British South Asians who hear voices: A
Narrative Analysis of understanding

Thesis submitted in partial fulfilment for the requirements of the
Doctorate in Clinical Psychology

By

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Statement of Originality

I confirm that this is an original piece of work. The literature review and research reports contained within this thesis have not been submitted by any other persons for any other degree or to any other institution.
Thesis Abstract

British South Asians who hear voices: A Narrative Analysis of understanding

By Noreen Naz

Part One: Literature Review

Introduction: The systematic literature review explored the conceptual models used by South Asian women in making sense of their experiences of depression.

Method: A systematic search of five databases generated a total of ten qualitative papers to be included in this review.

Results: A total of four themes emerged in explaining beliefs about depression. These were: a) Inter-Generational Identity and Conflict, b) Marital Abuse and Adjustment, c) Somatisation and Medical Treatment and d) Distress as Part of Gods Plan. Many of the themes were shared by South Asian women living in South Asia and those living in the West.

Discussion: There is evidence to suggest that South Asian women are not averse to receiving support from mental health services but Western models of mental health are not inclusive of cultural factors resulting in isolation of these women from receiving appropriate and timely support for depression.

Part Two: Research Report

Introduction: The aim of the current study was to explore the types of narratives held by South Asian individuals who hear voices.

Method: A qualitative approach was adopted for this study. Seven South Asian participants who actively heard voices were interviewed. These were audio recorded, transcribed and analysed using Narrative Analysis with a particular focus on Frank’s narrative typologies.

Results: Results demonstrated that individuals held a range of narratives in understanding their experiences of hearing voices. These included elements of Restitution, Chaos and Quest. Cultural stories enabled effective meaning making and created more opportunities for collaborative interventions inclusive of religious and spiritual strategies. The absence of cultural dimensions in stories increased conflict between mental health services and South Asian individuals.

Discussion: Supporting individuals to explore cultural stories and facilitating these to be incorporated into existing biomedical frameworks is more likely to result in individuals moving towards restitution in their experiences of hearing voices.

Part Three: Critical Appraisal

This chapter described the reflexive account of the researcher throughout the research project.
Acknowledgments

I would like to start by thanking all the individuals who participated in this research project for so graciously sharing their stories with me. I would also like to thank my research supervisor, Dr Jon Crossley, for his support, guidance and patience throughout this research process. Thank you for all your words of encouragement. I would also like to thank my field supervisor, Dr Sanjeev Ramharakh for so willingly sharing your insights and knowledge with me.

I would also like to thank my friends in my cohort for all your peer support over the past three years. Finally I would like to thank my best friend Abid and my wonderful family for believing in me when I did not believe in myself.
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Part Two

Research Report: 12050

Part Three

Critical Appraisal: 3583

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(Not including mandatory appendices)
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Literature Review Abstract

Noreen Naz

How do South Asian women construct their experiences of depression?

Introduction
The way in which depression is conceptualised is influenced by culture. In the western world dominant narratives of depression fail to incorporate culture-specific models, isolating those from South Asian communities. In order to better engage with South Asian women in mental health services, we must first understand their explanations for depression and beliefs about help-seeking and treatment.

Method
A systematic search of five databases was conducted. A total of ten qualitative papers were quality appraised using the CASP and are included in this literature review to investigate how South Asian women construct their experience of depression. The process of synthesis was informed using Noblit and Hare’s Lines of Argument Synthesis.

Results
Results were synthesised to reach a new understanding of the existing literature. A total of four themes emerged in explaining causal beliefs about depression. These were; a) Inter-Generational Identity and Conflict, b) Marital Abuse and Adjustment, c) Somatisation and Medical Treatment and d) Distress as Part of Gods Plan. Many of the themes were shared by South Asian women living in South Asia and those living in the West. Experiences of isolation and loneliness were common.

Conclusion
The picture of depression in South Asian women is a unique one. South Asian women are not averse to receiving support from mental health services but report many barriers to achieving this. A culturally sensitive and inclusive model of depression may enable South Asian women to place confidence in accessing support from mental health services but first a shared understanding must be reached. Further research is required to better understand the experience of depression in this community and precautions should be taken in generalising results given the vast differences between communities in South Asia.
Literature Review

How do South Asian women construct their experiences of depression?

1. Introduction

According to the National Institute for Clinical Excellence (NICE, 2009), the term depression is used to describe a range of mood related disorders characterised by multiple emotional, physical and behavioural symptoms. Although these will vary from one individual to another, people experiencing depression commonly report persistent low mood, loss of interest or pleasure in things (anhedonia), and low energy or fatigue (NICE, 2004). Furthermore, depression has also been shown to influence an individual's expectations and motivation (Andrews & Henderson, 2000) which can determine their beliefs, help-seeking behaviours and treatment preferences (Prins, Verhaa, Bensing, & Meer, 2008). Research has highlighted that depression can create immense emotional distress for individuals, impacting on their daily functioning and often leading to lasting social and economic consequences (Bijl & Ravelli, 2000). It can interfere with the quality of spousal and wider familial relationships (Burke, 2003) and has been shown to correlate with a number of factors including low education, marital disputes and economic instability (Kessler & Bromet, 2013). For many individuals, depression is persistent and recurring in nature, despite access to care (Zajecka, Kornstein & Blier, 2013). High levels of anxiety, increased substance use and suicidality are therefore, sadly not uncommon in people who suffer from depression (Kessler, Gruber, Hettema, Hwang, Sampson, & Yonkers, 2008).
1.2 Depression Prevalence Rates

The World Health Organisation (WHO, 2012) estimate around 350 million people around the world suffer from depression making it a leading cause of disability and economic strain. Furthermore, The Health and Social Care Information Centre, who regularly publish adult psychiatric morbidity data for England, found 23% (1 in 4) of adults experienced a psychiatric disorder in 2007. Common mental health disorders (CMD), including depression and anxiety, were more prevalent in women compared to men (19.7% and 12.5% respectively) and affected more South Asian women in England compared to their White female counterparts (HSCIC, 2007). Other studies have also demonstrated similar trends. For example, Kessler et al., (2008) found women to have a higher lifetime risk of depression compared to men, while Garter et al., (2009) found higher prevalence rates of depression in British Pakistani women (31%) compared to White British females (12.9%). Increased first onset of female depression was accountable for the gender difference rather than suggestions that females experienced more episodes of depression (Kessler, 2003).

This paper critiques a range of theories proposed in understanding the causality of depression and its prevalence in women. The paper goes on to outline a systematic search of literature to review the conceptual models used by South Asian females for their experiences of depression. Data is organised in themes.

1.3 Biomedical Explanations

Biomedical explanations for depression are the dominant discourse in the Western world (France, Lysaker, & Robinson, 2007). It has been argued that biomedical causal models of depression have been shown to lessen stigma towards depressed individuals and reduce self-blame (Deacon & Baird, 2009). Furthermore, evidence
also suggests greater confidence in pharmacological interventions such the use of antidepressant medication in depressed individuals who adopt biomedical causal narratives (Budd, James, & Hughes, 2008). The monoamine hypothesis for depression and the role of sex hormones in causation are briefly outlined below as examples of biomedical discourses.

i. **Monoamine Hypothesis (Chemical Imbalance Theory)**

The Monoamine Theory, or “chemical imbalance theory”, of mental illness states that depression is caused by an imbalance in the activity of neurotransmitters dopamine, serotonin and norepinephrine in the brain (Schildkraut, 1965). The theory has been widely reported in research and supported by the pharmacological industry. It forms the basis for the use of antidepressant drugs which are designed to increase the concentration of monoamines and reduce depressive symptoms (Massand & Gupta, 1999). They are said to reduce an individual’s stress-sensitivity and increase positive reward-experiences (Wichers, et al., 2009).

The validity of the hypothesis has been called into question by others who have observed similar serotonin and norepinephrine levels in depressed individuals compared to non-depressed controls (Delgado, 2000) as well as fuelling the debate of the placebo effect of anti-depressant medication (Kirsch, Scoboria, & Moore; 2002). Furthermore, the hypothesis has been criticised for being reductionist in its approach to understanding complex human phenomena, framing understanding in terms of mechanics without the appropriate evidence base to support these claims. The very concept of measuring ‘imbalance’ and ‘balance’ could be considered rudimentary given the lack of sophistication in neuroscience at present (Brogan, 2014). Thus, whilst it may be feasible that some truth exists in the hypothesis, the absence of other contextual factors in shaping this understanding is a stark limitation of its clinical applicability.
ii. **The Role of Sex Hormones**

Given the consistent gender differences in the prevalence of depression between men and women across the lifespan and in different cultures, biological explanations with reference to the role of reproductive hormones have been hypothesised. The gender gap in the onset of depression first appears when girls are around 11-14 years old (Angold, 1998), raising interesting questions about the function of hormones involved in puberty and menarche on mood. Furthermore, a further shift in reproductive hormones during the menopausal transition has been suggested to increase the likelihood of women reporting depressive symptoms by as much as three times (Freeman, *et al.*, 2004). The same study goes on to show a reduced risk of depressive symptoms post-menopausal adjustment.

Although biomedical causal models for depression have been widely endorsed by physicians and the pharmacological industry, it has been shown that biomedical explanations are not usually adopted by depressed people themselves (Hansson, Chotai, & Bodlund, 2010). Furthermore, research highlights that these models of understanding depression can reduce sufferers’ self-efficacy in managing their experiences of mental illness (Kemp, Lickel, & Deacon, 2014).

1.4 **Psychological Explanations**

Psychological theories of depression aim to explain the way individuals think, feel and behave within the context of their personality traits, early experiences and interpersonal relationships (Nemade, Reiss, & Dombeck, 2007). A number of hypotheses have been proposed of which three are briefly outlined below.
i. **The Stress Vulnerability Model**

The Stress Vulnerability Model proposed by Zubin and Spring (1977) has been widely utilised as a theory of understanding the development and maintenance of mental ill-health. The model, which is also referred to as the Diathesis-Stress model, hypothesises that individuals are biologically vulnerable to the development of psychiatric disorders such as anxiety, depression, or schizophrenia. This biological vulnerability is thought to be determined by the impact of genetic markers, prenatal care, nutrition, and early childhood experiences (Heim & Nemeroff, 2001; Lacerda-Pinheiro *et al.*, 2014; Rao, Asha, Ramesh, & Rao, 2008).

The role of environmental stressors and adverse life events such as relationship difficulties, bereavements, and financial strain are thought to amplify or trigger an individual’s underlying biological vulnerability to certain mental health symptoms and can compromise their resilience and ability to cope effectively. For example, teenage patients diagnosed with Borderline Personality Disorder who had experienced significant childhood trauma, such as abuse, were found to have smaller pituitary glands compared to those who had not (Garner, Chanen, Phillips, Velakoulis, Wood, Jackson, Pantelis, & McGorry, 2007). Furthermore, Jaracz (2008) also found anatomical differences in patients with depression who were shown to have smaller amygdalas. The amygdala is known to play a key role in the processing of emotions, emotional learning and memory, as well as other aspects of emotional influences on social behaviour (Phelps & LeDoux, 2005).

ii. **Learned Helplessness Theory**

The learned helplessness theory was first conceptualised by Seligman (1968) in their study of classical conditioning with dogs. The study reported how animals quickly learned to become helpless when faced with continued unexpected or adverse events. The theory was later extended to explain a similar phenomena experienced
by humans (Abramson, Seligman, & Teasdale, 1978). The theory states that individuals are inclined to attribute negative events to either internal or external causes that can be stable or unstable in nature and global or specific. Thus, attribution styles adopted by individuals can predict feelings of helplessness and the experience of depression. Learned helplessness can result in passivity to cope, low self esteem and a negative effect on mood.

However, it could be argued the theory oversimplifies the lived experience of depression and fails to incorporate the complexities of cognitive processes at play or explain the severity of depressive symptoms experienced by some.

1.5 Biopsychosocial Explanations

The biopsychosocial model (Engel, 1997) seeks to incorporate biological, psychological and social factors in the approach to understanding human functioning and development. The model states that each of these factors is interlinked in complex relationships. These links can serve to either promote health or contribute to the development of mental and physical ill health.

The model encourages clinicians to explore each of the three areas in explaining mental health problems such as clinical depression, stating that biological, psychological and social factors are inevitably interdependent and should form the basis for diagnosis and in developing individual therapy packages (Cattapan-Ludewig & Seifritz, 2010; Garcia-Toro & Aquirre, 2007).

The biopsychosocial model has been increasingly applied to understanding depression in patients with chronic pain (Campbell, Clauw, & Keefe, 2003) as well as
in studies of racism, stress and depression amongst ethnic minority populations (Hammack, 2003)

1.6 Alternative Explanations

i. Socioeconomic Inequality

A study by Gilman et al., (2002) found an increased risk for the development of Major Depressive Disorder (MDD) in adulthood for individuals who had grown up with a low socioeconomic status during childhood. Researchers investigated socioeconomic factors such as parental occupation and the level of education of respondents. They found low socioeconomic status in childhood increased the lifetime risk for MDD amongst males and females. This adds to other research linking socioeconomic inequalities in childhood to mental health in adulthood. For example, Wilkinson and Prickett’s work on the Spirit Level of social equality (2010) demonstrates how economic inequality is associated with a vast range of adverse factors including increased mental health problems.

We know that poor socioeconomic status, such as unemployment, poverty and low education, increases mental health morbidity and is related to poor access to health care (Andrade, Caraeo-Anduaga, & Berglund, 2000; Riolo, Nguyen, Greden & King, 2005). The UK Poverty Site provides statistical information on the economic status of people living in the UK based on Census data. It suggests that people from manual labour backgrounds are more likely to develop mental illness such as depression compared to people from non-manual backgrounds. It goes on to highlight that people from ethnic minorities are more likely to hold low income jobs compared to White families. In 2007, up to a third of Bangladeshis and Pakistanis living in the UK were not in paid employment and a large proportion (80%) of women
from these ethnic groups did not work, thus increasing the risk of depression in ethnic minority populations.

ii. Acculturation and Adjustment Theories

Acculturation refers to the adaptation of an individual’s language, attitudes, lifestyle and cultural identity when coming into direct contact with members of a different culture (Miller & Chandler, 2002). It can be used to explain how immigrant communities absorb elements of culture and tradition from their host communities as a means of integrating and reducing conflict (Persons, 1987). Furthermore, the acquisition of alternative customs that are in keeping with those of the host community are thought to be a method in reducing alienation and promoting adjustment and acceptance amongst immigrant populations. However, the adoption of aspects of the dominant culture can be at the cost of individuals’ native traditions (Szapocznik, Kurtines, & Fernandez, 1980) resulting in feelings of loss. Ineffective acculturation amongst immigrant communities is thought to create greater feelings of alienation and isolation reducing how well individuals are able to adjust and integrate with host communities.

The extent to which individuals undertake cultural changes is thought to be dependent on their level of ‘cultural awareness’ and ‘ethnic loyalty’ (Keefe & Padilla, 1987; Padilla, 1980), thereby suggesting generational differences in the amount of changes that are adopted. There is growing evidence for differences in the types of struggles faced by first, second and subsequent generations of immigrant families. In a study by Abouguendia and Noels (2001) second-generation South Asian immigrants in Canada had lower levels of self-esteem compared to first-generation counterparts, whilst outgroup difficulties were predictors for depression. Meanwhile, for first-generation individuals, in-group stressors were greater predictors of depression. Thus, acculturation is experienced uniquely by members of different
generations, each exposed to varying stressors. A further study by Sonuga-Barke and Mistry (2000) identified differences in adjustment amongst different generations of extended Muslim and Hindu families, with starkly better adjustment seen in children and grandmothers compared to mothers. This highlights a link between family structure and mental health in these communities and disputes the notion that the availability of extended familial support is beneficial to immigrant women, despite contributing to better mental health and adjustment in children.

Sadly, along with the presence of cultural and ethnic difference, there is the difficult introduction of discrimination in the form of exclusion, hate crime or restriction which can be direct or indirect, subtle or obvious. The role of racial discrimination in the onset of mental health disturbances, such as anxiety and depression, is well researched (Barbee, 2002; Burke, 1984; Fernando, 1984). This is thought to contribute to the higher prevalence rates of mental illness amongst African-Caribbean and South Asian individuals in the UK (Nazroo, 1997), which are not reflective of rates in their countries of origin (Hickling & Rodgers-Johnstone, 1995). Thus, providing evidence against biological based models discussed earlier in this paper and raising interesting questions about the links between cultural membership and ethnic identity on mental health for ethnic minorities.

1.7 Understanding Depression; South Asian Perspective

The South Asian community in the UK is a growing population. According to the 2011 Census, people of Pakistani, Indian, Bangladeshi and Sri Lankan origin make up approximately 7.5% of the population in England and Wales. Those of Indian (2.5%) and Pakistani (2%) descent made up the greatest proportion of this figure.
Prevalence data of common mental health problems including depression in South Asians has mainly originated from South Asian countries such as Pakistan and India, and has demonstrated higher rates of depression in females compared to males (Mirza and Jenkins, 2004; Parker, Dawani & Weiss, 2008). Furthermore, research into mental health service access by these communities has yielded inconsistent findings into service uptake with some suggesting higher first admission rates for South Asians and others suggesting service underutilisation (Carpenter & Brockington, 1980; Cochrane & Bal, 1989). However, it is generally accepted that there is an underrepresentation of South Asians in mental health services overall (Bhui, Stansfeld, Hull, Priebe, Mole, & Feder, 2003; Goodman, Vikram & Leon, 2008.) with others reporting low service user satisfaction amongst Black and minority ethnic communities (BME) which have failed to improve over time (Bhui & Bhugra., 2002).

Increased levels of stigma related to mental health in South Asians are well documented and have been found to result in the denial of mental illness amongst this population altogether (Gilbert, Gilbert & Sanghera, 2004; Gureje, Simon, Ustan & Goldberg, 1997). The somatisation hypothesis suggests individuals, particularly women, from ‘traditional’ South Asian communities are more inclined to attribute psychological distress to physical illness (Kawanishi, 1992). For example, there is a growing body of research that investigates the presentation of gynaecological symptoms and reproductive events in depressed South Asian women (Patel & Oomman, 1999; Patel et al., 2005).

The Department of Health publication, *Delivering Race Equality in Mental Health Care* (Department of Health, 2005), stressed the importance of services meeting the mental health needs of individuals of all ethnic groups. However, despite its five year action plan aimed at reducing service inequalities for ethnic minority groups, this
continues to be a struggle for mental health care commissioners in the United Kingdom.

1.8 Conclusion

A review of how South Asian women construct their experiences of depression was felt to be important given the continued inequalities in mental health service access and the well established high prevalence rates of depression in this population.

At present, the dominant models for depression attempt to create universal theories rather than incorporate the vast cultural variations that exist, thus, hindering our effective engagement with depressed women from South Asian communities. Depression, along with other human experiences, is constructed within a cultural context which varies from one culture to the next (Furnham & Malik, 1994). As such, ethnic differences have also been observed in the help-seeking behaviours and treatment preferences of depressed South Asians, who have been shown to place a greater emphasis on family support (Lawrence, Banerjee, Bhugra, Sangha, Turner & Murray, 2006).

Unfortunately, culture-specific elements of understanding depression are not only omitted from the dominant causal models available at present, but in every element of mental health care; from the measures used to diagnose depression to the interventions aimed at treating patients. A more thoughtful integration of cultural variations into the process of assessing and treating depression is needed in order to create services that are responsive to the needs of individuals experiencing depression from South Asian communities. Whilst some models such as the Spirit Level theory make an important step in recognising the impact of social inequality between cultures, such as wealth and employment, on the mental health of
individuals, further development of cultural factors are needed. However, in order to do this effectively, we must first understand how South Asian women themselves construct their own experiences of depression and the beliefs they hold about its cause and treatment.

2. Method

Literature Review Question

How do South Asian women construct their experiences of depression?

The aim of the present literature review was to examine the explanatory models used by women of South Asian origin to construct their experiences of depression.

Terminology

The use of diagnostic terminology such as ‘depression’ and ‘Depressive Disorder’ has been avoided where possible. However, it is important to acknowledge that this review is guided by the psychiatric construct of ‘depression’ which continues to be the dominant model in the UK. It is therefore likely that the use of such terminology will have influenced the papers returned in the literature search. However, the researcher would like to draw attention to the widely contested construct of ‘depression’ and make clear that psychiatric understanding is not exclusive. Alternative discourses exist within psychology, social and anthropology fields where alternative terminology such as ‘low mood’ are used in place of diagnostic terms. Thus, whilst care has been taken to avoid using psychiatric terminology where possible, terms such as ‘depressive disorder’ are used in reference to the broad experience of mood disturbance.
Literature Search Process

A systemic search of existing literature was conducted between December 2014 and February 2015. Given the discovery orientated nature of the review question at hand, it was felt that qualitative research would be best placed to shed light on this question. Qualitative research was also recognised as potentially useful in considering the likely complexities, variations and nuances in the data. As such a systematic search of published peer-reviewed literature was conducted using five online journal databases (PsychInfo, Science Direct, MedLine, Web of Science and PubMed). These databases were chosen to ensure a thorough search of literature covering journals of both psychological and wider scientific and medical perspectives. Each database was searched using the following terms in varying combinations:

South Asian OR Pakistani OR Indian OR Bangladeshi OR Sri Lankan
AND
Depression OR Depressive Disorder OR Common Mental Health OR Low Mood
AND
Narratives OR Experiences OR Explanatory Models OR Construct OR Understanding OR Theory
AND
Women OR Females AND Qualitative OR Interviews

Initial search returns were limited to include literature published within the past 10 years (2005-2015). However, given the limited number of articles generated within this time frame, the search was expanded to include research published within the past 15 years. This enabled two further core papers to be identified and included in this review. It is also important to note that literature was limited to only include papers published in the English language.
A total of 489 papers were generated from initial searches. Following the removal of duplicate papers and those that did not meet the search criteria, the titles and abstracts of the remaining 85 papers were read to further remove unrelated articles. The full-text of the remaining 14 articles were read to ascertain relevance to the review question using a series of inclusion and exclusion criteria. These were applied to ensure transparency in the systematic approach adopted.

**Inclusion Criteria**

- Papers related to how South Asian women construct experiences of depression
- Papers using qualitative methodological approaches
- International papers

**Exclusion Criteria**

- Papers published over 15 years ago (prior to 2000)
- Papers written in languages other than English
- Papers using quantitative or mixed method approaches

Figure 1. below outlines the data filtering process which is formatted according to the flow diagram developed by Moher, Liberati, Tetzlaff, & Altman (2009). This process is described in greater detail in Appendix A.
The remaining ten papers were read in greater depth and quality appraised at this final stage of the systematic literature search process. By identifying the quality of papers to be included, it was further ensured that a rigorous systematic protocol was followed for the purposes of conducting this review.
The Critical Appraisal Skills Programme (CASP), a tool designed by the Public Health team in Oxford and the programme of North Thames Research Appraisal Group (NTRAG), to assess the quality of qualitative research papers, was applied to each paper. This generated a ‘quality’ score out of a total of ten based on several criteria. A cut off score of at least six out of ten was decided upon to identify papers of ‘High Quality’. This was a similar threshold as used in other reviews, for example Xi (2010), and provided a rudimentary baseline of quality for all papers included in this review. No papers were rejected as a result of the application of the quality check. Papers were of similar quality and all were felt to be relevant in contributing information to the review. Quality appraisal information can be seen in Table 1. below.
Table 1. Tabulated quality appraisal information of papers using CASP

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Data Extraction

To enable data from each paper to be presented in a more manageable format for synthesis, a process of data extraction was applied through reading and re-reading each article several times.

The following factors were specifically extracted at this stage:

- Study Title, including date
- Study Location (Country and/or setting)
- Study Aims
- Sample Information (including gender and diagnosis)
- Study Method (data collection and analysis)

Table 2. below details information extracted from each paper. The table is organised in chronological order with the most recent paper first. This is also the order in which papers were attended to for synthesis.
Table 2. Details of key articles used in this literature review

<table>
<thead>
<tr>
<th>Title</th>
<th>Author, Year and Location</th>
<th>Study Aim</th>
<th>Sample and Setting</th>
<th>Method and Analysis</th>
</tr>
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<tbody>
<tr>
<td>A qualitative study of factors affecting mental health amongst low-income working mothers in Bangalore, India</td>
<td>Travasso, Rajaraman, &amp; Heymann (2014) India</td>
<td>To analyse the specific needs of low-income working mothers in India to examine life stressors affecting mental health and strategies to cope.</td>
<td>N=48 low-income working mothers of children aged between 0-8 years old. Women aged between 19-40 years old were recruited.</td>
<td>A qualitative methodology using a short questionnaire to collect demographic data followed by in-depth interviews. Participants were employed in one of four occupations (construction, domestic, factory, or street vendor).</td>
</tr>
<tr>
<td>Qualitative cross-sectional study</td>
<td>Ekanayake, Ahmed</td>
<td>To explore how women of                                                   N=10 South Asian</td>
<td>Qualitative methodology</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Author, Year and Location</td>
<td>Study Aim</td>
<td>Sample and Setting</td>
<td>Method and Analysis</td>
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<tr>
<td>of the perceived causes of depression in South Asian origin women in Toronto.</td>
<td>&amp; McKenzie (2012) Canada.</td>
<td>South Asian origin living in Toronto, Canada understand and make sense of the causes of their depression</td>
<td>immigrant women aged between 22 and 65 years of age who all presented with symptoms of depression were recruited to partake.</td>
<td>using Thematic Content Analysis and drawing on elements of Grounded Theory were adopted for this study. Participants were interviewed and data was analysed to identify emerging themes in participant narratives.</td>
</tr>
<tr>
<td>The explanatory models of depression and anxiety in primary care: a qualitative study from India.</td>
<td>Andrew, Cohen, Salgaonakar &amp; Patel (2012 India)</td>
<td>To illicit the explanatory models of common mental health disorders; anxiety and depression with a view to identify any gender</td>
<td>A total of 117 (30 males and 87 females) participants were recruited from Primary care settings. All scored 7 or higher.</td>
<td>A cross-sectional qualitative study nested within a larger research project. Participants completed semi-structured interviews.</td>
</tr>
<tr>
<td>Title</td>
<td>Author, Year and Location</td>
<td>Study Aim</td>
<td>Sample and Setting</td>
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<tr>
<td>Isolation, feeling 'stuck' and loss of control: Understanding persistence of depression in British Pakistani women.</td>
<td>Gask, Aseem, Waquas &amp; Waheed (2011) UK</td>
<td>To examine why and how women of Pakistani origin living in the UK fail recover from depression and remain persistently low in mood.</td>
<td>N=15 British Pakistani women aged between 23 and 73 years old who had all been diagnosed by their General Practitioner (GP) as suffering from depression (with or without anxiety) were recruited to</td>
<td>A qualitative thematic analysis study nested within a larger three-centre research project. Interview data was transcribed and coded. Thematic analysis enabled emerging themes to be</td>
</tr>
<tr>
<td></td>
<td></td>
<td>differences in causal models adopted.</td>
<td>more on the General Health Questionnaire – 12 (GHQ-12) indicating a common mental disorder of moderate-severe degree.</td>
<td>interviews and data was analysed using thematic analysis.</td>
</tr>
<tr>
<td>Title</td>
<td>Author, Year and Location</td>
<td>Study Aim</td>
<td>Sample and Setting</td>
<td>Method and Analysis</td>
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<tr>
<td>The experience of postnatal depression in South Asian mothers living in Great Britain: a qualitative study.</td>
<td>Wittkowski, Zulma, Glendenning &amp; Fox (2011) UK</td>
<td>To examine the factors that led to and maintained how British South Asian women with postnatal depression (PND) were feeling and to explore how they defined and experienced PND.</td>
<td>N=10 South Asian mothers aged between 16 and 23 years old who scored at least 12 on the Edinburgh Postnatal Depression Scale were recruited through health visitors and midwives. All participants had given birth in a couple of months prior to recruitment.</td>
<td>A qualitative methodology using constant comparison and a grounded theory approach was adopted. Participants were interviewed and results were organised under core categories.</td>
</tr>
<tr>
<td>An exploration of the presence and content of metacognitive depression in Pakistani</td>
<td>Zounish (2010)</td>
<td>To explore the experience of depression in Pakistani</td>
<td>N=7 Pakistani women aged between 24-48 years</td>
<td>A qualitative design using semi-structured interviews</td>
</tr>
<tr>
<td>Title</td>
<td>Author, Year and Location</td>
<td>Study Aim</td>
<td>Sample and Setting</td>
<td>Method and Analysis</td>
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<tr>
<td>beliefs about depressive rumination in Pakistani women</td>
<td>UK</td>
<td>women and to identify metacognitive beliefs about rumination.</td>
<td>old were recruited from a specialist counselling service.</td>
<td>was adopted. Data was analysed using template analysis to generate themes.</td>
</tr>
<tr>
<td>The explanatory models of depression in low income countries: Listening to women in India</td>
<td>Pereira, Andrew, Pednekar, Pai, Pelto &amp; Patel (2007) India</td>
<td>To explore the experiences of depressed women in India with a particular focus on their narratives or idioms of distress and their views on the impact of social circumstances on their illness. The study was nested within a larger</td>
<td>N=35 Indian women aged between 21 and 50 years old. All women were or had been married and all had a diagnosis of a depressive disorder in line with the ICD-10 diagnostic criteria.</td>
<td>Qualitative methodology using two in-depth interviews spaced 6 months apart. Interviews consisted of questions related to interview themes. Interview data transcribed and coded. Themes were identified and reported.</td>
</tr>
<tr>
<td>Title</td>
<td>Author, Year and Location</td>
<td>Study Aim</td>
<td>Sample and Setting</td>
<td>Method and Analysis</td>
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<tr>
<td>Marriage, depression and illness: Sociosomatic models in a South</td>
<td>Karasz (2005) USA</td>
<td>To examine how South Asian women conceptualise the experiences of</td>
<td>N=35 ‘traditional’ non-English speaking married South</td>
<td>A qualitative methodology was used in the study. Women were interviewed about three</td>
</tr>
<tr>
<td>Asian immigrant community.</td>
<td></td>
<td>depression in relation to marriage roles, health and illness.</td>
<td>Asian women were recruited using the snowball sampling</td>
<td>fictional vignettes related to Marriage, Fatigue and Depression. Interview data was</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>method. Participants were aged between 23 and 62 years</td>
<td>used to develop sociosomatic models of understanding.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>old.</td>
<td></td>
</tr>
<tr>
<td>Living with depression: coping strategies used by South Asian women,</td>
<td>Hussain &amp; Cochrane (2003)</td>
<td>To examine the beliefs held by South Asian women around coping with</td>
<td>N=10 South Asian women suffering from depression and n=3</td>
<td>A qualitative methodology using a Grounded Theory approach was adopted.</td>
</tr>
<tr>
<td>living in the UK, suffering</td>
<td></td>
<td></td>
<td>carers were</td>
<td></td>
</tr>
<tr>
<td>Title</td>
<td>Author, Year and Location</td>
<td>Study Aim</td>
<td>Sample and Setting</td>
<td>Method and Analysis</td>
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<tr>
<td>from depression</td>
<td>UK</td>
<td>depression within a cultural and religious context and to explore the coping strategies employed by this cohort.</td>
<td>recruited to partake in this study. Participants were recruited through mental health services in Birmingham.</td>
<td>Participants were interviewed using an interview schedule and data was analysed to identify themes.</td>
</tr>
<tr>
<td>Depression in South Asian women: Asian women’s beliefs on causes and cures.</td>
<td>Hussain &amp; Cochrane (2002) UK</td>
<td>To explore the models used by South Asian women to make sense of their depression with a particular focus on their beliefs about causes and treatment.</td>
<td>N=10 South Asian women suffering from depression and n=3 carers were recruited to partake in this study. Participants were recruited through mental health services in Birmingham.</td>
<td>A qualitative methodology using a Grounded Theory approach was adopted. Participants were interviewed using an interview schedule and data was analysed to identify themes.</td>
</tr>
</tbody>
</table>
3. Results

The process of synthesis was informed by Noblit and Hare’s (1988) work on meta-ethnography of qualitative studies. They describe synthesis to be “an activity in which separate parts are brought together to inform a whole”, and describe three main types of synthesis; Reciprocal translation, Refutational synthesis and Lines of Argument (LOA). In order to most effectively answer the literature review question in this paper, the use of LOA synthesis was felt to be the most appropriate method to adopt. Thus, the focus was on further developing existing concepts towards second and third order interpretations of data from the ten primary studies. The process of synthesis followed the protocol outlined by Noblit and Hare shown below.

<table>
<thead>
<tr>
<th>Figure 2. Noblit &amp; Hare’s meta-ethnography protocol (1988)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Getting started</td>
</tr>
<tr>
<td>2. Deciding what is relevant to the initial interest</td>
</tr>
<tr>
<td>3. Reading the studies</td>
</tr>
<tr>
<td>4. Determining how the studies are related</td>
</tr>
<tr>
<td>5. Translating the studies into one another</td>
</tr>
<tr>
<td>6. Synthesising translations</td>
</tr>
<tr>
<td>7. Expressing the synthesis</td>
</tr>
</tbody>
</table>

After reading and re-reading the papers several times, the researcher was able to familiarise herself with the themes that emerged and begin to formulate how they were interrelated. This was done by arranging the papers in chronological order (newest first) and comparing the concepts in papers one and two, then these with the third paper and so on. Given that each paper had a slightly different focus; for
example, causes, treatment, beliefs, and so on, new themes were added as they emerged. As the aim here was to interpret findings, first order themes and second and third order interpretations were tabulated as they were developed, seen below.

Table 3. Representation of themes

<table>
<thead>
<tr>
<th>First Order Themes</th>
<th>Second Order Interpretations</th>
<th>Third Order Interpretations</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MIGRATION</strong></td>
<td>Cultural differences</td>
<td>a) INTER-GENERATIONAL</td>
</tr>
<tr>
<td>Difficulties adjusting to</td>
<td>apparent in host country.</td>
<td>IDENTITY CONFLICTS</td>
</tr>
<tr>
<td>migration following marriage</td>
<td>Affected immigrants as</td>
<td>The burden of being a first</td>
</tr>
<tr>
<td></td>
<td>well as younger females</td>
<td>and/or second generation</td>
</tr>
<tr>
<td></td>
<td>born to immigrant parents</td>
<td>South Asian female living</td>
</tr>
<tr>
<td></td>
<td></td>
<td>in the West impacted on</td>
</tr>
<tr>
<td></td>
<td></td>
<td>their sense of identity and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>belonging with host</td>
</tr>
<tr>
<td></td>
<td></td>
<td>community.</td>
</tr>
<tr>
<td><strong>FAMILY SYSTEMS</strong></td>
<td>Abuse, financial strain,</td>
<td>b) MARITAL ABUSE AND</td>
</tr>
<tr>
<td>Reports of difficulties with</td>
<td>infidelity, overwhelming</td>
<td>ADJUSTMENT</td>
</tr>
<tr>
<td>husband and in laws</td>
<td>domestic responsibilities,</td>
<td>Seen to cause and</td>
</tr>
<tr>
<td></td>
<td>lack of support and</td>
<td>maintain depression.</td>
</tr>
<tr>
<td></td>
<td>understanding.</td>
<td>Resignation to suffering</td>
</tr>
<tr>
<td></td>
<td></td>
<td>as a part of life and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>impact on rumination and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>isolation.</td>
</tr>
<tr>
<td><strong>PHYSICAL HEALTH</strong></td>
<td>Onset of depression;</td>
<td>c) SOMATISATION AND</td>
</tr>
<tr>
<td>Physical complaints such as</td>
<td>Gender specific complaints</td>
<td>MEDICAL TREATMENT</td>
</tr>
<tr>
<td>weakness, fatigue and</td>
<td>resulting in reproductive</td>
<td>Expression of physical</td>
</tr>
<tr>
<td>gynaecological problems.</td>
<td>problems.</td>
<td>symptoms resulted in</td>
</tr>
<tr>
<td></td>
<td></td>
<td>medical treatment being</td>
</tr>
<tr>
<td></td>
<td></td>
<td>sought.  Perhaps less</td>
</tr>
<tr>
<td></td>
<td></td>
<td>stigmatising than</td>
</tr>
<tr>
<td></td>
<td></td>
<td>expression of emotional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>distress.</td>
</tr>
<tr>
<td><strong>MEDICAL TREATMENT</strong></td>
<td>Shared culture of doctors</td>
<td></td>
</tr>
<tr>
<td>Medical examinations and</td>
<td>resulted in more honest</td>
<td></td>
</tr>
<tr>
<td>medication sought for physical</td>
<td>expressions of distress.</td>
<td></td>
</tr>
<tr>
<td>symptoms.</td>
<td>Medication for physical</td>
<td></td>
</tr>
<tr>
<td></td>
<td>symptoms valued.</td>
<td></td>
</tr>
<tr>
<td>First Order Themes</td>
<td>Second Order Interpretations</td>
<td>Third Order Interpretations</td>
</tr>
<tr>
<td>--------------------------------------------</td>
<td>-----------------------------------------------------------------</td>
<td>------------------------------------------------------------------</td>
</tr>
<tr>
<td>RELIGIOUS</td>
<td>Varied greatly. Easy to access as they are immersed in the community.</td>
<td>d) DISTRESS AS PART OF GODS PLAN</td>
</tr>
<tr>
<td>Culture specific treatment options such as praying, herbal remedies and visiting spiritual healers.</td>
<td></td>
<td>Spiritual or religious healers held in high regard. Common shared language and culture made these options more accessible and less stigmatising.</td>
</tr>
<tr>
<td>SPIRITUAL</td>
<td>Limited options of who to talk to. Issues of community confidentiality limiting use of community as support.</td>
<td></td>
</tr>
<tr>
<td>Communities seen as a potential source of rich support but also as potential triggers for depression</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The aim of the synthesis was to interpretively integrate findings rather than cluster them into descriptive themes. First order themes were derived from coding papers, namely the results sections of these, and comparing them across studies. Second order interpretations were derived from a further consideration of the key findings from the papers, with a particular focus on the researchers’ discussions. Finally, third order interpretations were synthesised to construct a new meaning about causes, symptoms and treatment of depression from these papers. Names for the new themes were selected as they were thought to better fit the findings from the combined literature. These are discussed below.

3.1 Inter-generational Identity Conflicts

First Generation South Asian Women

Of the papers analysed, seven discussed the difficulties women experienced as a result of migration following marriage. Upon moving to the West, they became vastly aware of the differences in their values and roles compared to those of women from their host communities. This extended further than physical
differences in language, food and dress, although these were reported by Hussain and Cochrane, (2002). Cultural differences included a deep sense of loss of an old way of life and an attempt by first generation females to recreate their previous social frameworks by forging close ties within their Asian communities. Whilst this was positive in allowing South Asian women to share common experiences, it also served to further isolate women from their host communities, adding to difficulties in integrating and experiencing the loss of an old life.

Although valued, the support women received from within their own community was not without its limitations. Issues of mistrust, lack of confidentiality and fears of stigmatisation were rife, limiting how much of their problems could be shared. For example, a women from a study conducted by Hussain and Cochrane (2003) reported her fears of disclosure saying; “well you tell one person and they tell another and they tell another and then they start gossiping…so I ended up not telling anyone how (I) felt”.

Ekanayake et al. (2012) interviewed South Asian women in Toronto. The study highlighted how women had migrated with high hopes for their new life, but struggled to adjust. This was more intense for women with stronger South Asian values and created tension with their parenting styles. Language barriers and a lack of understanding of resources available impaired their ability to seek professional support, maintaining a sense of not belonging.

Second Generation South Asian Women

Whilst first generation women battled with difficulties in adjusting following migration, second generation females experienced a slightly different dilemma. Despite being born in the West, these women also struggled with forming an identity and did not feel they belonged. The stark differences in the values, rules
for living and roles of women between their parent’s cultural norms and those of the
West created tension between first generation parents and second generation
children. “In our culture children have changed a lot they don’t listen to their
elders…we have the same value systems as our parents but our children don’t
think like that”. (Gask et al., 2011).

For second generation South Asian females, this lead to experiences of exclusion
from both cultures and a fragmented identity. “There was a lot of differences with
my friends...because of different cultures. For example if it was non uniform day, I
used to dwell on it and think “Oh I don’t want to go to school” because I would have
had to wear my Asian clothes”” (Gask et al., 2011)

3.2 Marital Abuse and Adjustment

The issue of marital abuse and adjustment was felt to be a separate theme given
the emphasis of this in the literature reviewed. Many South Asian females from
both South Asian counties as well as those living in the Western world reported the
onset of their depression as beginning when they got married. For example, in a
study by Wittkowski et al., (2011), one women recalled; “I have good memories of
my life in Pakistan before marriage”, whilst another remarked, “I compare my life,
you know, before I got married I was really happy you know”. The theme is divided
into sub-themes below.

Conflict with In Laws

Women from South Asian communities often live within extended family systems
which can cause interpersonal difficulties. Reports of interpersonal conflicts with
their husband’s family were reported in five out of the ten reviewed studies, with
particular reference to difficult relationships with female family members such as
mothers and sisters in law. Women attributed the cause and maintenance of their depression as a result of ongoing harassment, conflict and significant domestic responsibilities placed upon.

A lack of mutual care and support was felt to be lacking, resulting in a great deal of worry. For example, Karasz (2005) found women commonly identified in laws as not caring or understanding “women in our culture even if they mention their problems, in laws will not care, they will expect the woman to do her work”. Similar experiences were documented in several other studies with some discussing direct harassment; “my mother in law and two sisters in law started cursing me” (Pereira et al., 2007).

**Domestic Violence**

Intimate partner violence in the form of physical, emotional, and/or financial abuse were reported in four papers. Women from these cultures felt their role was to fulfil the needs of their husband despite any alcoholism, violence and infidelity. There was felt to be a clear power imbalance in how South Asian females rated their status in comparison to the status of their husband. An example of this can be seen in the study by Ekanayake et al., (2012), where one woman reported; “In India it’s perfectly normal for your husband to beat you…you have no choice other than suffering”.

Sometimes children were also exposed to, or victims of domestic abuse. South Asian mothers were highly distressed by this but often felt powerless to stop it. One mother was seen to take drastic measures in protecting her children by sending them to a hostel; my husband is an alcoholic. When he drinks and comes home he uses bad words in front of the children…he hits the children also. I feel so bad seeing them get beatings so I sent them away to a hostel” (Travasso et al., 2014).
Marital Entrapment

Given the emphasis placed on marriage in the South Asian community and the discouragement of separation or divorce, many women felt stuck in their unhappy marriages. Therefore the experiences of marital abuse were not only seen as triggers to the onset of depression but also as a factor in maintaining depression given that these were felt to be irresolvable.

3.3 Somatisation and Medical Treatment

The onset of depression was commonly traced back to reproductive events and gynaecological complaints such as pregnancy, childbirth, sterilisation as well as general discomfort. For example, a study by Andrew et al., (2012) found women to identify historic gynaecological events as continued triggers for their depression; “It’s been five years now since I got my uterus removed. Since then I have been having these problems of body ache and weakness”.

Subsequently, there was a greater emphasis on the communication of physical symptoms such as aches and pains, anaemia, bodily weakness and exhaustion. Women frequently described these experiences and sought help with managing these from their general practitioners. Preference for medical based interventions and treatments was common in these instances and in particular for women with additional long-term health conditions such as diabetes or infertility. This perhaps suggests that it is more acceptable to complain of physical ailments and be treated for these than mental health difficulties in this community. It also suggests that the conceptualisation of difficulties in biological terms results in preference for medical interventions.

However, adherence to medication regimes varied as many women raised concerns about side effects from taking medication long-term. Mixed views
towards medication were summarised in data collected by Zounish (2010). For example, one woman refused the use of medication saying “if you take tablets, they will have side effects and make you ill, then you’ll have to take more to deal with the side effects”. As such, some women sought out traditional and herbal remedies recommended by faith healers as these were also seen to be effective.

3.4 Distress as Part of Gods Plan

The presence of spiritual and religious causal models predicted South Asian women’s preferences for treatment options that complimented these explanations. All studies included in this review identified religious and/or spiritual factors in some guise. Evil spirits (Jinns), black magic, karma and evil eye were seen to be one of the reasons for distress experienced by women. Whilst these explanations externalised the problem and subsequently reduced stigmatisation associated with mental illness, they also reduced the women’s agency to seek help and support from mental health services.

Instead, many women talked about accessing support and advice from religious leaders, faith healers, and through prayer. They talked about actively increasing their religious and spiritual activities such as visiting places of worship such as temples and praying to God for help and relief. Often this was done prior to accessing support from the general practitioner and/or services and was also seen to be the preferred source of support by the women’s partners and families.

The extent to which this was seen to be helpful varied, but overall women talked positively about these options and appeared to seek refuge in beliefs and values such as; “God does not burden you with more than you can bear” (Hussain and
Cochrane, 2002). Ultimately the success of any treatment undertaken, whether religious or not, was seen to be decided by God.

3. Discussion

This final section outlines a range of methodological considerations which presented some challenges in the synthesis of the ten studies reviewed in this paper, before moving on to discuss some clinical implications of the findings and suggestions for further research.

4.1 Methodological Considerations

Location of study

Whilst all studies recruited South Asian women to talk about issues related to their experiences of depression, the papers originated from different countries. Given the limited literature available, it was felt to be acceptable to include papers from both South Asian countries as well as those published in the Western world. Of the ten papers included in this review, three provided evidence from research carried out in India. The remaining seven papers were published in the UK, Canada, and the USA.

Although there were many overlapping themes that emerged across all ten studies regardless of their country of origin, there were some themes that were specific to the South Asian women living in the West. For example, the issues related to immigration and generational differences did not arise in the Indian literature but played a significant role in the papers from the West, whilst issues of poverty and economic strain were more apparent in the literature from India.
Differences in diagnostic screening

Not all studies included in this paper screened participants for diagnosis of depression. Of those studies that did recruit depressed participants, a wide variety of diagnostic tools and criteria were adopted. For example, Andrew et al. (2012) used a measure called the General Health Questionnaire – 12 (GHQ12) to select participants with a common mental health disorder of moderate-severe severity. This was in contrast to Pereira et al. (2007) who recruited participants with a diagnosis of a depressive disorder in line with the ICD-10 criteria, and Wittkowski et al., (2011) who recruited women specifically with Postnatal Depression using the Edinburgh Postnatal Depression Scale. However, the use of a formal diagnosis was not required in the study by Zounish (2010), who instead made cautious assumptions about the participants’ mental health status based on their reports of symptoms. This requires consideration as the use of multiple screening methods and inclusion criteria across the ten papers may have resulted in a less homogeneous sample for the synthesis.

Furthermore, there were differences in recruitment methods adopted by studies with some recruiting participants through counselling or mental health services whilst others used techniques such as snowballing (Karasz, 2005), or referral from midwives and health visitors. This would have resulted in participants with varying levels of access to treatment and support being recruited.

4.2 Implications of Review Findings

The literature reviewed here illustrates a unique picture of how depression is conceptualised by South Asian females living in both the West and in South Asia. No one causal theory was always preferred, just as no one treatment option was always championed. Instead these women conceptualised their experiences of
depression at many levels by identifying a range of biopsychosocial and religious/spiritual factors in explaining the onset, maintenance and treatment of their depression. Whilst a biospsychosocial framework is gaining popularity in the West, the stark absence of more dominant cultural, religious and spiritual narratives may be preventing South Asian women from discussing them.

In relation to the models of depression discussed in the introduction of this review, it seems that South Asian women may relate to varying combinations or elements of these existing models given the breadth of causal factors they identified. However, but no one model was felt to fit. The somatisation hypothesis suggests that people from traditional (non-western) cultural backgrounds are more inclined to interpret psychological distress as part of physical illness or somatic representations. Research has found that increased levels of stigma related to mental health in ethnic minority groups is likely to result in the denial of mental illness problems altogether (Gureje et al., 1997). This may account for the presence of somatisation as a key theme in the current literature review. The role of stigma is well established in research with South Asian populations with regards to mental illness (Gilbert et al., 2004) where the denial of psychiatric problems can be an attempt to maintain position in social and familial hierarchy. Thus, it is vitally important for mental health services to fully understand the implications of diagnosis and treatment for this population in the context of their wider communities, should they hope to engage clients in their services.

In the study by Zounish (2010), women discussed the impact of rumination of past events, losses and current circumstances in causing and maintaining depression. Women in this study recognised the impact of negative meta-cognitive beliefs on their mental wellbeing. This was supported by other studies in the review that identified ‘over-thinking’ as a cause for the experience of depression and isolation
(Gask et al., 2011; Andrew et al., 2012). This provides some support for the Cognitive model of depression proposed by Beck (1967).

Furthermore, although all papers recruited South Asian women, it is essential that they are not all considered to be identical in their beliefs, values and experiences. The use of a collective ‘South Asian’ cohort in this literature review failed to report on the vast differences in religions, cultures, traditions and customs from one part of South Asia to the next. Bearing in mind that explanatory models are known to influence help-seeking behaviours, it is vital that these findings are not overly generalised in a reductionist manner. It would perhaps be more appropriate to consider findings from this synthesis as providing some support in steering assessment questions with this population. This would enable a more detailed shared understanding to be reached with South Asian women.

5. Suggestions for further research

Given the value of better understanding the lived experiences of depression in South Asian women in effectively engaging with them, one must first invest in further research to understand how to achieve this. Greater thought into the development of assessment measures that identify depressive presentations in this community, recognition of preferred causal models within a cultural context, and development of interventions complimentary of cultural needs would be important areas for future research.
Literature Review References


http://www.madinamerica.com/2014/12/depression-serotonin


Delivering Race Equality in Mental Health Care (2005), Department of Health


Research Report: British South Asians who hear voices: A Narrative Analysis

of understanding

Abstract

Introduction
The experience of hearing voices is incredibly distressing and stigmatising for individuals. In the UK, dominant models for voice hearing are within biomedical frameworks which fail to incorporate cultural and social understandings. The extension of these biomedical models to South Asian individuals may not be appropriate given the vast differences in beliefs, values and lifestyles that exist. This may explain the difficulties mental health services have in engaging with this community.

Aim
This research project aimed to explore the individual and cultural narratives that people from South Asian communities held about their experiences of hearing voices.

Method
Seven South Asian participants (two females and five males) were recruited from mental health services across Birmingham and Leicestershire, UK. They were interviewed about their experiences of hearing voices. Interviews were transcribed and analysed using Narrative Analysis, with a particular focus on Frank’s typologies of illness narratives to guide this exploration of meaning making.

Results
Individuals held a variety of narratives in understanding their experiences of voice hearing with elements of Chaos, Restitution and Quest running through most participants’ stories. The experience of restitution related to the increased hope in coping with voices rather than curability of voice hearing and quest narratives demonstrated an increase in purpose and the desire of voice hearers in helping others. Chaos narratives represented a lack of hope for recovery and were further perpetuated when cultural narratives were not facilitated.

Conclusion
Participants described complex frameworks of understanding for their experiences of hearing voices and discussed the role of social and cultural stigma as a barrier to accessing mental health support. By understanding the narratives of South Asian individuals who hear voices, services are better placed to engage with and support this community.
1. Introduction

Auditory hallucinations, also known as ‘hearing voices’, are a globally experienced phenomenon, reported across all societies and throughout human history. They are described as experiences of sound without obvious external origins that are separate from an individual’s own mental processes (Wing et al., 1990). Auditory hallucinations are among the most feared and stigmatising of human experiences and have been routinely associated with ‘madness’, insanity, and violence (Thornicroft, 2006). In most cases they are described as unwanted, intrusive and/or unintentional in nature, and can be experienced as a powerful reality, sometimes conveying difficult memories (Karlsson, 2008). They are undoubtedly extremely distressing and isolating for many individuals who have these experiences (Sartorius, 2002).

It is estimated that between 1-10% of the general population may experience auditory hallucinations at any given time (Johns, 2005; Verdoux & Van Os, 2002). In the Western world, the dominant discourse in understanding hearing voices is within a biomedical framework, where individuals are primarily viewed as symptomatic of psychiatric illnesses such as Schizophrenia. Whilst it is thought that nearly 75% of people with a diagnosis of psychosis experience voices, it is also understood that not everyone who experiences voices has psychosis (Johns, Nazroo, Bebbington, & Kulpers, 2002; Mueser et al., 1998). Alternative discourses for understanding voices, such as being a reaction to difficult life experiences or simply due to individual human differences also exist.

The Hearing Voices Network promotes the importance of working with individuals to develop meaning in their experience rather than imposing explanations upon them. Evidence that supports this position includes the research findings that up to
70% of individuals who hear voices do so after a traumatic and intense emotional event such as bereavement (Romme & Escher, 1989), and the high correlation of hearing voices and childhood sexual abuse (Andrew, Gray & Snowden, 2008). Given the multiple explanations that may exist for why individuals hear voices, the now worldwide Hearing Voices Movement established by Romme and Escher in 1987 insist that the phenomenon of auditory hallucinations should be regarded as a meaningful human experience and should not be used as a symptom of mental illness in isolation of other factors. Of the individuals who do hear voices, only a minority of are thought to require and seek mental health support from services. Those referred to mental health services tend to have voices that are persistent, negative in nature and generate immense distress. In contrast, the occurrence of auditory hallucinations in non-psychiatric populations is often appraised as positive and non-threatening by the voice hearer (Choong, Hunter, & Woodruff, 2007).

This paper begins by outlining a range of explanatory models for the experience of voice hearing before going on to describe the development of the current research question. The use of a qualitative methodology guided by a narrative inquiry approach is demonstrated in collating stories of voice hearing amongst British South Asian individuals. Results are ordered in narrative types and discussed in relation to the individual stories collated in this study.

1.1 Explanatory Models of Auditory Hallucinations

Kleinman (1980) introduced the term ‘explanatory model’ to explain how patients, clinicians and members of the general public conceptualised illness. The understanding developed by individuals in relation to an illness (physical and/or psychological) includes their beliefs about the cause of symptoms, the perceived impact of illness, and their management or treatment preferences (Karasz, 2005).
Thus, the explanatory models or discourses held by individuals for mental health problems are likely to influence how individuals relate to and make sense of their experiences and therefore determine their help seeking behaviours, engagement with services and compliance with treatment programmes.

A range of models have been proposed to explain the onset of auditory hallucinations. Theories of auditory hallucinations as ‘inner speech’ suggest that defective source monitoring can lead to the false attributions of inner speech, or thoughts, to an external source (Bental, Corcoran, Howard, Blackwood, & Kinderman., 2001). This concept of ‘inner speech’ has been further developed by socio-cognitive models of voices which add that an individual’s beliefs about, and appraisal of, the misguided inner speech can determine the future occurrence and characteristics of the voices they hear (Chadwick & Birchwood, 1994). How voices are interpreted, for example in their perceived origin and intent, can also influence an individual’s emotional and behavioural response to voice, including their coping strategies (Beck & Rector, 2003). Beliefs about voices are therefore seen to be critical in the assessment of risk (Juginger, 1995).

Furthermore, Romme and Escher (1989) proposed a three-phase model for the experience of hearing voices. The initial **Startling Phase** describes the onset of hearing voices which is likely to result in the denial of this experience, followed by withdrawal and isolation. This is followed by the **Organisational Phase**, where the initial panic becomes anger. In this stage, the voice hearer begins to introduce and use coping strategies to manage their voices. If the voice hearer is able to accept and take responsibility for the voices, they are said to move onto the final stage; **Stabilisation Phase** when an individual accepts the experience of voice hearing as part of their lived experience, taking control over this and reaching acceptance.
The model suggests that individuals can move back and forth between phases or become stuck at one.

1.2 Cultural and Religious Context

Whilst the dominant models in the Western world tend to favour the notion of voices as being a result of brain dysfunction requiring drug-based interventions and are well documented in literature, they may not be helpful for everyone (McCathy-Jones, 2012). These models often fail to incorporate the spiritual and cultural dimensions which can form the very contexts in which these experiences are understood by many voice hearers, resulting in the alienation of those for whom dominant models are not preferred or compatible.

There is vast diversity in the spiritual and cultural discourses that exist in relation to unusual human experiences such as voice hearing. Individuals in many parts of the world conceptualize voices as evidence of a higher spiritual connection, as supernatural (e.g. jinns and spirits) and even as demonic rage (Grof & Grof, 1989). There are examples of individuals hearing voices across all cultures, in religious scriptures, Greek mystic tales and folklore for thousands of years which can all shape the way people continue to understand these experiences in the modern age.

The religious texts of Christians and Muslims explicitly describe many incidents of voice hearing within the context of it being a unique and special experience. In Islam the Prophet Muhammed is believed to have heard the voice of Angel Gabriel and despite the Prophet’s initial shock, disbelief and distress, he later came to accept and value this experience. Over many years the Prophet had the entire text of the Quran revealed to him through the Angel Gabriel’s voice which remained
unheard to others. Similarly, other religious records include those of Jeudo-Christian scriptures where God is thought to have spoken directly to Adam with instructions for his duties in the Garden of Eden as well as records of God speaking directly to Moses.

Furthermore, in tracing how the history of religion has shaped our understanding of voice hearing, we also come across dominate theories of possession and witchcraft which were widely used by the Catholic Church to explain this phenomenon. In this instance, auditory hallucinations were seen as a dark and evil force not in keeping with the teachings of God and resulted in dramatic interventions such as exorcism and even sentences to death. Today, in many cultures that have maintained alternative cultural models, similar beliefs and practices may still exist.

The role of religion, culture and spirituality in understanding unusual experiences such as hearing voices has continued to evolve and develop, albeit less openly than the dominant psychiatric narratives seen in the West. Often ideas cemented within the context of religion and culture have generated debate and have raised important questions about the role of spirituality in health promotion and between spiritual leaders and mental health services (Friedli, 2000).

In Islam there are thought to be a range of spiritual beings including, Jinns (spirits made of smokeless fire), Shaytaan (the Devil and satanic demons), Faristas (angels). Jinns are believed to attack individuals who are thought to lack confidence or self identity, are perhaps weak willed, or greedy and driven by earthly possessions (Al-Ashgar, 2003).

A study by Saeed, Gater, Hussain and Mubbashar (2000) sought to understand the practice of faith healers in Pakistan. The study, which observed the faith healers
with 139 attendees found the classification of mental disorders was based on mystic causes such as ‘saya’ also known as black magic (27%), jinn possession (16%), and ‘churail’ or female ghosts (14%). The study found faith healers to be the major sources of care for mental health problems in Pakistan, particularly for women with little education.

Whilst beliefs of spirit possession are not exclusive to South Asian populations and are in fact well documented across cultures, the identification of spirit possession tends to be pathologised in western societies, where there is a preference for scientific approaches to understanding mental ill health. Possessed individuals are thought to sometimes display symptoms associated to schizophrenia, epilepsy and Tourette syndrome. Within a cultural context this may be understood in spiritual terms, whilst in the western world individuals are seen to be suffering from a mental illness (Dein & Illaiee, 2013).

In the UK alone, South Asians make up approximately 7.5% of the population in England and Wales according to the 2011 Census. The term ‘South Asian’ is used to describe people of Pakistani, Indian, Bangladeshi and Sri Lankan decent. Those of Indian (2.5%) and Pakistani (2%) origin make up the largest proportion of this, followed by Bangladeshi communities (0.75%). The remaining 2.25% includes individuals of Sri Lankan, Chinese and other Asian decent. Although this continues to be a growing population in the UK, the numbers are not reflected in the diversity of people who access mental health services.

For those who do access services, low service user satisfaction rates amongst South Asian and other minority ethnic groups have failed to improve over time (Bhui, Chandran, & Sathyamoorthy, 2002). Fundamental differences in values, beliefs and lifestyles may mean they hold alternative narratives for understanding
voices. Thus, the imposition of western psychiatry to non-western cultures may be contradictory and ineffective for this population, and perhaps contributes to the distancing of ethnic minority communities from accessing and benefitting from mental health provisions. In order to better engage these hard to reach communities, we must first invest in understanding their voice hearing narratives.

1.3 Importance of Narratives in Cultural Research

As humans we are natural storytellers who live in a world constructed through narratives (Bruner, 1996). We make sense of ourselves and the world around us through multiple stories that follow the chronological order of events through time. We articulate these through language and use stories to relate to other people (Baldwin, 2005). Stories are personal and unique, following the trajectory of life. The progression of events through time helps to order and tell the story, with the past impacting on the present and future. Furthermore, Roberts (2000) talks about narratives as providing cognitive and emotional significance to our experiences and argues that they are essentially a means of “constructing and negotiating a social identity, giving moral weight and existential significance to actions and events”.

In recent years the use of narrative analysis as a qualitative research method has grown in interest amongst those undertaking psychological and social research tasks. The interest in how people make sense of their lived experiences and how they construct an account of these is of great importance in understanding human phenomena. Naturally, narrative research is not only interested in how one tells a story, such as their choice of words and how events are organised, but also the conscious and unconscious meanings given to their experiences. Newton (1995) terms this ‘The Said and The Saying’ of stories. Experienced based narratives are
“assumed to be individual, internal representations of phenomena – events, thoughts and feelings – to which narrative gives an external expression” (Andrews, Squire & Tamboukou, 2013). Other emphases of narrative inquiry are interested in how narratives develop, how they are co-constructed in conversations between the narrator and the audience, and the role of societal factors on their development (Bakhtin, 1981). Thus, given that narrative inquiry is a methodological approach that facilitates individuals in telling their narrative, it is a valuable tool for researchers interested in the individual experiences, yet remains to be applied to the field of voice hearing.

1.4 Cultural Variations in Narratives for Mental Health Problems

Invariably, cultural influences on the understanding of psychological distress are accepted to exist. Research has demonstrated that cultural differences in the explanatory models for mental health problems influence help-seeking behaviours and preferences for culturally compatible coping strategies. For example, Wahass and Kent (1997) found Saudi Arabian patients were more likely to attribute auditory hallucinations to Satan or Black Magic and adopted coping strategies related to their religious beliefs. This was in comparison to UK patients who preferred physiological strategies and attributed their auditory hallucinations to diagnoses such as Schizophrenia or medical causes such as brain damage. Interestingly, confidence in their preferred coping strategies was high in both culture groups, suggesting that both were appropriate in their given contexts. This emphasises the importance of facilitating culturally appropriate interventions in order to increase engagement of service users distressed by auditory hallucinations. However, in order to develop culturally compatible interventions, we must first invest in understanding the narratives of individuals within their cultural frameworks.
Reassuringly, there is now a growing acceptance for the value of multi-faceted models for mental health experiences. Jablensky and Sartorius (2008) have argued that religious and cultural understandings of mental health experiences should not be viewed as primitive, but rather as part of complex and helpful frameworks of understanding. They have suggested this to be the reason for why patients diagnosed with Schizophrenia do better in the developing world, compared to the developed world. However, whether primitive or not, these cultural narratives need to be recognised and understood in order to successfully engage and work with ethnic minority individuals in the UK. Cultural narratives can offer services and service users with a more meaningful and accurate understanding of their auditory hallucinations, reduce distress for voice hearers and allow services to provide more tailored and effective interventions from the outset.

Given the importance of cultural narratives in the understanding of mental health difficulties, the present study was interested in exploring the types of narratives held by South Asian voice hearers, how these were constructed and how others interacted with and influenced these stories within the cultural context. This was felt to be particularly important given the absence of similar research having already taken place and the ineffective application of dominant western models to this population.

Terminology
The use of diagnostic terminology such as ‘schizophrenia’, ‘auditory hallucinations’ and ‘mental illness’ have been avoided where possible. The use of such terms are clearly guided by a psychiatric construct and are becoming increasingly contested by voice hearers themselves. Alternative discourses exist within psychology, social and anthropology fields where other terminology such as ‘voice hearing’ is used in place of diagnostic terms.
Thus, whilst care has been taken to avoid using psychiatric terminology where possible, terms such as ‘schizophrenia’ are used in reference to the broad experiences including the presence of hearing voices within the psychiatric construct of ‘psychosis’.

Research Question

What individual and cultural narratives do South Asian people hold about their experiences of hearing voices? What influences how these are constructed and how they are shared?

2. Method

The researcher was keen to select a methodological approach that would not only be congruent with the research aims, but one that would also ensure that participants’ experiences would not become fragmented or objectified in the process of this project. The use of a qualitative method was therefore felt to be the most appropriate in carrying out research into the lived experiences of individuals who hear voices. In doing so, the researcher carefully considered two qualitative approaches; Thematic Analysis in general and the specific use of Interpretative Phenomenological Analysis as a type of this, and Narrative Analysis.

In order to best answer the research question, the researcher decided against focusing explicitly on individual experience and instead chose to include the influences of broader social factors including cultural discourses and narrative traditions on the development of individuals’ accounts of voice hearing. This was to enable the researcher to understand more deeply how individuals from South Asian communities form narratives to make sense of and share their experiences of voice hearing. It was felt that the use of Interpretative Phenomenological Analysis would
have restricted the opportunities to do this effectively given the methods idiographic focus and lack of attention to stories and storytelling. As such, the use of Narrative Analysis was decided upon. A particular focus on Frank’s (2010) work on the typologies of illness narratives was used to guide this analysis, enabling the researcher to focus not only on the types of narratives individuals held about hearing voices, but also the factors influencing how these stories were developed and shared.

2.1 Design

Many approaches to interviewing participants in qualitative research exist. They include structured, semi-structured and unstructured interview types, each with its benefits and limitations. The main difference between these types of interviews lies in how strictly an interviewer must adhere to an interview schedule or set of rules outlining the interview questions and process. Whilst a structured approach can be useful in gaining very factual and specific types of information from a participant, it allows less space for details of an individual’s understanding to develop. On the other hand, a semi-structured interview provides the interviewer with some flexibility during the interview to elaborate on certain areas of interest, but still requires the interviewer to follow a protocol. The benefit of these interview designs is that they enable interviews to be carried out in a more uniform manner with all participants, thus increasing the validity and reliability of the approach and making it easier to replicate in the future or for interviews to be carried out by more than one interviewer.

In contrast to the varying structured approaches, the unstructured interview allows for the most amount of flexibility and therefore enables the individual story to unfold more naturally. This approach gives the participant the freedom to talk about what
is important to them in relation to the topic area without continual prompting or
guidance from the interviewer. Unstructured interviews therefore call for a more
relaxed atmosphere and can enable a better rapport to develop in the room.
However, in order to maintain some degree of focus to the research question with
the time constraints of the project, the researcher was required to impose some
parameters to this process. For example, all participants were aware of the nature
of this research and were asked specifically about their experiences of hearing
voices at the start of the interview. Participants who did not generate any specific
information on their voices or understanding of these were prompted to do so. The
interviewer was guided by the participant in identifying what was important to share
and was not prescriptive with a protocol or script.

2.1.1 Ethical Approval
An application for ethical approval from the East Midlands Ethics Committee was
granted in February 2014. Further submissions for permission were made to and
granted by the Research and Development Departments across Leicestershire and
Birmingham and Solihull (see Appendix H). This allowed the researcher to recruit
participants from all mental health services including Early Intervention, Community
Mental Health and Assertive Outreach Teams in these locations.

2.1.2 Recruitment
The researcher identified and contacted the managers of appropriate mental health
teams in the first instance to explain the purpose of the research. In some cases
the researcher attended their team meetings to further advertise the research.
Teams were provided with the Participant Information Sheets (Appendix C) and the
inclusion/exclusion criteria were explained to staff. Potential participants who met
the inclusion criteria were contacted by staff such as their Care Coordinators to
promote the study. The researcher gained full informed consent prior to carrying out interviews (Appendix D). The recruitment process is described in further detail in the figure below.

**Figure 3: Recruitment Process**

**Phase 1**
Mental Health Services were contacted via telephone calls or emails. Clinical Psychologists with direct involvement with local Hearing Voices Groups and/or South Asian community organisations were also approached.

**Phase 2**
Care Coordinators were briefed about the purpose of the study and provided with Participant Information Sheets (PIS). They were asked to identify and approach potential participants who met the inclusion criteria.

**Phase 3**
Potential participants were approached by their Care Coordinators. Participants showing interest were given PIS to take away and consider for at least seven days. Participants gave verbal consent to be contacted via telephone by the researcher.

**Phase 4**
Interested participants were contacted by the researcher to confirm their willingness to partake. Researcher double checked inclusion criteria were met and answered questions. A date/time/location was arranged for the interview.

**Phase 5**
Prior to the interview, the researcher took time to go through the PIS and consent form, answering questions and ensuring they understood that taking part or later withdrawing consent would not affect their level of care. Consent form signed with a copy for the participant to keep, before the interview was conducted.

2.1.3 *Inclusion and Exclusion Criteria*
Before participants were approached for recruitment to this study, a set of criteria were considered. This helped care coordinators to identify potential participants who they could approach and served to help them to exclude those who would not have been appropriate to interview in this particular study. This included consideration of how well participants were at the time of the study to avoid approaching and potentially causing further distress to acutely unwell participants. These are outlined below.

**Table 4: Inclusion and exclusion criteria**

<table>
<thead>
<tr>
<th>Inclusion Criteria</th>
<th>Exclusion Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Asian adults aged 18 years and over who report actively hearing voices.</td>
<td>Potential participants who did not meet the inclusion criteria. Individuals for whom current mental health prevented them from providing informed consent or talking about their voices.</td>
</tr>
<tr>
<td>Able to speak English or Urdu/Punjabi and be supported by Mental Health Services across Leicestershire and Birmingham. Those able to provide full informed consent.</td>
<td></td>
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</tbody>
</table>

2.1.4 Sample

A total of seven participants were recruited from a range of mental health services across Leicestershire and Birmingham. All participants identified themselves as South Asian and were aged between 20 and 54 years old (n=7, mean age of 38.7 years). Two female participants and four male participants were recruited. Every participant reported actively hearing voices and had varying psychiatric diagnoses. To protect their identity, all participants were given a pseudonym and only an age range is reported.
Table 5: Demographic information about sample. Participants are organised in chronological order of interviews.

<table>
<thead>
<tr>
<th>*Participant Name</th>
<th>Gender</th>
<th>Age Range</th>
<th>Generation and Ethnic Group</th>
<th>Mental Health Service</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kal</td>
<td>Male</td>
<td>18-24</td>
<td>Second generation British Indian</td>
<td>Early Intervention</td>
</tr>
<tr>
<td>Musa</td>
<td>Male</td>
<td>25-34</td>
<td>First generation British Bangladeshi</td>
<td>Assertive Outreach</td>
</tr>
<tr>
<td>Aslam</td>
<td>Male</td>
<td>35-44</td>
<td>Second generation British Pakistani</td>
<td>Community Mental Health</td>
</tr>
<tr>
<td>Hitesh</td>
<td>Male</td>
<td>45-54</td>
<td>First generation British Indian</td>
<td>Hearing Voices Group</td>
</tr>
<tr>
<td>Neha</td>
<td>Female</td>
<td>35-44</td>
<td>Second generation British Indian</td>
<td>Assertive Outreach</td>
</tr>
<tr>
<td>Priya</td>
<td>Female</td>
<td>45-54</td>
<td>First Generation British Indian</td>
<td>Community Mental Health</td>
</tr>
<tr>
<td>Sandeep</td>
<td>Male</td>
<td>35-44</td>
<td>Second generation British Indian</td>
<td>Hearing Voices Group</td>
</tr>
</tbody>
</table>

* All participants have been given pseudonyms to protect confidentiality

2.2 Procedure

2.2.1 Participant Information Sheet and Consent Form

In line with research ethical guidance, participants were required to provide full informed written consent prior to being interviewed. A Participant Information
Sheet detailing the purpose and procedure of the study as well as information regarding how data would be used and how participants could withdraw consent was developed. Any further queries which may have arisen for potential participants were discussed and clarified before consent was sought. A written consent form was also developed to ensure participants were aware of and consenting to each element of the research, analysis, and dissemination procedures.

2.2.2 Interviews

A time and place convenient for the participant was arranged for the interview. This included mental health service buildings, supported accommodation and community bases. Each interview was carried out by the researcher and lasted up to one hour. Interviews were recorded using a digital recording device and participants were informed that they could ask to have a break if they wished to do so. The researcher began interviews by asking participants to talk about the onset of their voices and followed this with further questions and prompts with the aim of building up a detailed account or narrative for each participant’s understanding of hearing voices. Furthermore, the researcher was careful to avoid asking closed or leading questions and instead asked for clarification and elaboration of points raised by participants. By doing so, the researcher was able to maintain a position of interest and enquiry to ensure narratives were detailed and clear.

Following the interview, participants were informed that they could request a summary of the anonymised research findings once the study came to an end. Although all participants reported feeling well during and after the interview, they were encouraged to contact their mental health teams for support should this change.
2.3 Analysis

Unlike other qualitative research techniques such as Grounded Theory of Interpretive Phenomenological Analysis, Narrative Analysis is not accompanied with explicit frameworks or instructions describing how to collect and analyse research data. This can be both liberating and anxiety provoking for researchers embarking on this journey. Differences in the focus of narrative inquiry and analysis vary depending on researchers’ preferred theoretical stance. For example, Andrews, Squire and Tamboukou (2013) outline three types of narrative research; event based, experience based and co-constructed narratives. Event based narrative research is concerned with the narrator’s verbal account of past events (Labov & Waletzky, 1967), whilst experience based narrative research explores accounts of real or imagined phenomena from a range of media including interviews, diaries and videos. Meanwhile co-constructed narratives look at how dialogue between people such as through conversation can lead to the development of a narrative that is socially constructed (Bakhtin, 1981).

Humans have an innate tendency to tell and make sense of stories (Bruner, 1990) and stories are almost certainly always told within a social context. Furthermore, stories can be considered as reconstructions of past events which are shaped by the circumstances in which they are told and will follow different formulas each time they are expressed (Andrews, et al., 2013). Therefore, the role of the narrator (i.e. the participant) and the listener (i.e. the researcher) require important consideration as both are actively involved in how a story develops (Ricoeur, 1991).

An approach complimentary of the types of narrative research described by Andrews et al. (2013) is Frank’s (2010) work on narrative typologies which focuses in particular on the illness narratives of individuals with cancer. Frank attempts to
group stories by type in an attempt to facilitate a better understanding of how these stories are generated and told. The approach does not seek to reduce understandings into predetermined categories but instead hopes to be more inclusive in recognising the various influences on how these narratives are shaped. Frank describes the use of typologies as acting as *Listening Devices* aiding both the storyteller and those listening to them. The approach is complimentary of the three types of narrative research described by Andrews *et al.* (2013) as it recognises that narratives are not composed in isolation of other social and cultural influences, but are instead co-constructed.

Furthermore, given the dominant discourse for hearing voices as being symptomatic of illness, it would not be misplaced to adopt Frank’s approach to physical illness narratives in the current context. In addition to this, Frank’s critical considerations into role of the medical model in physical illness as medicine eclipsing meaning are all too familiar within the mental health arena. Thus, the use of narrative analysis, with a particular focus on Frank’s narrative typologies to guide this understanding was considered to be appropriate in the present study.

**Narrative Typology**

Frank (2010) in his extensive work on illness narratives suggests a set of three typologies that exist. Each type provides a therapeutic function for the storyteller, who through the process of repeatedly telling and retelling the story can unravel and make sense of their experiences.

The three narrative types that Frank identifies are the Restitution Narrative, the Chaos Narrative and the Quest Narrative. Each is briefly described below;

1. **Restitution Narrative**: in this example of a narrative type, the storyteller has achieved a position of restored health following a significant period of ill-
health. The individual has benefited from and is complementary of the treatment they have received, which has enabled them to return to a state of good health. These types of narratives are endearing for audiences to hear evoking pleasant feelings for both the narrator and listener.

2. **Chaos Narrative**: in contrast to a restitution plot, a chaos narrative is often the most intense, the least narrated and the most difficult to hear. Individuals who have this type of narrative have generally experienced multiple set-backs in their treatment without any resolve to their illness. As a result, the narrator becomes overwhelmed by the intensity of his experiences and finds it impossible to tell the story in a coherent manner. They lack in sequencing and are told by an individual who cannot yet reflect on their experiences.

3. **Quest Narrative**: in this type of narrative, the individual has experienced a range of setbacks in their recovery journey but has been able to gain strength and knowledge along the way. This individual finds purpose in their illness and seeks to create positive change for themselves or others as a result of their own suffering by directly tackling the symptoms. They provide the individual to find alternative ways of being ill which are rewarding and fulfilling.

In the western world we are often exposed to and strive for the ideals of a restitution plot whereby the ill person experiences the benefits of modern medicine and is restored to full health, or at least expects to recover in due course. These stories are well rehearsed in the media and easily shared by storytellers. However, Frank talks about how illness narratives are developed in collaboration with the individual, his or her family, friends and health services. By identifying the narratives held, we can better understand the interactions that have helped to
shape this lived experience. The exploration of narrative typologies in the analysis of the current research was therefore felt to be relevant for this reason. The method allows the researcher to understand how individuals are affected by the experience of hearing voices whilst actively paying attention to the context of their cultural and social interactions and resources.

**Narrative Analysis Process**

The process of narrative analysis based on Frank’s typologies involved several steps. Following one to one interviews with participants, the researcher chose to independently transcribe each audio recording into a transcript. This provided the researcher with the opportunity to familiarise herself with each participant’s story and to become immersed in the narrative data presented. Transcripts were transcribed verbatim and the use of a reflective journal was used to not any points of interest. Each transcript was read and re-read several times. Interesting themes about the plot, characters and events were pulled out and considered within the context of Frank’s work on narrative typologies. This allowed the researcher to identify best-fit typologies for each individual interview based on Frank’s three narrative types. As such, line by line coding was not necessary, but was helpful in generating details about specific issues that may have been pertinent for individuals.

2.4 Research Quality and Integrity

The scientific rigour of qualitative research is often brought into question, particularly in regards to its reliability and validity. However, measures can be put into place to ensure to reassure readers of its integrity, quality and credibility. Elliott, Fischer & Rennie (1999) presented a set of seven guidelines common to
qualitative and quantitative research as well as a further set of seven guidelines specifically qualitative guidelines.

Box 1. Elliott, Fischer and Rennie (1999) evolving guidelines for qualitative research

<table>
<thead>
<tr>
<th>A. Guidelines shared by qualitative and quantitative research:</th>
</tr>
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The researcher found these guidelines to serve as a valuable checklist in designing, conducting and reporting the present research project. They ensured the researcher paid attention to the appropriateness of the research method, the role of the researcher’s own experience, beliefs and values in relation to the present study, and the importance of providing space for credibility checks to take place. The researcher put in place a range of measures to ensure the present study was credible in light of this guidance.

**Reflexivity**

Reflexivity requires the researcher to be aware and critically reflective of their own values, behaviours and assumptions with a view to understand how these may
impact on the research process (Gerrish and Lacey, 2006). Reflexivity therefore forms an integral part of qualitative methodology and can be executed in a number of ways including through supervision and a reflective journal. The researcher of this study used a reflective journal to document any thoughts or wonderings as they arose, revisiting these throughout the research process. Regular supervision with the research and field supervisors was also a valuable resource to reflect on the researchers own biases and the influence of these on the research findings.

i. Bracketing
Bracketing interviews are commonly used by qualitative researchers during the process of data collection and analysis as a way of identifying and temporarily putting aside the researchers own beliefs, values and assumptions (Tufford and Newman, 2010). Whilst this is not a fool-proof method resulting in complete separation, it can be a useful exercise for researchers before they embark on qualitative research activities. The researcher of this study completed a bracketing interview prior to data analysis. This was in line with the thoughts of Giorgi (1998) who advocated for the timing of bracketing to take place post interview stage and pre-analysis of data so a to not interfere with the engagement of participants. The bracketing interview was helpful in allowing the researcher to think about the set of beliefs, values and assumptions held in relation to the research topic and allowed this to be reflected upon. An overview of the interview is shown in Appendix F.

ii. Providing Credibility Checks
The use of analyst triangulation was implemented during the data analysis phase and was felt to be key in ensuring a robust and fair interpretation of interview material, thus increasing the validity of qualitative research (Patton, 1999). This was carried out in collaboration with the research and field supervisors, both Clinical Psychologists with experience of qualitative research. It is worth noting
that the goal of triangulation here was not primarily to reach a consensus in interpretation, but to ensure the researcher was attending to the material as comprehensively as possible. The use of triangulation therefore prevented the researcher from being limiting in how thoroughly the data was examined from a number of perspectives.

The researcher is a female second generation South Asian who identifies as a British Muslim. She has almost a decade of experience working in the NHS within a range of mental health service provisions and is training as a Clinical Psychologist. Her experience, cultural and religious beliefs, as well as the assumptions she had were regularly discussed and reflected upon during supervision. This allowed the researcher to be mindful of how these factors may have impacted on the interpretation of research findings.

3. Results

The researcher obtained a wealth of information from the analyses of interviews and considered different approaches of how best to present this. Approaches included reporting the findings case by case or, alternatively grouping findings by typologies and themes. Whilst it was important to the researcher that individual stories would not become fragmented and therefore meaningless, it was also important that information was organised in a rational and useful way. The researcher decided upon structuring findings by typologies as this was felt to be the most suitable method in reporting how the individuals’ understanding of voice hearing related to the types of illness narratives described by Frank. This format of presenting findings was also used by Thomas-MacLean (2004) in a study of breast cancer stories and the structure was felt to translate well in the current paper. As such, findings are presented in relation to the three narrative typologies;
Restitution, Chaos and Quest, described by Frank (2010). The researcher uses extracts from interview material to illustrate these results.

Restitution Narrative

Frank talks about restitution narratives as being the most desirable type of stories to be heard by others and are considered the easiest narratives to be told by an ill person. Good health is considered to be the ‘normal’ human state that one hopes is restored after a period of ill health. These stories are shaped by the dominant cultural preference for recovery and are frequently told in physical health contexts where one is unwell, receives appropriate treatment and subsequently recovers. There is usually a positive medical discourse and physicians are often held in high regard as heroic. In the present study the participants primarily identified with experiences of mental ill health, particularly in respect to their voices.

Whilst restitution narratives refer to recovery from symptoms, it did not seem to fully fit with the narratives of this sample and subsequently no participant told a restitution narrative in its purest form. This could be explained by the fact that all participants continued to actively hear voices at the time of interview. All participants were also actively receiving support from mental health services, and varied in the chronicity of their symptoms. As such, in the current context of hearing voices, the restitution narrative was not told in relation to an absence of symptoms but rather in relation to the ability of individuals in accepting these, with the realistic hope of returning to a level of functioning similar to that of pre-onset of their voices. When adjusting the restitution theme to accommodate this concept of acceptance and hope, many narratives were seen to resonate with this typology more effectively.
Restitution narratives required the individual to be able to reflect on their experiences, thus created some distance from the immediacy of the distress they may have felt in relation to their voice hearing. Interestingly, this narrative type was also seen to translate across cultures and was also seen to be desired by the South Asian individuals interviewed in this study, who craved an improved state of mental wellbeing. Restitution was aspired to and even romanticised by many of the individuals for whom dominant narratives were chaotic, unpredictable or embedded in suffering. The extent of this optimism for restitution varied between participants and for many it was rooted in their religious beliefs and faith in the support networks around them, including family, friends and mental health services.

One participant, Sandeep a second generation Indian male aged 40 years old, began his story at the point of onset of his voices. His story moved smoothly through his experiences of breakdown, hospital admissions and conflicts between the cultural discourses held by his family in understanding his voices. His story was gripping to hear, was full of examples of how he had overcome adversity, and described how his relationship with his voices, mental health services, and friends had changed over time. He ended his narrative at a place where he was able to accept that his voices may never go away, but now ‘owned’ this phenomenon as part of his lived experience. For Sandeep the concept of time as a healer was important and there was a clear recognition of how far he had come in his journey with reflections on how traumatic the early days of his illness had been. For this participant in particular, the role of acceptance was important in moving forward.

What ever I was thinking, they (the voices) were talking about it and I just couldn’t come to terms with it at first. No, it was too much, it was too much. I didn’t know what was happening to me. I was just so ill I couldn’t understand what was happening to my life and it was horrible in those
days…but slowly slowly I’ve come to deal with it better and try to cope with it better. (Sandeep, 40)

Whilst not completely rid of their voices, many participants talked about an improved state of functioning compared to the past, and in particular, compared to the peak of their mental illness. This seemed to generate further hope for resolve in their situations and allowed the restitution narrative to grow and become increasingly dominant over other types of stories in these cases. Furthermore, it seemed that the presence of hope in narratives was further enabled in instances where cultural stories were also facilitated to flourish, and particularly in cases where the biomedical model was questioned and scrutinised by individuals. The value in religious activities such as praying to God and visiting places of worship were seen to contribute further to hope for recovery, as well as improved mental well-being and overall coping.

One individual, 36 year old second generation Pakistani called Aslam, demonstrated through his narrative how advice from a religious scholar had allowed him to understand his experiences in a way that made sense to him and offered coping strategies embedded in his religious beliefs. For this participant, visiting an Imam (Islamic scholar) was his preferred route of assessment and support.

I thought I would explain what was happening and I told him (the Imam) about the voices and he told me from an Islamic background of what it possibly could be and gave me a passage from the Quran that he told me to wear that will help ward off spirits. (Aslam, 36)
Interestingly, the emphasis of cultural stories in this study differed from the examples of restitution narratives discussed by Frank in his work with cancer patients. In Frank’s work, restitution was very much demonstrated by an investment of hope and attribution of recovery to biomedical models and in particular to the physicians working to treat cancer patients. There were no clear examples of this in the restitution narratives of South Asian participants who hear voices. Instead, for some individual’s the cultural narratives were seen to clash with the dominant biomedical models and led to a fierce battle in participants trying to choose one over the other without space for integration of multiple stories. This resulted in cultural narratives becoming increasingly restricted at an individual level by three participants, Musa, Neha and Kal, despite continuing to exist and function in their wider familial support networks. This tension perhaps individuals from reaching a point of restitution in their narratives and may have led to continued angst when biomedical interventions consistently failed to relieve them of their auditory hallucinations. It also generated differences in preferred coping styles between the individuals and their families and created conflicts in understanding.

Thus, the importance of cultural narratives in providing meaning was seen to be protective for participants and allowed them to explore alternative ways of coping that were in keeping with their cultural and religious beliefs. In cases where mental health services were accommodating of cultural stories, participants seemed to have greater hope in their recovery and engaged well with services. There appeared to be better service satisfaction and participants were able to adopt and benefit from a range of coping styles. This was especially important given the failure of medication alone in being able to cure people of their voices in this sample.

Chaos Narrative
The chaos narrative seems to fit well with the stereotypical way in which mental ill health and hearing voices are portrayed in modern media, as unpredictable, highly emotive and not readily discussed. Chaos narratives, according to Frank's work, are both difficult to tell and difficult to hear, making them the stark opposite to restitution narratives. In chaos narratives the storyteller finds it challenging to organise and reflect upon past, present and future events and seems deeply rooted in a place of suffering. This results in a disjointed narrative with a great deal of repetition, disruption and uncertainty. In the present study, there were many examples of chaos running through some individuals’ stories. For example, one participant in particular, a 33 year old Bangladeshi man named Musa, told a story very fitting of a chaos narrative. A striking feature of Musa's narrative was his tendency to list and repeat his problems to demonstrate the sheer intensity and impact hearing voices had had on every aspect of his life:

I have like, family problems, childhood problems, life problems, money problems. All the problems that (can) happen in life….I don't know what to do and when to do it and that's what its like (for me). I'm in a place where I can't do anything. I have life problems, money problems, childhood problems and mostly family problems. (Musa, 33).

In the chaos stories heard in the present study, there was often a conflict between the cultural discourses and biomedical frameworks of understanding. In these instances, the onset of voices was sometimes talked about in relation to mystical forces and Black Magic. These narratives generated feelings of helplessness in participants as they were seen to have little control over their own mental health and wellbeing. It also created a sense of victimisation whereby the individual had been punished by another. Furthermore, the role of Black Magic was also seen to
be accepted by families of voice hearers and the preferred interventions were spiritual or religious in nature. However, in these cases of chaos narratives, it seemed that these individuals had been unable to further invest in or explore these cultural discourses. This generated confusion for participants and led to further difficulties in talking about their experiences, reducing them to taking on a 'sick role'. A clear example of this was in the narrative of Sandeep who was exposed to strikingly different explanatory models for his voices based on the cultural ideas of his family and the biomedical model presented to him by the mental health services:

'Religious people (were) saying that someone had done something to me, like some kind of black magic and I was saying “no, this is not it”. Even my family in India were saying “bring him here and we’ll try and sort him out”. I was like no way! You know I have a condition. I’m not, I’m not bloody possessed by someone. I’m just not well”. (Sandeep, 40)

The use of the 'sick role' in participants with dominant chaos narratives were also seen to be indicative of a lack of agency in coping, whereby the prime responsibility of treatment was handed over to mental health services. In doing so, the participants were relieved of many responsibilities they may have been expected to assume if they were not unwell. This exemption from responsibilities was seen to be functioning as it allowed mental health services to continue pushing the biomedical model without incorporating alternative cultural stories and it freed the individuals from engaging in difficult life tasks. Therefore, the mental health teams supporting these individuals were seen to be the active contributors towards treatment and voice hearers became the passive recipients of this.
Unfortunately the loss of cultural stories in this process was at the cost of moving these individuals towards restitution. It instead increased the dependency of participants on services to be cured and reduced their own agency in contributing towards this. It also shut down any opportunities to incorporate and reflect upon cultural and religious beliefs about onset and treatment, leading to a mismatch in beliefs about Black Magic as a cause and biomedical treatments. The unfortunate result of this was the increased alienation of individuals from society which perpetuated further distress and isolation:

Ever since then (onset) I have been staying home like this, hearing voices, not knowing what to do and getting angry, violent, staying home all day. (I) stay home 24 hours a day for the last 12 years, I've been staying home 24 hours a day...people don't give me chances in life and no one likes me and no one talks to me. (All) they see (is my) screaming and shouting...I want to work in a restaurant for 40-45 years and earn money. But I stay in the house and (I) smoke cigarettes. (Musa, 33).

Furthermore, all participants talked about the onset of their voices as being unexpected, confusing and distressing as well as coming at a time of heightened stress or at points of significant life transition. Almost every participant described hesitation in their decision to disclose to family or friends that they were hearing voices although reasons for this varied. Some participants reported fear of being labelled as mad or crazy whilst others did not wish to worry their families. Upon talking about their voices, some participants reported relief at having been able to share this and all received psychiatric assessment and intervention as a result.

One participant, a 35 year old Indian female called Neha, talked about the excitement she had felt at finally moving out of the family home and the
opportunities she could look forward to. However, the onset of hearing voices and her mental health difficulties disrupted these hopes and eventually made it impossible for her to continue living independently. When reflecting on this time in her life, Neha was aware of her naivety in expectations of independence versus the reality that presented, almost mocking herself in the narrative:

    Before that point I was fine, I mean I was okay, I was getting on with my life. I was getting on with things that I wanted to do and I was quite happy with what I was doing, you know? It was like a fresh start for me because I’d just moved out of the family home, so it was a fresh start for me and everything was going quite well…so I had this new flat and I was like “ooh, you know, ooh this is so good, I can get myself a job, I can get myself a man, thinking I can settle down, I can do what I want”, and little did I know I was going to start hearing all these voices. (Neha, 35)

Frank talks about the onset of illnesses as narrative wreckage where the individual loses their way and struggles to reconnect to the past or move towards a destination, likening it to a storm. Whilst stories work to repair this damage, in chaos narratives the individual is unable to access new ways forward and becomes stuck. The process of storytelling is therefore unable to form a bridge to recovery and instead the illness causes repeated disruptions to individual’s experience.

In the present study, the shattering effect of hearing voices and mental health breakdown on participants’ lives was not limited to the point of onset but continued to disrupt their daily lives at present. Participants spoke about the how the experience of hearing voices impacted on their mood, ability to form and maintain relationships, and how the voices caused ongoing anxiety about the present as well
as the future. Participants spoke about disruption as manifesting in a variety of ways including relapses in mental health and inpatient admissions.

It could be argued that the lack of weight given to cultural discourses about onset and coping by mental health services further perpetuated narrative wreckage and prevented participants from finding meaning in their experiences. Instead, a focus on biomedical frameworks of understanding, whilst perhaps containing for mental health services, served to further complicate opportunities for recovery and resulted in the further distress for individuals when medical interventions failed to help.

Thus, the types of chaos that manifested in the present study were comparable to those seen in Frank’s illness narratives for physical health. However, the researcher was also aware of the difficulty in engaging with chaos narratives and the uncomfortable experiences of bearing witness to narratives that were so emotionally charged and chaotic. These narratives, or elements of these, generated feelings of sadness, anxiety and hopelessness in the researcher and were the most difficult to engage with. The researcher was able to see how services could perhaps unconsciously resort to taking on the active role of treating psychosis and endorse biomedical and scientific approaches to voice hearing. However, in sacrificing cultural dimensions of understanding, individuals seemed to lose the freedom to engage in meaning making. Thus, chaos was seen to thrive when hope for recovery was absent.

**Quest Narrative**

Whilst restitution narratives demonstrated a position of hope for restored health in the future and the acceptance of voices as part of their lived experiences, quest narratives afforded individuals with the ability to find purpose in their experiences
and set backs for the benefit of themselves and/or others. Of the interviews conducted in the present study, many participants appeared to demonstrate elements of quest in their storytelling. This was perhaps most evident in their agency in managing their own voices and in their eagerness to share their stories.

Elements of quest in these narratives involved the active participation of individuals in the decision making of their care. This included the decision to invest in some coping strategies and to reject others. In quest narratives, participants were active players in their own recovery and mental health services were seen to be a source of additional resources and support. Some participants spoke about a range of coping strategies and displayed greater confidence in utilising these. There appeared to be greater awareness of the limitations of biomedical models and an appreciation for the value of alternative cultural narratives in their individual meaning making.

Priya, Sandeep and Hitesh all narrated their experiences in a way that enabled them to move seamlessly from the shock, disbelief and trauma of onset, through to the difficulties in adjusting to their voices and finally reaching a place where they were able to use their experiences to help themselves and others. Priya confirmed this with a profound reflection on how vastly her role as a mental health service user had been altered, placing her in a position to now offer support to others experiencing auditory hallucinations:

“Now it’s changed for me. I’m volunteering now. I used to be a service user, then I started (the) group and now I am a volunteer…I say to them (other women), you (keep) busy, occupy your mind and don't listen to your voice and things like that”. (Priya, 54)
Frank talks about the role of heroism in illness narratives. The perceived hero varies according to the type of dominant narrative individuals engage with. In quest narratives, the role of heroism was attributed to numerous individuals, not least to the voice hearer themselves. This was seen in individuals taking responsibility for their own recovery, questioning the use of psychiatric medication and refusing to invest belief in the threats made by their negative voices. In doing so, several participants were able to move away from the chaos and immediacy of their distress.

During Hitesh’s memoir he recognised what he believed to be the cause of his mental health breakdown and used this as a lesson learned in keeping well. He valued the role of spiritual and religious explanations as well as biopsychosocial models and talked about these as interconnected. However, for Hitesh the experience of stress placed upon him by others was perceived as the primary trigger for his mental health deterioration which, as history demonstrated, resulted in traumatic hospital admissions for him. The element of quest in this narrative was Hitesh’s conscious attitude in no longer tolerating unfair demands placed upon him. This elevated his position and was seen to be protective:

*I have to play it right, you know what I mean, because I’m not going to be put in a situation where somebody’s going to say “you’ve got to do this”… I say “look I’ll do whatever you want me to do but if something goes wrong I’ll hold you responsible (because) my family has to pick up the pieces”…I’m not going to allow people to put me in that stress again, you know what I mean? I have to put a stand against it.* (Hitesh, 53)

Hitesh’s explanation revealed his desire to not only protect himself but to also protect his family. The implications of hearing voices were clearly not limited to the
voice hearers themselves, but extended further and impacted on families as a whole. In the interviews conducted in the present study, there was an underlying sense from several individuals in wanting to protect their families from the repercussions of their auditory hallucinations. In the South Asian community it seemed individuals represented their families and not just themselves. As such, there was a perceived pressure to manage their difficult experiences for the greater good of the family reputation. Aslam framed his denial of distress as a means of protecting his family from worry as well as a way of avoiding stigma from the community. The impact of mental health therefore appeared to be experienced collectively rather than individually:

*I tend not to (tell anyone) because people talk in the community and obviously I don't want it to affect what people think of me or what people think about my mum and dad.* (Aslam, 36)

The quest narrative was not one absent from the experience of suffering. Instead, suffering was given meaning and purpose. The onset of voices themselves were reflected upon as the catalysts for change and framed as an opportunity to help themselves and others. In these cases, participants were driven by the need to understand their voices as a way of reaching recovery, rather than to seek recovery in the absence of meaning. In line with the work of Frank, participants appeared to begin by identifying, and in some cases naming their voices. Sandeep named his voice “the Devil” whilst Priya identified her voices as women from her community. In doing so, both participants instantly changed their relationship to their voices and this resulted in greater agency in managing them.

However, the space to reflect on cultural understandings of voice hearing was not always facilitated through mental health services. Instead participants
demonstrated the exploration of these through community led mental health groups. These groups did not appear to actively endorse biomedical explanations and instead sought to normalise voice hearing and enable a range of alternative stories to unfold. Accessing such services was often seen as the turning point in moving individuals away from chaos to quest. In these cases participants were able to reflect on their cultural contexts with others from similar backgrounds. For example, through attending a community led mental health group, Priya was able to reflect on the role of giving birth to daughters and no son on the pressures she experienced in her marriage. She recognised this as a possible contributor to her mental health deterioration at the time of onset. She was also able to explore cultural and spiritual explanations such as black magic, complex family conflicts and the role of migration on the onset of her voices. In being able to do this, Priya was able to reflect on her past experiences and cultural beliefs in developing interventions complimentary of her causal models. This facilitated better engagement with mental health services and increased collaboration in her care.

Finally, in conclusion of the research findings, one can argue that all three narrative types must be heard and understood in order to fully appreciate the way in which South Asians understand their experiences of hearing voices. However, the use of Frank's narrative typologies to the experience of hearing voices in South Asian participants was not without limitations. The role of cultural stories appeared to cause conflict at times with dominant biomedical models which made it difficult for stories to fit neatly into either restitution, chaos or quest narrative types. Instead, most narratives had elements of all three types running through them. The lack of space given to cultural stories appeared to perpetuate further chaos and reduced opportunities for meaning making for individuals. Thus, providing space for multiple stories to develop in the context of cultural influences is likely to increase
engagement of South Asian individuals to mental health services and enable them to move towards restitution and/or quest.

4. Discussion

This section aims to summarise findings of the current paper in relation to existing literature in the understanding of how South Asian individuals make sense of their voice hearing experiences. This section moves on to exploring some of the clinical implications of the current findings for mental health service provisions and sheds light on some of the overall strengths and limitations of the study.

4.1 Summary of Findings

The aim of the present study was to explore the types of narratives used by South Asian individuals who hear voices in order to facilitate a better understanding of their experiences. Frank's work on narrative typologies was used to guide this analysis. The main finding of the present study demonstrated that South Asian individuals who hear voices used a range of narrative types in making sense of this phenomenon. These included elements of restitution, chaos and quest narratives running through most participants' stories. However, the conflicts created between cultural narratives and biomedical models resulted in difficulty for individuals to move out of chaos towards restitution. Furthermore, the role of stigma experienced by this group was seen to reduce opportunities for restitution or quest as it increased individuals' likelihood of withdrawing from society. Participants held various explanatory models for understanding the cause of their voices which varied from biological disease based models, spiritual and cultural understandings, and psychosocial ideas, with many describing combinations of
each resulting in complex multilayered narratives. All participants were exposed to multiple explanatory models from their families and mental health providers which were often not in keeping with their own understanding of their experiences. This led to confusion and conflict for many participants. Subsequently, participants utilised a range of coping strategies to manage their voices which included the use of medication, attendance to therapeutic groups, establishment of daily routines, as well as prayer and meditation. One participant in particular talked very openly about his initial rejection of the religious and spiritual explanations that were presented to him by his parents and instead invested in the biomedical explanations widely held by mental health services. He later incorporated elements of spiritual, religious and cultural ideas into his narrative and had a range of coping strategies to reflect his complex understanding. Overall, it appeared that participants who were able to integrate cultural and biomedical models as part of their understanding, were better placed to move towards restitution and quest.

Elements of restitution in the context of hearing voices related to the acceptance of hearing voices as part of their lived experience and hope for restored mental health in the future. This differed from the illness narratives described by Frank in his work with cancer patients where restitution related to restored health. Instead, South Asian participants who were facilitated to explore cultural narratives were often better able to adjust to and accept their auditory hallucinations.

Elements of chaos were similar to those seen in the illness narratives described by Frank in many ways including the difficulty participants had in telling these stories. These narratives were difficult to articulate and were often told in a manner that jumped from one event to another without any coherent sequence. These narratives were also very emotive and described intense feelings of distress and hopelessness. There was a clear absence of any hope or optimism for restoration.
and unhelpful coping strategies such as smoking, illicit drug and alcohol use, and isolation were frequently described as part of chaos narratives. Chaos was further perpetuated by the ineffective integration of cultural stories for these individuals and resulted in the adoption of a ‘sick role’. This limited opportunities for meaning making and hindered positive change.

Furthermore, quest narratives also shared some similarities to those described by Frank in the desire of participants in wanting to generate positive change for themselves and others as a result of their own experiences of hearing voices. For example, several participants demonstrated elements of quest in their involvement with therapeutic groups where they were able to support others with similar experiences. Elements of quest were also seen in individuals who actively participated in the decision making of their care with many questioning the use of medication in the management of their voices, preferring alternative strategies.

4.2 Previous Literature

Findings from previous literature has placed value on the importance of understanding the narratives held by individuals in understanding their experiences in order to facilitate better engagement (Hinyard and Kreuter, 2007). Whilst every narrative is unique to each individual, elements of these can be shared within cultural groups, thus demonstrating dominant cultural discourses. The types of narratives held by individuals do not remain static over time but change in response to a number of influences around them including the audience to whom they are telling the story (Frank, 2010). Furthermore, narratives may represent to some extent the progress an individual makes towards a goal. In the chaos narrative individuals remain stuck and unsure of how to reach a positive outcome, resulting in narrative wreckage. In restitution narratives individuals have reached a point of
wellness and in the quest narrative they hope to facilitate meaning in their experiences.

The present study recruited British South Asian adults of whom three were first generation and four were second generation British citizens. For first generation individuals, the role of migration was discussed as part of their narratives for hearing voices. One participant in particular talked about the difficult circumstances in which she moved to the UK and how this had impacted on her mental health. Upon arriving in the UK, the shift in her quality of life and the world she had left behind was also a difficult adjustment. The role of migration on mental health has been discussed in existing research which has deemed the vast differences between traditional South Asian and Western host communities’ beliefs, values and lifestyles as affecting integration (Sheikh & Furnam, 2000) Furthermore, a lack of effective integration and lower social-economic status of Black and Ethnic minority communities is known to result in increased social stressors such as unemployment, racism and mental health deterioration leading to the concept of ‘ethnic vulnerability’ for poorer mental health outcomes in these groups (Bowl, 2007; Sashidharan, 1993).

For second generation South Asian participants, the cultural conflicts were also evident with many describing a lack of agreement between their own and their parents’ preferences for causal explanations and treatment options. However, the experience of mental health stigma was cross-generational and highlighted by every participant interviewed as part of this study. This is supported by existing research which demonstrates the strong dynamics of shame within collective cultures as acting as a barrier to effective help seeking in order to maintain family honour (Gilbert et al., 2004; Meltzer et al., 2000). Thus, issues of shame and
stigma as well as the importance of maintaining confidentiality are important considerations for mental health services in supporting South Asian individuals.

4.3 Clinical Implications

Unfortunately, cultural and spiritual aspects of an individual’s understanding are often unattended to as part of psychiatric assessments, particularly in the numerous standardised measures and rating scales used as part of routine clinical practice. By investing time and resources into training staff to feel confident and competent in exploring the meaning that individuals place on their experiences of hearing voices, within their cultural, social and spiritual contexts, would enable South Asian individuals feel better understood. The importance of facilitating a safe space for South Asian individuals in sharing their narratives is a key consideration for mental health services wanting to engage with this community. The use of Open Dialogue (Seikkula & Olson, 2003), an approach that facilitates and encourages the dialogues of individuals as well as their families and wider social networks, would enable cultural stories to be shared and for their value in meaning making to be better understood.

All participants talked about the limitations of medication in managing their voices. Many participants felt medication was ineffective, too strong or generated too many side effects for it to be considered a helpful intervention. This too is supported by research that has shown up to 50% of psychiatric patients continue to experience positive symptoms such as auditory hallucinations whilst taking medication (Gould, et al., 2001). Thus, the use of medication in the absence of additional or alternative coping strategies is not considered effective in itself and instead the use of multiple interventions including therapy and family support would be preferred by adults who hear voices. This would allow cultural dimensions to be included in the
development of care plans for South Asian individuals who hear voices and would result in better engagement and service user satisfaction.

The value of Hearing Voices Groups (HVG) was also discussed by the participants who had attended and benefited from these. Three participants spoke about the value in sharing their experiences of voice hearing with others and the importance of this in normalising their distress. Shared cultural stories made it possible for individuals to see that restitution was possible and enabled them to explore alternative coping strategies, thus moving away from chaos to a point of increased acceptance of their voices and agency in managing these. Given the current economic pressures of the NHS in continuing to provide a service despite budget constraints and increased waiting times, the implementation of group therapy over individual therapy is likely to be an attractive solution. However, consideration of language barriers and cultural sensitivity are important should HVGs enable helpful narratives inclusive of cultural dimensions to evolve.

Finally, the value of existing models in their applicability to South Asian individuals should not yet be dismissed as inaccurate. Romme and Escher’s (1989) three-phase model for hearing voices appeared to have some interesting overlaps with the narratives described in this study. For example, the initial Startling Phase had some stark similarities to the Chaos Narrative where individuals were shocked and dismissive of their voices, resulting in withdrawal from others and intense feelings of distress. The Organisational Phase shared some components of the Restitution Narrative whereby individuals had begun to develop increased agency in managing their voices, and finally the Stabilisation Phase was similar to the Quest Narrative in that it represented individuals who had reached a level of increased control in the decision making about their care.
The three-phase model suggests a progressive and perhaps linear progression from onset to recovery, accepting that individuals can become stuck at earlier stages. Meanwhile, Frank’s narrative typologies demonstrate how understanding can be shaped by an individual’s resources and the narratives of those around them. Engaging with individual’s in listening to their narratives and providing space for them to share this understanding is difficult when there is chaos in their story. A narrative approach does not seek to locate the difficulty within the individual and instead aims to move people forward.

Thus, facilitating individuals to share their narratives would support professionals in identifying the phase of voice hearing an individual is in and therefore inform an appropriate intervention.

4.3 Strengths and Limitations

The present research study enabled an exploration of South Asian individuals’ narratives for their understanding of voice hearing. This was felt to be a valuable addition to the current literature base given the absence of similar research having already taken place and the clear need to better engage with this community in mental health services. The findings presented in this paper therefore serve as a useful starting point for unpacking this topic further and help to provide some useful insights into these narratives. The application of narrative analysis using Frank’s typologies was felt to be an appropriate method as it allowed the researcher to determine how illness narratives were formed in the context of hearing voices and within a cultural perspective. Although these were limited to the three narrative types of Restitution, Chaos and Quest, no single story could be exclusively placed within one type, although some seemed to fit more closely to one type than another. Participants were found to have complex narratives that shared elements
across all three narrative types. This suggested that all three narrative types were applicable and relevant to some degree; however other types may also exist for this phenomenon and within this cultural context.

A further strength of the present study was the use of unstructured interviewing techniques. The researcher was keen to allow narratives to be shared without directing or restricting these with rigid interview protocols. In doing so, the researcher was able to create a more relaxed environment, build a rapport with participants, and facilitate information sharing.

However, although the study enabled insight into how South Asians understood their experiences of hearing voices, there was little space for a more in-depth analysis of language, characters and plots. Although these were alluded to as part of Frank’s approach, they did not form an explicit part of the data analysis. It is therefore possible that some valuable aspects of the storytelling were unintentionally overlooked and the additional use of structural analysis would have been useful.

A further limitation of the present study would be in relation to the various recruitment difficulties that were presented. The researcher was unable to recruit an equal number of South Asian male and female participants with significantly more men taking part (two females and five males). The role of gender is likely to influence the narratives of South Asian participants given the possible gender differences in roles and responsibilities that exist in traditional non-western cultures. Unfortunately, gender differences in narratives could not be explored in any great depth and it was not fully understood why more women were not approached by mental health teams and recruited. One possible hypothesis may be that potential female participants did not speak English (or a language spoken
by the researcher) as fluently as their male counterparts and would therefore have been unable to share their stories in this instance. Another hypothesis may be that the mental health services approached during the recruitment phase were cautious in approaching female clients to discuss research opportunities. These would need to be addressed in future research to ensure the narratives of South Asian women who hear voices are not lost.

Furthermore, despite the researcher’s bilingual skills, all interviews were conducted in English. For at least three participants, English was the second language and may have interfered with how comprehensively and accurately narratives were articulated. In these cases, the participants spoke a language or dialect unfamiliar to the researcher.

4.4 Conclusion

The participants in this study shared a range of typologies in understanding their experiences of voice hearing. These narratives included elements of chaos, restitution and quest. Some stories were seen to fit more closely into one type, but not exclusively. Whilst this suggests that other narratives should be explored and developed to better fit the phenomenon of hearing voices with South Asian individuals, they nonetheless provide helpful insights into understanding these experiences within a cultural context, thus extending further than dominant biomedical models in the UK.

Given the differences that exist between individuals from one part of South Asia to another in their religious and cultural beliefs and values, care should be taken in applying the findings from this study across all. Given that the sample was not
homogenous, it is inevitable that some regional and gender differences in narratives for hearing voices across will exist and would require further attention.

The role of spirituality and religion was considered an important part of meaning making for individuals who hear voices and in many ways shaped the coping strategies they chose. This included meditation, prayer and yoga as preferable strategies. In addition to this the role of culture on the experience of social stigma as a barrier to diagnosis and access to mental health services was also evident. Thus, facilitating individuals to share their narratives would enable mental health services to better engage with and support individuals from South Asian communities living in the UK and to offer culturally sensitive interventions.
References for Research Paper


Hearing Voices Network (2015). www.hearing-voices.org


Part Three

Critical Appraisal

1. Development of Research Idea

My interest in the area of voice hearing began during my time on a clinical placement at a local Community Mental Health Team (CMHT) during my first year of Clinical Psychology training. During my time on placement I was privileged enough to co-facilitate a Hearing Voices Group for South Asian males. This was run in collaboration with a grass-roots organisation and was delivered in community languages. Whilst running the group I became fascinated by the discussions that took place each week. South Asian men would talk about models of understanding that I had not seen so openly shared in mental health services before. I was impressed at how some group members would actively challenge or reject the models presented to them, namely biological explanations. Instead they would talk about a vast array of explanations including the concepts of God’s will, Jinns, and black magic. Whilst many of these ideas were familiar to me given my own ethnicity and religious beliefs, I remained a little unsure of how to navigate around these discussions. However, what quickly became apparent to me was how valuable this opportunity had been for the men attending as well as the professionals running the group. It seemed that simply facilitating a safe space for these stories to be shared and explored was enough in normalising the experiences of voice hearing amongst group members. It was at that point that I started searching for and reading existing literature on Hearing Voices in South Asian communities. I came across many models of auditory hallucinations that I had been taught previously. When revisiting these, I was struck by how little attention was paid to the cultural and spiritual
aspects of an individual's lived experience and how dominant models were
frequently framed within biomedical frameworks.

I developed my research proposal and was allocated my research supervisor.
During our initial meetings I shared my ideas with my supervisor and was
introduced to the world of Narrative Analysis. This was a qualitative method which I
previously knew very little about. However, given my interest in the stories shared
by individuals, I was curious to learn more about the method and spent a few
weeks reading and familiarising myself with the approach. The more I seemed to
read, the more I felt aligned to this form of qualitative research.

2. Gaining Ethical Approval

Having made the decision to carry out my research in the narratives of South Asian
individuals who hear voices, I was faced with the challenge of further developing
my research proposal and applying for ethics consent. Fortunately, the University
of Leicester organised a range of teaching sessions around Good Clinical Practice
(GCP) and applying for ethics approval. These proved useful in helping me to
navigate through this process and I was subsequently granted ethics approval.

Unfortunately I faced a series of delays with gaining approval from the Research
and Development (R&D) from one of my sites. The problems arose because I was
not employed by that Trust and was required to obtain an honorary contract prior to
collecting any data. Fortunately I had secured a field supervisor in the same Trust
who was able to support this application.
3. Literature Review

My decision to review current literature on the experiences of depression amongst South Asian women was derived from my previous experience of working with this client group in community based mental health settings. I had noticed how difficult these women were to engage and was interested in learning more about the current literature base. This was also felt to be a complimentary area of research given my interest in the mental health of South Asians living in the UK.

In beginning my literature review I realised the importance of recording the process of systematic searching of databases as I went along. I had access to a vast number of database search engines and whilst this was a little daunting to begin with, I soon regained confidence and completed a thorough literature review.

4. Recruitment

In recruiting participants, I was keen to get started early. I began by contacting all local mental health services, starting with those where I was aware of a Clinical Psychologist working in the team. I had been hopeful that this would generate plenty of interest in my research project and I had not expected the underwhelming response that I actually received. Many team managers did not acknowledge my request to recruit participants from their teams and of those that did get back to me, very few followed through with forwarding information to care coordinators and clients. Many team managers cited the lack of time and resources due to staff shortages or service restructuring as a reason for being unable to partake in the research study at that time. Others stated that they did not have many South Asian clients given the geographical areas they covered and one team stated that the
team had recently been used for another research project and would not be able to facilitate another project so soon.

Whilst this was frustrating, I was pleased to be invited to attend several team meetings to promote my study to care coordinators. I found this to be the most fruitful method in generating interest in the project and was subsequently able to begin recruiting. Meeting professionals face to face and having the opportunity to share the rationale for my study, as well as to answer any questions teams may have had, helped immensely in engaging staffs interest.

Recruitment took far longer than I had envisioned and meant that I was still trying to recruit well past the time line that I had planned. One participant rearranged her interview date three times before eventually meeting with me. Although this was frustrating as a researcher, I was pleased that I had been able to accommodate her needs, allowing her to take part. I was able to recruit seven participants in total which was less than I had hoped for. However, in hindsight given the narrative analysis method that I used, this was felt to be an appropriate number for the purposes of this study.

5. Interviewing Participants

I decided upon the use of unstructured interviewing as a way of facilitating narratives to be shared with little direction or researcher influence. This was the first time I had carried out an unstructured research interview and I was anxious about getting it right, not wanting to miss anything important and being able to generate interesting narratives. I had been a therapist for so long that switching to a researcher role was both difficult and daunting. I had to repeatedly remind myself that I was not interested in formulating the individuals’ experiences of hearing
voices and that I would not be seeing them again for follow up sessions. It was also
strange meeting participants without having access to the background contextual
information I would have normally seen when meeting clients for therapy.
Fortunately, I had been able to discuss this in supervision and could draw upon the
teaching I had attended on the differences between therapeutic interviews versus
research interviews. Despite my initial anxiety, I need not have worried as the
unstructured interview approach worked well and participants spoke about their
voices with very little prompting or direction.

For the most part I thoroughly enjoyed the process of listening to participants
stories and was frequently amazed by the strength of these individuals in living with
the experiences of hearing voices. Some stories were easier to hear than others
and paying attention to the elements of individual narratives that triggered emotions
within me was interesting. I found myself drawn in by the stories of the two women I
had interviewed as they talked about many issues that I related to as a South Asian
woman myself. I found myself wanting to champion these women’s narratives and
ensure their stories were not lost. In particular I was struck by how determined both
these women were in overcoming adversity and how they had managed to turn
their lives around. This filled me with hope that other women in their position would
also be able to do the same given the correct support.

The narratives of the men I interviewed varied in the emotions they made me feel. I
found myself feeling sad when they talked about the stigma they experienced from
their communities and thought back to the men in my own family and wider
community who were traditionally seen to be the strong breadwinners. Although it
was never explicitly said by any male participant, I had an overwhelming feeling
that many felt like failures. In response to their comments about unemployment and
being considered as unsuitable bachelors for marriage, I found myself thinking “you
have not failed. You have experienced so much and you are a survivor”. I also
found myself feeling irritated that these stereotypes continued to exist in the
modern age by people living in the UK.

The amount of information and detail shared in narratives varied from one interview
to another. Some participants required slightly more prompting to generate further
information about their story. However, others were able to articulate these with
very little input from me. I wondered how this could be understood in terms of
Frank’s typologies and why certain elements of narratives were easier to relay for
some participants than others. It also made me wonder about the unshared stories
and what these may have been. It was whilst thinking about unshared stories that I
began to wish I had the opportunity to meet participants again. However, this was
not a feasible option given the time constraints of my project, and interestingly I did
not feel it was also not required for all participants. Perhaps I was slipping back into
a therapist role and moving away from a researcher perspective or perhaps I was
simply being a curious researcher?

I felt incredibly honoured that all participants had agreed to share their stories with
me and I was left feeling determined that their narratives would not be told in vain.
Although I had clearly valued the role of qualitative research prior to starting the
project, it was whilst listening to these narratives that I realised how much could be
learnt from the way in which they understood their own voices and how others
helped to shape these narratives. I began to wonder about how I may have helped
to shape the narratives of friends, family and clients who I had spent time with. I
found myself thinking about whether I had been able to have a positive effect on
these individuals’ stories and empower them or whether I had unintentionally
created further tension and worry for them. In particular, I reflected on my roles as
an Assistant and Trainee Clinical Psychologist where I had varying amounts of
supervision and direction. I also thought ahead to my future role as a qualified clinical psychologist and how this experience of narrative analysis would shape my clinical work.

6. Transcribing

For the type of narrative analysis that I had decided upon, a verbatim transcript was produced and pseudonyms were given to each participant. I had initially planned to pay an independent transcriber to do this for me, however, given the small sample size I eventually decided to transcribe each interview myself. On reflection it was a useful exercise as it allowed me to re-familiarise myself with each participant and their narrative. Whilst listening back to the recordings it was interesting for me to hear how I interacted with the participants and responded to different elements of their stories. I noticed the sadness in my voice when talking to participants about the negative impact of their voices on their lives. I also noticed that when talking to participants with chaos narratives, I was left feeling a little confused by how their stories jumped from one even to another and found myself checking and re-checking that I had understood them correctly.

In listening back to tapes and reflecting on the interviews I had completed, I became aware of how participants may have positioned me as aligned to mental health services. I had recruited through local mental health teams and all participants were aware that I worked as a Trainee Clinical Psychologist. In hindsight I wonder whether this information may have influenced the types of stories they felt able to share with me and I now wonder whether this perhaps limited the amount of freedom they perceived to have in sharing cultural, religious and spiritual narratives.
The process of transcribing took much longer than I had expected it to. This may be partly because it was the first time I had carried out qualitative research and been required to transcribe interview data. The more interviews I transcribed, the more I was able to pick up speed with this.

7. Analysis

My experience of narrative analysis was varied. I moved from feeling excited at the prospect of making sense of the material available to me, to also feeling worried that I may not do justice to the process. At other times I felt frustrated at the lack of direction in narrative analysis for researchers undertaking this task and would have gratefully accepted an instruction manual to help me along the way. I found myself feeling unsure about my own competencies as a researcher but found solace in talking to other Trainee Clinical Psychologists who were experiencing similar emotions in undertaking their own research projects. I found I had become self-blaming for the slow recruitment which had left me with little time to analyse the data. I still do not know how I could have improved the recruitment phase to be more effective and now recognise that many of the set-backs were not in my control. Looking back now, I wonder whether being on placement in a mental health team whilst recruiting participants would have made the process a little easier.

Listening to the interviews on audio whilst transcribing the text allowed me to get an initial overview of each narrative. I read and re-read each transcript several times, each time looking for ways in which these stories fit or did not fit with the narrative typologies of restitution, chaos and quest. I was daunted by the amount of information that had been generated in the seven interviews and I again lost confidence in my abilities to do this project justice. It was whilst discussing my
anxiety with my research supervisor that I realised I had been trying to keep each story in mind at all times. Not only was this impossible to do, but it also clouded my vision when attending to individual participants’ narratives. I realised that the pressure of getting the project completed within the short amount of time that I had left, was the reason I had been the reason behind my anxiety and not because I had become disillusioned with the approach. At this point, I found it helpful to revisit several chapters of Frank’s book ‘The Wounded Storyteller’. By doing so, I felt re-motivated to undertake the task of analysis.

I found it to be a challenge to keep my analysis grounded in the data without being pulled into a position of merely describing the interviews. I could not escape from the fact that I too had expectations and beliefs about hearing voices in the South Asian community, being a South Asian myself. I found myself constantly battling with how my own beliefs and values were influencing the analysis as well as how I could actually use my cultural knowledge to the advantage of this study. I quickly realised when reading through some interviews, that participants had sometimes assumed I understood what they meant. I was pleased that I had asked for clarification in these instances and did not blindly feed into this expectation. I also struggled to attend to how culture played a role in these stories whilst trying to understand how they fit with Frank’s typologies.

I also began to think about the ethics of interpreting participants’ personal stories and found myself thinking about how they would react to the ideas of illness narrative types. I reminded myself of the value in making sense of how individual’s understood the experience of hearing voices in order to better inform clinical practice. I was also keen for individual narratives to be reflected as much as possible without losing the cultural and experiential elements of their stories. At times I found the approach to be restricting in reflecting the cultural dimensions of
narratives and was frustrated at the lack of focus on how narratives were shaped. In hindsight, I feel that incorporating some structural analysis would have been useful in better understanding how stories were told.

The completion of the analysis phase was one of relief as well as urgency. Upon completing this phase, I was faced with deciding how best to organise and write up the findings. With the looming deadline and pressures of juggling clinical placement, teaching and research, whilst commuting from one city to another left me feeling drained. I found I was taking very few breaks and using weekends to work on my research. This was a common experience amongst many of my friends who were also undertaking postgraduate research. I realised I was better able to reflect and progress with my work when I maintained some work-life balance. However, time out felt like an unjustifiable luxury and I struggled to enjoy time off. Instead I settled for short breaks during the day which seemed to work well.

8. Writing up

Reaching the phase of writing up my thesis felt like an exciting milestone. I enjoyed writing up the introduction and method sections of the project and then found myself drafting and re-drafting the results. I played with different ways of organising the information and eventually decided upon structuring this by narrative type rather than theme or individual stories, having come across a good example of this in existing literature (Thomas-MacLean, 2004). I found the word allowance to be incredibly restricting as this had been recently reduced by the University from 15000 words to just 12000. It meant I had to be more selective with reporting findings than I would have liked and choosing quotes to illustrate points was a very difficult task given the amount of rich data that I had access to.
I struggled with ensuring my thesis was written in a coherent manner and when reading over early drafts I realised I had a tendency to jump from one topic to another as well as repeating information unnecessarily. On reflection my earlier drafts were perhaps representative of chaos narratives. I found myself jumping between past and present tenses in my writing styles and found my own anxiety creating chaos in my research progress. As my drafts developed over time, I became clearer in the story I was trying to tell and how best to do this. At that stage I felt more in control of the project at hand and had hope that I would be able to produce a decent piece of work. Perhaps I had reached a stage of restitution in my research journey?

Throughout the project I was well aware of my perfectionist traits and realised how I had allowed these to hold me back in the earlier phases of the study. Realising that no piece of research could ever be without flaw, allowed me to embrace the limitations of my own project and consider how I would overcome these in future research ventures. Without doubt I learned as I went along and completed this project with greater confidence in my competencies as a researcher and clinician. Seeing the different parts of the research come together in the write up was exciting and also reassuring.

More than anything, I finish this project at a place where I realise what a very privileged role I hold as a soon to be Clinical Psychologist. Everyday people share their stories with me and I try to make sense of these by developing formulations. What I now realise is that the stories themselves are in fact types of formulations. Since completing the project I have continued to read more about narrative research and have become increasingly interested in narrative therapy. I look forward to applying what I have learned in my clinical work and hope to further
enable the narratives of clients I meet within cultural frameworks that were so obviously missing in the existing models of hearing voices.

9. Dissemination

I plan to disseminate my findings in a number of ways. To begin with, my research will submitted to the University of Leicester in part completion of my Doctorate in Clinical Psychology. Subsequently, a hard copy of this thesis will be held by the university library and will also be accessible as an electronic version on the e-library. I also plan to summarise findings and make these available for the mental health services and participants who took part in the study. They are able to request this directly from me.

Finally, I plan to disseminate my findings further by presenting the study at a research conference organised by the Clinical Psychology trainees at the University of Leicester in September 2015 and to prepare this research for publication in a peer-reviewed journal. My journal of choice is the journal of Mental Health, Religion & Culture published by Taylor & Francis. The publication guidelines are outlined in Appendix G.
References for Critical Appraisal


Appendix A

Record of Systematic Search of Literature Databases

Only searches that yielded results are shown below. Many combinations of search terms resulted in zero search returns. These have not been reported here.

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<th>Key Search Terms</th>
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Appendix B

Epistemological position of main researcher

The main researcher took a social constructionist stance in the present paper whereby the relationship between an individual and those around them is thought to generate understandings rooted within social and cultural contexts. Roberts (2000) talks about narratives as providing cognitive and emotional significance to our experiences and argues that they are essentially a means of “constructing and negotiating a social identity, giving moral weight and existential significance to actions and events”. In adopting this approach, the researcher was able to focus on the cultural influences in shaping individual stories about voice hearing and to consider the ways in which these narratives interacted with the dominant discourses of mental health problems in the Western world. Thus, the analysis carried out in this research project explored the types of illness narratives that existed in the South Asian culture and how these facilitated meaning making in relation to hearing voices.
Appendix C

Participant Information Sheet

Study Title: An exploratory study of British South Asian individuals’ narratives about living with auditory hallucinations

The aim of this participant information sheet is to allow individuals interested in participating in the present study to gain a better understanding of what this will involve.

Why is this study important?
The experience of hearing voices (auditory hallucinations) is known to be a very frightening and distressing one for many individuals. Although research has previously focused on understanding why people hear voices and how to treat these, there is less research into how individuals who hear voices make sense of this phenomenon. Culture is known to influence how people make sense of their experiences and that appraisals of experiences can affect emotional and behavioural responses. Despite the South Asian population growing in the UK, we continue to know little about how they understand and make sense of voice hearing. By developing a better knowledge base of this, we can help to progress how Mental Health Services engage and work with people of South Asian origin who experience auditory hallucinations.

What will the study involve?
The study will involve completion of a brief pre-interview questionnaire and a one to one interview that will last between 45-60 minutes. During the interview you will be asked questions about your experience of hearing voices and how you make sense of this. The interview will be held at a time and place that is convenient for you and will be recorded using an audio-recorder.

Do I have to take part?
No. Participation in the present study is voluntary. You will have the opportunity to ask the Chief Investigator any questions you have before deciding whether or not you wish to take part. Before taking part, you will be required to complete a consent form.

Who will know I am participating?
The mental health team from which you have been recruited will be aware of your participation in this study. If you chose to do so, your GP will be sent a letter explaining that you are taking part. However, no information about the things you say will be shared with these individuals. All information will be anonymous and it is your decision whether or not your GP is informed.

Will my information in the study be kept confidential?
Yes. All information you provide as part of the study will be anonymised so that you are not identifiable. Interviews may be transcribed by an independent transcriber who is
familiar with dealing with sensitive information and will be required to sign and adhere to a privacy policy. Any quotes used from interviews as part of the write-up will also be anonymous. No real names will be used. All participants will be allocated a participant number which will be used to identify interview transcripts. All data collected as part of this study will be kept locked and destroyed five years after the completion of the study (including write up).

Are there any instances in which confidentiality will be broken?
The interviewer will only break confidentiality if she is concerned that you may be at risk of harm to self or others. Should this be of concern, the interviewer will ensure that she discusses this with you. She will talk to you about her concerns and who she would like to pass this information on to. This is likely to be either your named nurse or Care Co-ordinator.

What will I talk about?
The study is interested in your experiences of hearing voices. You will be supported by the researcher who interviews you to only share information that you feel comfortable to talk about. The interview can be halted at any time if you would like a break.

What will happen to the results?
The results of the present study will be written up and presented in a range of formats. This includes a thesis which will be submitted to the University of Leicester and for journal publication which will be identified at a later stage.

Are there any disadvantages to me taking part?
It is not envisaged that there will be any negative consequences for you in taking part in the present study. It is, however, possible that talking about your experience in this way may cause some distress. The Chief Investigator will provide you with a list of helpful resources that you may wish to access as well as the opportunity to debrief after the interview. During the debrief you will be able to discuss how you found the experience of taking part and how you are feeling as a result.

Who has reviewed this study?
This study has been cleared for ethical approval by IRAS. It has also been approved by the Research and Development Departments of the appropriate NHS Trusts.

What if I change my mind?
If you later decide that you do not wish to take part or would like to withdraw consent for the use of your information in the present study, you will be able to do so by contacting the Chief Investigator. You will be able to do this up until the data analysis process begins, which is envisaged to be in November 2014.

Patient Advice Liaison Service (PALS)
You are able to discuss any concerns that you may have about taking part in this study with the Patient Advice and Liaison Service. You can contact them on:

Birmingham and Solihull Mental Health Foundation Trust:
Telephone: 0800 953 0045 (Monday - Friday 8am - 8pm)
Email: pals@bsmhf.nhs.uk

Leicestershire Partnership Trust:
Telephone: 0116 295 0830 or 0116 295 0831 (Monday – Friday 9am – 5pm)
Email: customerservices@leicspart.nhs.uk

Any further queries? If you need any further information, you can contact me:
Noreen Naz
Trainee Clinical Psychology
Email: nn77@leicester.ac.uk
Address: Clinical Psychology, 104 Regent Road, Leicester, LE1 7LT
Informed Consent Form

Title of Project: An exploratory study of British South Asians’ narratives about living with auditory hallucinations

Name of Chief Investigator: Noreen Naz

Please initial all boxes

1. I confirm that I have read and understand the information sheet dated 20.02.2014 (version 2) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. I have been given a copy of the Participant Information sheet to keep.

2. I understand that my participation is voluntary and that I am free to withdraw at any time up to the stage of data analysis without giving any reason, without my medical care or legal rights being affected.

3. I agree to take part in an interview with the Chief Investigator lasting between 45-60 minutes. I understand this interview will be audio recorded, transcribed by an independent professional transcriber and analysed.

4. I agree for anonymised interview material being used in the write up of this project including quotations.

5. I agree to my GP being informed of my participation in the study.

6. I agree to take part in the above study.

__________________________  ______________________   ______________________
Name of Participant       Date                   Signature

__________________________  ______________________   ______________________
Name of Person             Date                   Signature
taking consent.
### Appendix E

#### Chronology of Research Process

<table>
<thead>
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<th>Research Step</th>
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<tbody>
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<td>Research Proposal Submission</td>
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<tr>
<td>Ethics Approval Granted</td>
<td>April 2014</td>
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<tr>
<td>Research and Development Approval (Leicester)</td>
<td>May 2014</td>
</tr>
<tr>
<td>Research and Development Approval (Birmingham)</td>
<td>November 2014</td>
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<tr>
<td>Recruitment of participants</td>
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</tr>
<tr>
<td>Interviews conducted</td>
<td>Began in October 2014. Completed in March 2015</td>
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<tr>
<td>Bracketing Interview</td>
<td>March 2015</td>
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<tr>
<td>Transcribing, Analysis and Write up</td>
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<tr>
<td>Submission of thesis to University of Leicester</td>
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<td>Research Viva</td>
<td>July 2015</td>
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</table>
Appendix F

Bracketing Interview

Researcher: Noreen Naz
Interviewer: Dr Jon Crossley

Date: 25th March 2015

Dr Crossley: What led you to becoming interested in this research subject and how did the idea develop?

Noreen: During my first year placement in a CMHT I was able to facilitate a Hearing Voices Group for South Asian men in collaboration with a grass-root organisation. In running the group I was fascinated by the stories these men told about their experiences of voice hearing and I noticed how these did not always seem to fit with the ideas we were bringing as ‘professionals’.

Dr Crossley: How might your own experiences shape what themes emerge from the data?

Noreen: As a British South Asian woman I am all too aware of the role of my own cultural and religious beliefs and values on my expectations of what may emerge in the data set. For example, I am aware of the stigma of mental health problems in the South Asian community and the impact of this on help-seeking behaviours. I will need to ensure I discuss these issues in supervision and reflect upon them throughout the process. I am also a Muslim so I have some understanding of the types of religious beliefs and values that may be shared with this sample. I am aware that this may serve as a useful insight and therefore aid analysis, but I am also cautious of it clouding my insights if not properly attended to.

Dr Crossley: Where there differences in how you related to the stories of males and females and why might this be?

Noreen: To an extent I think it was a little easier for me to relate to the stories of the two women who I interviewed as I was able to notice some shared feelings in some elements of their narratives relating to the role of gender in their lives as South Asian
women. I must ensure that I do not stress the weight of these narratives over the narratives of male participants during my data analysis phase. I will do this by bringing parts of my analysis to supervision to discuss with my supervisors.

**Dr Crossley:** Have you thought about how you might pay attention to your own assumptions during the data analysis process?

**Noreen:** I have already spent a lot of time reflecting on this and I have kept a reflective journal as a way of noting down and processing some of these issues. I also feel it would be important to use research supervision with both my supervisors to further reflect on these issues.
Appendix G

Targeted Journal; Mental Health, Religion & Culture (Publisher: Taylor & Francis)

Manuscript preparation

1. General guidelines

- Manuscripts are accepted in English. British English spelling and punctuation are preferred. Please use double quotation marks, except where "a quotation is ‘within’ a quotation”. Long quotations of 40 words or more should be indented without quotation marks.

- A typical manuscript will not exceed 6000 words including tables, references, captions, footnotes and endnotes. Manuscripts that greatly exceed this will be critically reviewed with respect to length. Authors should include a word count with their manuscript.

- Manuscripts should be compiled in the following order: title page; abstract; keywords; main text; acknowledgements; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figure caption(s) (as a list).

- **Abstracts** of 150 words are required for all manuscripts submitted. Abstracts should not include any citations or references, and should not be structured (i.e. contain headings).

- Each manuscript should have 3 to 7 **keywords**.
• Search engine optimization (SEO) is a means of making your article more visible to anyone who might be looking for it. Please consult our guidance here.

• Section headings should be concise.

• All authors of a manuscript should include their full names, affiliations, postal addresses, telephone numbers and email addresses on the cover page of the manuscript. One author should be identified as the corresponding author. Please give the affiliation where the research was conducted. If any of the named co-authors moves affiliation during the peer review process, the new affiliation can be given as a footnote. Please note that no changes to affiliation can be made after the manuscript is accepted. Please note that the email address of the corresponding author will normally be displayed in the article PDF (depending on the journal style) and the online article.

• All persons who have a reasonable claim to authorship must be named in the manuscript as co-authors; the corresponding author must be authorized by all co-authors to act as an agent on their behalf in all matters pertaining to publication of the manuscript, and the order of names should be agreed by all authors.

• Biographical notes on contributors are not required for this journal.

• Please supply all details required by any funding and grant-awarding bodies as an Acknowledgement on the title page of the manuscript, in a separate paragraph, as follows:
  
  • For single agency grants: “This work was supported by the [Funding Agency] under Grant [number xxxx]."
For multiple agency grants: “This work was supported by the [Funding Agency 1] under Grant [number xxxx]; [Funding Agency 2] under Grant [number xxxx]; and [Funding Agency 3] under Grant [number xxxx].”

- Authors must also incorporate a Disclosure Statement which will acknowledge any financial interest or benefit they have arising from the direct applications of their research.
- For all manuscripts non-discriminatory language is mandatory. Sexist or racist terms must not be used.
- Authors must adhere to SI units. Units are not italicised.
- When using a word which is or is asserted to be a proprietary term or trade mark, authors must use the symbol ® or TM.

2. Style guidelines

- Description of the Journal’s article style.
- Description of the Journal’s reference style.
- Guide to using mathematical scripts and equations.
- Word templates are available for this journal. If you are not able to use the template via the links or if you have any other template queries, please contact authortemplate@tandf.co.uk.

3. Figures

- Please provide the highest quality figure format possible. Please be sure that all imported scanned material is scanned at the appropriate
resolution: 1200 dpi for line art, 600 dpi for grayscale and 300 dpi for colour.

- Figures must be saved separate to text. Please do not embed figures in the manuscript file.
- Files should be saved as one of the following formats: TIFF (tagged image file format), PostScript or EPS (encapsulated PostScript), and should contain all the necessary font information and the source file of the application (e.g. CorelDraw/Mac, CorelDraw/PC).
- All figures must be numbered in the order in which they appear in the manuscript (e.g. Figure 1, Figure 2). In multi-part figures, each part should be labelled (e.g. Figure 1(a), Figure 1(b)).
- Figure captions must be saved separately, as part of the file containing the complete text of the manuscript, and numbered correspondingly.
- The filename for a graphic should be descriptive of the graphic, e.g. Figure1, Figure2a.

4. Publication charges

Submission fee

There is no submission fee for Mental Health, Religion & Culture.

Page charges

There are no page charges for Mental Health, Religion & Culture.

Colour charges
Colour figures will be reproduced in colour in the online edition of the journal free of charge. If it is necessary for the figures to be reproduced in colour in the print version, a charge will apply. Charges for colour figures in print are £250 per figure ($395 US Dollars; $385 Australian Dollars; 315 Euros). For more than 4 colour figures, figures 5 and above will be charged at £50 per figure ($80 US Dollars; $75 Australian Dollars; 63 Euros).

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6. Supplemental online material

Authors are encouraged to submit animations, movie files, sound files or any additional information for online publication.

- Information about supplemental online material

Manuscript submission

All submissions should be made online at the Mental Health, Religion & Culture Scholar One Manuscripts website. New users should first create an account. Once logged on to the site, submissions should be made via the Author Centre. Online user guides and access to a helpdesk are available on this website.

Manuscripts may be submitted in any standard editable format, including Word and EndNote. These files will be automatically converted into a PDF file for the review process. LaTeX files should be converted to PDF prior to submission because ScholarOne Manuscripts is not able to convert LaTeX files into PDFs directly. All LaTeX source files should be uploaded alongside the PDF.

Books for review should be directed to Professor Christopher Alan Lewis. For queries regarding book reviews, please contact Professor Christopher Alan Lewis at: Institute for Health, Medical Sciences and Society, Glyndwr University, Plas Coch Campus, Mold Road, Wrexham, LL11 2AW, Wales, UK. Email: ca.lewis@glyndwr.ac.uk.
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Last updated 27/08/2014
Appendix H

Ethics and Research and Development Approval Letters
24 April 2014

Mrs Noreen Naz
Trainee Clinical Psychologist
Leicestershire Partnership Trust
104 Regent Road
Leicester
LE1 7LT

Dear Mrs Naz

<table>
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<td>Protocol number:</td>
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<td>IRAS project ID:</td>
<td>144143</td>
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Thank you for your letter of 24th April 2014. I can confirm the REC has received the documents listed below and that these comply with the approval conditions detailed in our letter dated 08 February 2014.

Documents received

The documents received were as follows:

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<td>Covering Letter</td>
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<td>Participant Consent Form</td>
<td>2</td>
<td>20 February 2014</td>
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<tr>
<td>Participant Information Sheet</td>
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<td>20 February 2014</td>
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Approved documents

The final list of approved documentation for the study is therefore as follows:

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<td>Covering Letter</td>
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<td>Interview Schedules/Topic Guides</td>
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<td>Investigator CV</td>
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<td>Mrs Noreen</td>
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<tr>
<td>Investigator CV</td>
<td>Naz</td>
<td></td>
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<tr>
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<td></td>
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<tr>
<td>Other: Confidentiality Statement for transcribers</td>
<td>Dr Jon Crossley</td>
<td></td>
</tr>
<tr>
<td>Other: Participant Debrief Sheet</td>
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<td>10 December 2013</td>
</tr>
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<td>Participant Consent Form</td>
<td>2</td>
<td>20 February 2014</td>
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<td>Participant Information Sheet</td>
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<td>20 February 2014</td>
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<td>144143/5466</td>
<td>10/1/364</td>
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<td>Summary/Synopsis</td>
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</tbody>
</table>

You should ensure that the sponsor has a copy of the final documentation for the study. It is the sponsor’s responsibility to ensure that the documentation is made available to R&D offices at all participating sites.

14/EM/0026 Please quote this number on all correspondence

Yours sincerely

Liza Selway
REC Manager

E-mail: NRESCommittee.EastMidlands-Nottingham2@nhs.net

Copy to: Dr Jon Crossley, University of Leicester
Mr David Clarke, Leicestershire Partnership NHS Trust
149

Leicestershire Partnership
NHS Trust
A University Teaching Trust

Noreen Naz
Trainee Clinical Psychologist
Leicestershire Partnership Trust
c/o University Of Leicester
104 Regent Road
Leicester
LE1 7LT

Provisional 16th May 2014 (Re-issued 9th December 2014)

Re: An exploratory study of British South Asian individuals' narratives about living with auditory hallucinations

Thank you for applying for NHS Permission to conduct recruitment for the above study within Leicestershire Partnership NHS Trust. I am now in receipt of confirmation of a favourable ethical opinion and this study has now been validated and reviewed according to the Standard Operating Procedure for research appraisal. Leicestershire Partnership NHS Trust has granted you full approval to conduct this research within the Trust on the condition that the Trust suffers no unforeseen costs as a result of this study being undertaken. Your research has been entered onto the Trust's Research Database.

Study Codes:

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<th>ETH00694</th>
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All research studies taking place are now subject to monitoring in respect of NHS Permission timelines, recruitment to time and target and so on. As a result, some of this information is reproduced in the table below. The key monitoring target is the 70-day timeline from "Valid Research Application", within which the first patient or participant should be recruited (this includes the 30 Day NHS Management Permission Target), please give due regard to this requirement and inform the R&D Office if this target is likely to be breached.

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This permission is contingent upon the following information being correct.

1 Underline as appropriate

Chair: Professor David Chadwick CBE Chief Executive: Dr Peter Miller
The conduct of your study (including examination of the site file) at this site may be subject to audit for protocol adherence and other monitoring. This approval is subject to the accuracy of the following information:

**Study Summary**

| Chief Investigator (Supervisor): | Dr Jon Crosley |
| Principal Investigator (Local): | Mrs Nooreen Huz |
| Other Investigators: | Dr Sanjeev Ramharakha (Birmingham & Solihull) |
| Indemnity Provider: | Leicestershire Partnership NHS Trust |
| NHI Portfolio: | Yes |
| Student Project: | No |
| Funding Source: | University of Leicester |
| Local NHS Support Costs: | N/A |
| Additional Sites: | Birmingham & Solihull Mental Health |

01/06/2014

24/04/2015

N/A

£300

The table below lists the documentation listed as approved for use in this study. Any changes to this may require an amendment notification to the Research Ethics Committee and Research Office.

**Approved Documentation**

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**Local Service Involvement**

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Please note that all research with an NHS element is subject to the Research Governance Framework for Health and Social Care 2005. If you are unfamiliar with the standards contained in this document, or the LPT policies that reinforce them, you can obtain advice from the R&D Office or your Sponsor. You must stay in touch with the R&D Office during the course of the research project, particularly if/when:

- There is a change of Principal Investigator;
- To fulfill requirements for performance reporting;
- The project finishes (please complete a summary report form);
- Amendments are made, whether minor or substantial;
- Serious Adverse Events occur (adhere to local and Sponsor SOPs).

This is necessary to ensure that your indemnity cover is in place and remains valid. Should any issues arise that inhibit study delivery it is essential that you contact the R&D Office immediately. If patients or staff members are involved in an incident, you should also contact the Clinical Risk Manager and report as per Trust Policy.

Chair: Professor David Chiddick CBE  Chief Executive: Dr Peter Miller
Provision against NHS Costs: The Trust reserves the right to invoice the study team, in the unlikely event of any unexpected costs arising from this study, including, but not limited to:

- Staff Time attending interviews.
- Travel and administrative costs

I hope the project goes well, and if you need any help or assistance during its course, please do not hesitate to contact the Office.

Kind regards

[Signature]

Dr. Dave Clarke (Operational Lead (Research & Development))
Noreen Naz  
Trainee Clinical Psychologist  
Leicestershire Partnership Trust  
do University Of Leicester  
104 Regent Road  
Leicester  
LE1 7LT

Provisional 16th May 2014 (Re-issued 9th December 2014)

Re: An exploratory study of British South Asian individuals’ narratives about living with auditory hallucinations

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<td>Full approval</td>
<td>☑</td>
</tr>
<tr>
<td>Approval in Principle</td>
<td>☐</td>
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<tr>
<td>Approval refused</td>
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<table>
<thead>
<tr>
<th>TIMELINE</th>
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<tr>
<td>Date of Favourable Ethical Review (A)</td>
<td>24/04/2014</td>
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<tr>
<td>Date Full Documentation (Valid Application) Received (Site) (B)</td>
<td>04/12/2014</td>
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<td>Sign-off timeline (A-B)</td>
<td>161 Days</td>
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<tr>
<td>Date of Funding Agreement/SSI Received</td>
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<td>Date of Final NHS Permission (C)</td>
<td>09/12/2014</td>
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<td>Sign-off timeline (E-C)</td>
<td>4 Days</td>
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<td>Target Date: First Patient/Participant Visit (FFPV)</td>
<td>12th February 2016</td>
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</tbody>
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This permission is contingent upon the following information being correct:

1 Underline as appropriate

Chair: Professor David Chiddick CBE  
Chief Executive: Dr Peter Miller
28 November 2014

Mrs Noreen Naz
Trainee Clinical Psychologist
Leicestershire Partnership Trust
104 Regent Road
Leicester
LE1 7LT

Dear Noreen

An Exploratory Study of British South Asian Individuals’ Narratives About Living with Auditory Hallucinations

Thank you for providing us with the documentation to support your application for R&D approval. We have received notification of a favourable ethical opinion and following a review of all the documentation this study has been approved by the Trust. You may therefore commence the work.

Please note that the Trust’s approval of this research is given on the understanding that you are aware of and will fulfil your responsibilities under the Department of Health’s Research Governance Framework for Health and Social Care, including complying with any monitoring/auditing of research undertaken by the Research & Innovation Department.

In particular, whilst conducting your study you should respect the confidentiality of data obtained from participants.

Please do not hesitate in contacting the Research & Innovation Department should you require any advice or support on any aspect of your project. When contacting us it would be helpful to quote our reference number for this project: NRR1288.

Yours sincerely

[Signature]

Professor Swaran P Singh
Interim Director of Research & Innovation