white kids**

- **Im too...**
- **Think of the theme name**
- **Where do I fit**
- **Conflict in dual nationality – youre not one or the other but you want to be accepted by both and where do I fit**
- **Gender steretypes are as pervasive in BP culture and maybe even stronger in Pakistani culture**
-

REMIND YOURSELF OF INTRO AND LIT REVIEW BEFORE DOING DISCUSSION

6 themes altogether not 8

With discussion – start off with my perspective

Appendix 11: Reflective diary Excerpts

- Brown Vs White Culture → Why is this triggering?
  - How can be mixed identities
  - So hard for people to understand the full extent
    - Still get this as an adult. Like if you're not experienced it you won't get it.
- Brown Cultural norms might trigger safeguarding
  - Even when I owned as a teacher I was shocked by what teachers referred to as safeguarding because that was just normal to me.
- You have to look perfect for the community
  - Literally my life growing up.

→ Breaking norms caused so many issues — is it worth it?

Reflections.

British

Pakistani

"free"

no one cares

less boundaries.

Could be seen as bad to be seen with too many British views

Traditional views

vs

New generation.

Stigma

difficult to tell anyone outside the family

Others will gossip

Shame

Easier to Share

Will feel to help it yourself

feels shame - that you are getting help