PAKISTANI MUSLIM TEENAGE GIRLS' CONSTRUCTIONS OF HELP-SEEKING FROM MENTAL HEALTH PROFESSIONALS AND THEIR UNDERSTANDING OF ITS RELATIONSHIP TO ETHNIC IDENTITY

Thesis submitted for the degree of
Clinical Doctorate in Clinical Psychology
at the University of Leicester

by

Emma Meldrum
Department of Clinical Psychology

July 1996
ACKNOWLEDGEMENTS

I would like to thank all the young women who took part in the research for giving up their lunch hour and talking so enthusiastically. Also the Mr Thompson and Mr Green who made it possible for me to carry out the interviews in their schools. My thanks also go to Celia McCrea for her supervision, Jennifer Clegg for her invaluable help and support at all stages in the research process, Loulou Philcox for her ideas and proof-reading, Zoe Brownlie for sharing times of excitement and anxiety and Gillian Hughes for being a pioneer. I would also like to convey my gratitude to Joe McElhinney and Liza Monaghan for their encouragement and unfailing patience.
ABSTRACT

The under-use of out-patient mental health services by people from ‘ethnic minority groups’ is widely documented. Most of the literature refers to adults, but there is also evidence that it is equally relevant to adolescents. Models and hypotheses have been developed to explain the underuse of services, help-seeking by adolescents and people’s health behaviour. These have tended to take an individualistic perspective in which cognitions are given a high priority and social and cultural influences are reduced to the status of ‘variables’ This study, however, aimed to take a social constructionist perspective to part of the process of mental health service use.

Using a grounded theory methodology, this study set out to investigate the meanings of seeking help from a mental health professional for Pakistani teenage girls in Derby and their understanding of the relationship between these and their ethnic identity. The Multi-group Ethnic Identity Measure (Phinney, 1992) was used to describe the teenagers’ ethnic identity. In depth interviews were conducted with twenty Pakistani teenagers in which they were encouraged to discuss how they would go about seeking help from a mental health professional for an emotional problem and the influences on them in the process. Eating disorders were chosen as a focus for the discussions as they have a high popular profile and there is concern about high levels of eating disorders among Asian girls.

The analysis illustrated how seeking help from professionals is a social process, shaped by the cultural meaning associated with emotional distress and wider social and cultural practices, values and structures. Of prime importance for the teenagers interviewed was the relationship between their family and the Pakistani community, and their roles as females in maintaining the family’s social position. Also of importance were their relationships with their parents and their fears about the client-professional interaction. The research suggests that all levels of influence need to be considered in the planning and provision of services, which should involve Pakistani teenagers and their families, as well as key members of the community.

Emma Meldrum
July 1996
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Abstract</td>
<td>i</td>
</tr>
<tr>
<td>Table of Contents</td>
<td></td>
</tr>
<tr>
<td>List of Tables, Figures and Appendices</td>
<td>iii</td>
</tr>
<tr>
<td>1.0 Introduction</td>
<td>1</td>
</tr>
<tr>
<td>1.1 Terminology</td>
<td>3</td>
</tr>
<tr>
<td>1.2 Literature Review</td>
<td>4</td>
</tr>
<tr>
<td>1.2.1 Use of mental health services by people from ethnic communities</td>
<td>4</td>
</tr>
<tr>
<td>1.2.2 Adolescents from ethnic communities and mental health</td>
<td>5</td>
</tr>
<tr>
<td>1.2.3 Explanations of service use by people from ethnic communities</td>
<td>6</td>
</tr>
<tr>
<td>1.2.4 Models that may help to explain service use</td>
<td>9</td>
</tr>
<tr>
<td>1.2.5 Research on help-seeking behaviour and attitudes</td>
<td>11</td>
</tr>
<tr>
<td>1.2.6 Health decision-making and adolescents</td>
<td>13</td>
</tr>
<tr>
<td>1.2.7 Ethnic Identity and service use</td>
<td>17</td>
</tr>
<tr>
<td>1.2.8 Broader perspectives</td>
<td>21</td>
</tr>
<tr>
<td>1.3 Research Topic and Questions</td>
<td>22</td>
</tr>
<tr>
<td>2.0 Methodology</td>
<td>26</td>
</tr>
<tr>
<td>2.1 The qualitative paradigm</td>
<td>26</td>
</tr>
<tr>
<td>2.2 Choice of methodology</td>
<td>28</td>
</tr>
<tr>
<td>2.2.1 Grounded theory</td>
<td>30</td>
</tr>
<tr>
<td>2.3 Data management and analysis</td>
<td>31</td>
</tr>
<tr>
<td>2.4 Participant selection and access</td>
<td>35</td>
</tr>
<tr>
<td>2.4.1 The local context</td>
<td>35</td>
</tr>
<tr>
<td>2.4.2 Gender</td>
<td>37</td>
</tr>
<tr>
<td>2.4.3 Age</td>
<td>37</td>
</tr>
<tr>
<td>2.4.4 Ethical approval</td>
<td>38</td>
</tr>
<tr>
<td>2.4.5 Access</td>
<td>38</td>
</tr>
<tr>
<td>2.4.6 Participant selection</td>
<td>39</td>
</tr>
<tr>
<td>2.4.7 Data collection</td>
<td>40</td>
</tr>
<tr>
<td>2.4.8 Multi-group Ethnic Identity Measure</td>
<td>42</td>
</tr>
</tbody>
</table>
LIST OF TABLES AND FIGURES

Figure 1. Model of cultural commitment (Levine & Padilla, 1980, cited in Wallen, 1992) 18
Table 1. Mean Ethnic Identity and Other-group Orientation Scores 45

LIST OF APPENDICES

Appendix one List of initial codes 96
Appendix two Example of initial coding 97
Appendix three Sample letter to parents (in English) 104
Appendix four Interview guide 105
Appendix five Vignette 106
Appendix six Multi-group Ethnic Identity Measure (Phinney, 1992) 107
Appendix seven Multi-group Ethnic Identity Measure scores 109
Appendix eight Original ethnic identity data from Phinney (1992) study 110
1.0 INTRODUCTION

“There is increasing concern about the way in which mental health services in hospitals, general practice and community settings are provided in Britain’s multiracial and pluralistic society. Psychiatric services have failed to respond to the needs and secure the confidence of Britain’s ethnic communities... Consultation with members of the ethnic communities about the planning and delivery of services has been sadly lacking.”

from A Cry for Change, Webb-Johnson (1991; p7)

This quote came from a report by a multiprofessional group, including social services development workers, nurses, psychologists and psychiatrists, and its message is repeated in much of the literature looking at the use of mental health services by people from the various ethnic communities in Britain (eg. Fatimilehin & Davis, 1995; Roach, 1992; Wilson, 1994).

The researcher’s experience as a white British trainee clinical psychologist on placements in some of the main cities in the Trent Region (Sheffield, Nottingham, Leicester and Derby) has been made up predominantly of direct work with white British people. Each city has substantial ethnic communities, but people from those communities were rarely being referred to the psychology departments or community mental health teams. This raised in her mind questions as to why that might be and how it might be addressed.

One response in Britain and the USA to the underuse of outpatient services by people from ethnic communities has been to develop separate services for particular ethnic communities (eg. The Asian Family Counselling Service (AFCS), Bradford; NAFSIYAT Intercultural Therapy Centre, London). In Leicester, one Asian psychologist was employed specifically to meet the needs of the Asian population and in Nottingham, research was being carried out by a black psychologist into the psychological need of African-Caribbean families in the city (Fatimilehin & Davis, 1995).
Various hypotheses have been put forward to account for differences in service use by different populations. Some have been developed into models, but these are yet to be tested widely. A lot of the research looks at predictors of service use and intervention outcome for people from ethnic communities, but there is very little published research investigating the views and ideas of people from ethnic communities on how existing services could be developed and/or improved to better meet their needs.

The research that does exist focuses primarily on adults or parents of children. In the United States, there have been studies into the perspectives of college students from ethnic communities on counselling (eg. Atkinson et al, 1990) and other mental health services (eg. Yeh et al, 1994), but in Britain there is a notable lack of research carried out with adolescents who use or might need mental health services. Given that adolescents from ethnic communities also tend to be under-represented in outpatient services (Roberts & Cawthorpe, 1995), it raises questions as to why that might be, and whether or not the models developed for adults are applicable to a younger age-group, many of whom are likely to have been born and educated in Britain.

There has been some exploration of adolescents' help-seeking behaviour, finding that adolescents are very reluctant to seek help for emotionally distressing problems, even from informal sources such as friends and family (Boldero & Fallon, 1995; Rickwood & Braithwaite, 1994). Factors that have been found to be important in the decisions made about seeking help are the gender of the adolescent and the nature of the problem. However, the research has shed little light on how adolescents go about seeking help, or why they make the decisions they do, and it has mostly been carried out with white populations.

The 'academic' context of this particular study was a dearth of research relevant to the use of mental health services by adolescents from ethnic communities, but some useful models and hypotheses relating to adults. The 'applied' context was one in which much concern was being expressed, but where the response of services was patchy.
1.1 Terminology

Before the literature review, terminology will briefly be addressed. Terminology in the area of race and culture is ever changing in both words used to express particular concepts and the meanings of those concepts. Indeed, Raymond Williams (1983) described culture as one of the three most complex words in our language. In this document, unless I am quoting from other people’s work, I will be using the meanings of race, culture and ethnicity given in the Clinical Psychology, Race and Culture resource pack for trainers (1995), which follow Fernando’s (1991) framework.

Race is determined by genetic ancestry, however, it is often characterised as referring to physical characteristics such as skin colour and as such is socially constructed. It is perceived to be permanent.

Culture refers to a system of meanings and actions that are created and used by any group of people. It is learned through upbringing and transmitted from generation to generation, therefore it is changeable and people can choose whether or not to participate in those meanings and conventions.

Ethnicity is an individual’s self-identification as a member of a group and therefore signifies a sense of belonging to that group. The word ‘ethnic’, as in ‘ethnic minority’ is often (mis)used in a way that implies that ethnicity is a characteristic only of people not of the mainstream or dominant culture (Ali, 1992). However, ethnicity is part of everyone’s identity.

As far as possible, people or groups will be referred to in terms of their ethnicity (eg. Pakistani), unless different cultural groups have been amalgamated. In those instances, ‘Asian’ will be used to refer to people from the Indian sub-continent (and their children) and ‘black’ will be used to refer to African-Caribbean and African people. In the absence of another recognised term, ‘ethnic’ will be used to refer to non-indigenous communities, although this is not meant to imply that they are the sole ‘possessors’ of ethnicity (see above discussion on ‘ethnicity’). Ethnic community will be used in preference to ethnic minority, unless a very broad group of people is being referred to in which case, ethnic group will be used. In the results section, as far as possible, terminology will follow that used by the participants.
1.2 Literature Review

In this review of the literature, summaries of bodies of research that have a bearing on the research topic will be critically discussed.

1.2.1 Use of mental health services by people from ethnic communities

According to the 1991 Census (HMSO, 1992 cited in Wilson, 1994) there are approximately three million black and Asian people living in England and Wales, which constitutes about 5.5% of the total population. Nearly half of these are of South Asian ethnic origin (from India, Pakistan and Bangladesh). These Asian communities are not evenly spread throughout the UK, but are found in largest concentrations in cities such as Birmingham, Leicester and Bradford and certain London boroughs (eg. Tower Hamlets, Brent and Newham).

The multi-ethnic nature of Britain is now being recognised in government papers, such as 'The Health of the Nation' (HMSO, 1992) in which the importance of meeting the unmet need in mental health of 'persons from ethnic minorities' is made explicit. This has been supported by a guide for service providers in the NHS in meeting Health of the Nation targets called 'Ethnicity and Health' (Balarajan & Raleigh, 1993) which includes a section on 'mental illness'. In it, it makes particular reference to the high admission rates of African-Caribbeans to psychiatric hospitals, raised diagnostic rates for schizophrenia in both African-Caribbeans and Asians and the high suicide rates in young Asian women.

The most common diagnosis among Asian patients is depression (Khan, 1983 cited in Webb-Johnson, 1991). Evidence concerning their prevalence for major psychiatric disorders is mixed, but on balance is thought to be roughly equivalent to the indigenous population (Wilson & MacCarthy, 1994). However, the over-representation of people from ethnic communities among compulsory admissions to psychiatric hospitals is well documented, as is their under-representation in out-patient services (Roach, 1992; Webb-Johnson, 1991; Wilson, 1994; Wilson & MacCarthy, 1994). In particular, Asians are rarely referred to services providing the 'talking therapies' (Campling, 1989 and Ilahi, 1988 cited in Webb-Johnson, 1991).
1.2.2 Adolescents from ethnic communities and mental health

There is very little research looking at the use of mental health services by children and adolescents from ethnic communities in Britain, although now, health services are required to record the ethnicity of their service users, therefore figures should be available for such studies.

From the United States, Hoberman (1992) writes that the majority of epidemiological studies on adolescent psychiatric disorders have either not reported on the range of ethnic groups represented in their data, or they have explicitly excluded adolescents from ethnic communities. As a result, epidemiological data on adolescents from ethnic communities is wanting (Roberts & Cawthorpe, 1995). The only conclusion Hoberman is prepared to draw from the studies available is that at least some mental health problems occur more frequently in some ethnic communities, but these findings cannot be generalised to all ‘minority’ adolescents.

In his article on the rate of psychiatric illness amongst Asians in the UK, Ananthanarayanan (1994) quotes only three studies on children and adolescents, all carried out in the seventies. Two look at aspects of behavioural disturbance among Asian children, finding them to have a significantly lower rate of ‘deviance’ than matched white and African-Caribbean children (Cochrane, 1979 and Kallarackal & Herbert, 1976 cited in Ananthanarayanan, 1994) and one found Asian children to be markedly less ‘neurotic’ than white children (Hill, 1975 cited in Ananthanarayanan, 1994). Roberts & Cawthorpe (1995) found a lower rate of psychiatric referral of Pakistani children and adolescents in Bradford than native whites (nine per thousand and twenty-one per thousand respectively), but this was a higher rate than that found in older studies. They also found some difference in the source of referral (although, a similar proportion of each group were referred by GP’s) and the keeping of appointments, with Pakistani families rarely keeping appointments following the initial assessment.

There is, however a growing concern about the prevalence of eating disorders amongst Asian girls (eg. Mumford & Whitehouse, 1988) and women (Dolan et al, 1990) and the high rate of suicide among young Asian women (Roach, 1992). A suggested source of distress is conflict between parents and adolescents, especially where the adolescents have been born and brought up in Britain and may feel
torn between the ethnic community norms and values and those of the mainstream community (Bryant-Waugh & Lask, 1991; Mumford et al, 1991). Bhadrinath (1990 cited in Ahmad et al, 1994) suggests that religious affiliation may also play a part, such as the complex dietary restrictions associated with being a Muslim.

Another explanation rarely seen in the literature is the potential difficulty associated with developing a positive ethnic identity in a mainstream culture in which racism (both personal and institutional) abounds. One exception is a paper by Ahmad et al (1994) in which they briefly discuss the role of self-concept and self-esteem in Asian adolescents' less healthy eating attitudes. These constructs have been linked with ethnic identity development by researchers such as Phinney & Chavira, (1992). Ahmad et al's hypothesis is that unhealthy eating attitudes may be a result of a poorer self-concept and self-esteem, which reflect difficulties these adolescents may experience integrating into the host community. This needs further exploration.

1.2.3 Explanations of service use by people from ethnic communities

Various hypotheses have been put forward to explain the findings about service use by people from ethnic communities, but these are rarely developed into integrated models:

2. Asian people do not seek help from existing services because of different culturally determined values and attitudes towards these services (Webb-Johnson, 1991),
3. Asian people are more likely to use support structures or healers from within their own communities (McCarthy, 1988 cited in Wilson & MacCarthy, 1994)
4. Asian people do not seek professional help because of a lack of culturally appropriate and sensitive services (eg. no workers from their ethnic communities, inadequate interpretation services, workers untrained in issues relating to working with people from ethnic communities) (eg. Ahmed et al, 1991),
Asian people do not seek professional help because they are unaware of the available services, or services are inaccessible to them (e.g. Fatimilehin & Davis, 1995; Patel, 1992).

Asian people do not get access to services because they are not referred by workers in primary health (GP's, Health Visitors) because of a range of assumptions made by these professionals about the ability and willingness of Asians to use these services (e.g. Nadirshaw, 1992; Webb-Johnson, 1991).

There is no reliable support for the first hypothesis. Beliappa, in his community study, concluded that there was an alarmingly high rate of undetected distress in the Asian community (Beliappa, 1991 cited in Ahmed & Webb-Johnson, 1995). In addition, research suggests that there is quite a bit of local variation in the levels of distress in ethnic communities, reflecting their different migration histories, local social and economic factors and the size and closeness of the communities (MacCarthy, 1988 cited in Wilson & MacCarthy, 1994)).

Support for the second, third and fourth hypotheses is mixed, for example, there is evidence that Asians in Britain consult traditional healers as well as, rather than instead of GP's (Bhopal, 1986 cited in Smaje, 1995). However, Eastern and Western philosophical traditions have given rise to very different conceptualisations of 'mental health'. Broadly speaking, Western ideas of what is important for good mental health include self-sufficiency, individual autonomy, efficiency and self esteem and fundamental to these is the concept of the mind-body dichotomy (originating with Descartes).

Eastern ideas are more characterised by notions of integration, harmony and balance (Fernando, 1995a). These concepts are applied both to the individual and the family or community, so that problems experienced by an individual are placed firmly in the context of roles and responsibilities within the family and community (Ahmad, 1990 cited in Imam, 1994). These very different perspectives will certainly have implications for how well people from cultures other than the dominant Western culture 'fit' into services designed and structured by the dominant culture.

In an attempt to integrate some of these ideas, Wallen (1992) discusses the under-use of outpatient mental health services by people from ethnic communities in terms of 'barriers' to use and provides research evidence to support this
conceptualisation. The three kinds of barriers she suggests are ‘economic’, ‘access’
and ‘cultural’. Cultural barriers are construed in terms of culturally specific
constructions of ‘mental health’ and therefore what constitutes appropriate care
and successful outcome. The dominance of the beliefs and values of the
mainstream culture gives rise to culturally insensitive structures, for example,
those lacking staff who speak the languages of the ‘minority’ communities and
involving potential misdiagnosis of problems.

Hoberman (1992) also frames his discussion of mental health service utilisation
by adolescents in terms of barriers, although none of these is very clearly defined.
Two are very similar to Wallen’s, namely economic and physical. The label he
gives to the third barrier is ‘psychological’, which includes the individual’s real or
imagined fears about his/her reputation.

What Wallen alludes to but seems almost to avoid naming, but which Fernando
and other authors are very clear about is racism in mental health services. This
is often divided into personal and institutional racism, but both apply in the
delivery of services. In the Clinical Psychology Race and Culture Special Interest
training pack on race and culture (1995), racism is defined as ‘the systematic
application of prejudice across personal and institutional contexts... on the
ground of perceived race’ (p22), with ‘prejudice’ referring to practices of power
which discriminate against people.

An example of such practices of power is the use of racial stereotypes. Some of
the most common stereotypes applied to Asian people are that they ‘look after
their own’ when problems arise and that they are not psychologically minded
(and therefore lack the necessary insight for certain therapeutic interventions
such as psychotherapy) (Ahmed & Webb-Johnson, 1995).

There are also other mechanisms as a result of which people from ethnic
communities may not gain access to services (sixth hypothesis), that are not
overtly racist but are as a result of a lack of cultural understanding and
sensitivity. For example, a study carried out by Wilson & MacCarthy (1994) found
that Asian patients who scored above the cut off on a measure of psychiatric
morbidity, were more likely than white patients to say that the purpose of their
visit to the GP was about a physical problem alone (65% vs 46%). Given that, on
a self-report questionnaire, Asian patients were selecting similar items to express
their emotional distress, one conclusion is that they communicate the presence of emotional distress in different ways to some white patients. This could be construed as a 'problem' in the way that Asian patients communicate or a difficulty in the interaction between Asian patients and their GP, such that the emotional distress of Asian patients was not addressed in the consultation.

Unfortunately, the former construction (that the problem of communication lies within the non-white patient) can be seen even in research that is attempting to raise the profile of the needs of people from ethnic communities. Roberts & Cawthorpe (1995) report, without comment, on research that talks about the 'inability' of Asian parents to recognise certain behavioural problems. Later in their paper, they acknowledge different idioms for the expression of emotional distress, but make no explicit link between this and the reported research.

1.2.4 Models that may help to explain service use

Some of the above research and resulting hypotheses have been developed into models that aim to explain service use. Two such models are described below.

1 Interaction Model of Client Health Behaviour (IMCHB) (Cox, 1982)

This is a model that aims to explain 'health behaviour', by which is meant the use of professional health services in order to remain healthy. Although it was not developed to explain the health behaviour of adolescents, it has been applied to adolescent's decisions to engage or not engage in 'premarital sexual intercourse' (Lock & Vincent, 1995). It is composed of groups of factors that have been found to explain some of the variance in health service use. These are organised into (a) 'elements of client singularity', comprising 'background variables' (demographic variables, social influence, previous health care experience and environmental resources), as well as psychological factors (motivation, cognitive appraisal and affective response), (b)'elements of client-professional interaction' and (c)'health outcome'.

The IMCHB was developed in the context of nursing, but incorporates many variables relevant to the use of mental health services. Indeed, the most common routes to mental health services for adolescents involve a health professional such as a GP, paediatrician, school doctor or nurse.
While the model includes social factors, these are only given the role of 'background variables'. As Radley (1994) points out, there is an important sense in which these 'variables' are not variable, but rather are social phenomena, with a degree of stability within particular social settings and relationships. Social factors are not included in the elements of client-professional interaction, except in so far as they have an impact on the client's motivation, cognitive appraisal and his/her affective response. It assumes that individuals are broadly autonomous (hence the inclusion of social factors in the category of 'elements of client singularity'), rather than including social factors in the process of health service use. Younger people tend to be less autonomous, with family and peers playing an important role, and there is cultural variation in the extent to which decisions are made by individuals themselves or as part of a social structure (eg. family or community).

The model raises the question of how the various factors may be organised (and differentially influential) for people from different cultural and age groups.

2 Practice Oriented Framework, as described by Yeatts, Crow & Foults (1992)

Like the IMCHB, the Practice Oriented Framework organises factors identified by research into health service uptake, but focuses mainly on how people initially get to services rather than looking at their ongoing use of services. It was originally developed to explain social service use, but has been applied more widely. It is interesting in that it intentionally focuses on those factors that can be altered by service providers (Yeatts et al, 1992).

It starts with the assumption that there is a perceived need for a service (although it does not clearly state who is defining this need) and says that this will be met if there is sufficient (a) knowledge of available services, (b) access to services and (c) intent to use services. The absence of one or more of these is described as a 'barrier' to service use.

This model fits in with much of the research into the use of mental health services by people from ethnic communities, and the hypotheses that have arisen from this as to why services tend to be underused (eg. lack of knowledge and access, unattractiveness of services due to cultural differences). The notion of
'barriers' to service use are quite popular (see Hoberman, 1992 and Wallen, 1992), with different writers grouping them into different conceptual categories (e.g. Hoberman has three types of barriers: economic; physical; psychological). It also maps onto the quality assurance framework of accessibility, acceptability, appropriateness and availability.

However, the three areas identified (knowledge, access and intent) are not independent from each other (nor necessarily independent from the perception of a need for a service, as perceived by an individual). For example, intent to use services may vary according to perceptions of their accessibility, and/or knowledge of what is available. It raises the question of how the areas might interact, the answers to which may be different for different cultural, gender and age groups (e.g. for teenagers, easy accessibility may be more influential than knowledge of the nature of the service on offer). They are also not independent of the context in which they are operating.

How then can the problems associated with the use of mental health services by people from ethnic communities be addressed? The American Psychological Association has produced guidelines for providers of psychological services to ethnic, linguistic and culturally diverse populations (APA, 1993). These include education of clients as to what can be provided, professional awareness and knowledge of research relevant to the population(s) being provided for, recognition of and respect for client's beliefs, values and structures and use of language requested by the client.

What they do not address, but is raised by other authors, is the involvement of ethnic communities in the planning and development of culturally appropriate and sensitive services (see Fatimilehin & Davis, 1995; Murase, 1977 cited in Zane et al, 1994; Roach, 1992; Wilson, 1994), and the location of services in the community.

1.2.5 Research on help-seeking behaviour and attitudes
Most of the research in the area of help-seeking behaviour and attitudes has been carried out with adults, but there is a growing body of research looking at adolescents.
A major finding is that adolescents rarely seek professional help for emotional problems, tending to rely primarily on their peers (Rickwood & Braithwaite, 1994). This fits with the popular model of adolescence as a time of striving for increased autonomy from parents and other authority figures.

The bulk of research has concerned itself with identifying factors that covary with or predict help-seeking behaviour and attitudes, the most consistently identified factors being gender, age, severity of symptoms and type of problem. A model has been suggested by Rickwood & Braithwaite that talks about an interaction between personality factors, demographic factors, support network and psychological symptoms (Rickwood & Braithwaite, 1994). However, their conceptualisation of ‘personality’ factors could be questioned. It includes ‘willingness to discuss mental health status’ which could be highly socially influenced and context dependent.

The model was only partially supported by their own research on a predominantly middle class sample of Australian adolescents. They found it adequate to explain help-seeking behaviour in general, but not help-seeking from professionals. Their main findings about help-seeking generally were in line with previous research, in other words, that help-seeking was predicted by gender (girls are more likely to seek help than boys) and the severity of the symptoms. In addition, help-seekers were more familiar with mental health services, reported themselves to be more at ease in discussing mental health matters and were more sensitive to and aware of their own reactions and feelings.

Boldero & Fallon (1995) used a different method to investigate the same area and in addition they investigated where adolescents went for help. They also found that gender was an important variable in whether or not help was sought for a problem that caused them ‘considerable distress’. Where they went for help depended on their gender, type of problem (personal, interpersonal, family etc.) and the problem characteristics (severity, stigma etc.), suggesting that there is some sort of cognitive appraisal process at work. Generally, adolescents in this study preferred the help of non-professionals over professionals.

Because of the methodology used to research help-seeking, there is little information on how adolescents go about making the decisions. The methodology relies on large samples and questionnaires, which are not suited to
looking in depth at the meanings of different types of help-seeking. As with the
other research that has been discussed, it does not explore how identified factors
(gender, type of problem etc.) are organised for individuals. Also, as Boldero &
Fallon (1995) acknowledge, it does not address the role of the wider context in
which help seeking takes place. Specifically, this body of research says little about
the part played by race and culture, as the bulk has been carried out on white
subjects (where ethnicity is actually mentioned), therefore it raises questions
about whether or not the findings on help-seeking patterns are applicable to
different cultural groups.

In relation to the models of health service use, it contributes to an understanding
of the potential barriers to service use (eg. knowledge of mental health services)
and adds some new dimensions (or variables), such as the nature of the problem
and its characteristics. These may be related to intent to use services, but further
research would be needed into the meanings of these dimensions to adolescents
to confirm or disconfirm this. Accessibility to sources of help is also not
addressed. However, one piece of research that addressed accessibility found that
it did not significantly predict help-seeking behaviour of a group of 16-20 year
olds who were mainly Mexican-American (Barker & Adleman, 1994).

To summarise, the above research has thrown up ideas as to which factors or
variables might be influential in adolescents' help-seeking behaviour, but little is
understood about the process of seeking help, especially help from professionals,
and even less is known about how adolescents from ethnic communities go
about seeking help for psychological distress.

1.2.6 Health decision-making and adolescents

Another relevant body of research is that to do with how people go about making
decisions in relation to their health behaviour. As with the models of service
use, the focus has been on physical rather than 'mental' health, but there are
important similarities between the two, with 'health behaviour' potentially
including the seeking of help (professional or informal), as well as actions whose
aim is to enhance mental health or prevent mental health problems. The earlier
models are briefly reviewed below, followed by a more detailed look at some of
the more recent models.
There are a range of models relating to health behaviour with different theoretical foundations. **Social learning theory** (Bandura, 1977 and Hodgson, 1984 cited in Bennett & Hodgson, 1992) in its simplest form argues that behaviour is guided by expected consequences (expectancies). Learning about expected consequences can occur vicariously, through watching television and seeing other people do the same thing, but for it to have an impact of an individual’s behaviour, the ‘model’ has to have a high status.

Theories arising from the area of social cognition, for example **Attribution theory** (Abramson et al, 1978 cited in Bennett & Hodgson, 1992), **Theory of Reasoned Action** (Ajzen & Fishbein, 1980 cited in Langer & Warheit, 1992) and the **Theory of Planned Behaviour** (Ajzen, 1988, 1991 cited in Conner & Norman, 1995) have been applied to health behaviour, their focus being the sense people try to make of the situation in which they find themselves (their attributions) and cognitive phenomena such as attitudes, beliefs and intentions.

The **Health Belief Model** (Becker, 1974 cited in Conner & Norman, 1995) is one of the most widely used models by social psychologists studying health care, but is really a loose association of variables that have been found to predict health behaviour. An individual under threat of illness is said to call on two sets of representations. (1) Perception of illness threat, which combines the person's beliefs about their susceptibility to the illness and its perceived severity. (2) Evaluation of behaviours to counteract the threat in terms of their perceived efficacy and a cost-benefit analysis. So an Asian adolescent is less likely to carry out a particular health action if they perceive an 'illness' to be primarily a problem for the white population, or if that action (eg. going to see a school nurse) will result in them being teased by their peers. Two other parts of the model are 'cues to action' (these are triggers (internal or external) to a person taking action) and the value people place on their health (health motivation).

While these social cognitive models are useful in identifying variables that are important to health behaviours, their focus is (unsurprisingly) limited to certain cognitive phenomena. Social structure is only important in so far as it has an impact on an individual’s internal constructs (eg. attitudes and intentions). However, help-seeking is a social activity, and therefore it will involve communication and other complex forms of interaction not included in the above models. In addition, it can take place in a range of contexts whose
structures will influence the whole process, for example by making certain resources more or less available to different social groups.

Going beyond psychology, sociology can contribute to our understanding of the dynamic interaction between individual behaviour and social structure, by raising the profile of power relations, gender, age and ethnicity, none of which are directly addressed in the above models. Additionally, as with many models from psychology, most of the above models have been developed in and tested on European and American populations, with little regard given to the role of culture in decision-making processes.

The Pre-Adult Health Decision-Making Model (PAHDM) (Langer & Warheit, 1992) attempts to address some of the above issues in ways that are relevant to adolescents. It draws heavily on the social cognition models but with some significant differences. At the core of the PAHDM is the concept of 'decision-making directedness/orientation'. This is the primary group to which the adolescent refers in making decisions and includes peers, parents or the self. The groups are not mutually exclusive and it is recognised that different permutations will exist for different adolescents. Thus decision-making is seen as socially interactive and negotiated with others.

Another difference in this model is the role of biopsychosocial factors. These are recognised as playing a part in all stages of decision-making, before and after a cue to action, including the knowledge and beliefs adolescents have and their decision-making orientation. However, the authors see decision-making orientation as 'typological', in other words, reflecting a consistency in terms of who adolescents refer to, but as yet have not suggested how biopsychosocial factors might affect that orientation, nor which factors might play a greater role.

A final model of interest is Leventhal et al's (1992) Illness Representation Model which was developed in the context of adherence to treatment regimes. Again, it is more a framework that aims to bring together many relevant research bodies, including emotions and social and cultural variables, but what makes it particularly interesting is the central position it gives to lay models of health threats. These include the representations people have of their illness. It argues that people represent illness along five dimensions:
Illness identity (the illness label and symptom indicator)
Antecedent cause of the illness (attribution)
Consequences of the illness (physical, social and economic)
Time-line (whether the threatened illness is acute, cyclic or chronic)
Potential for cure and/or control of illness

These representations shape the procedures a person uses for coping with or controlling the illness and in appraising the outcomes of coping. The authors of the model recognise that these may change over time, depending on the phase of the illness. These phases come out of the work of others, but the first two (and most relevant) are described in the 1992 article as follows: 1) self-evaluation phase, at the end of which a decision is made as to whether or not one is ill; 2) illness phase, which may include attempts at self treatment and also denial, at the end of which the individual may decide to seek professional care.

Whilst the representations are conceived of as intrapersonal phenomena, it is recognised that they are shared by other members of society. This raises the possibility for non-sharing, which might be between the individual and those close to them or the individual and the professional. Leventhal et al discuss the implications of the latter in terms of both the choices people make about which professional (or body of professionals) they go to and their adherence to treatment.

In summary, early social cognitive and learning theory models were very focused, but fairly limited in their application to real life health decisions. This can be partly explained by the fact that they were developed outside the health arena. Models that incorporate social and emotional dimensions are very broad and therefore do not have the same potential predictive power. They are also in their infancy (Langer & Warheit, 1992) and need further testing. However, they raise interesting areas of consideration in the decision to use services, elucidating the dimensions relevant to the intent to use services put forward by the service-use models described in section 1.2.4.
1.2.7 Ethnic identity and service use

As was mentioned earlier, ethnic identity has been suggested as a possible mediator of mental health service use.

The research in this area comes largely from the United States. Ethnic identity is described as "one’s sense of belonging to an ethnic group and the part of one’s thinking, perception, feelings and behaviour that is due to ethnic group membership", (Rotheram & Phinney, 1987, p 13 cited in Phinney & Rosenthal, 1992). It is a multifaceted construct including an individual’s sense of belonging to a group and shared values, beliefs and practices (Phinney & Rosenthal, 1992), but it is not fixed (Hutnik, 1991) and may change over time and between environments.

Current conceptualisations of the development of ethnic identity build explicitly on Marcia’s four ego identity statuses (Marcia, 1980 cited in Phinney & Chavira, 1992), which are themselves grounded in Erikson’s (1968) writings on ego identity. Phinney (1989) suggests a progression from a position in which ethnic identity is unexamined (diffusion and foreclosure), through exploration of ethnic identity (moratorium) to ethnic identity achievement.

In a study of 15 to 17 year olds from three different ethnic groups, Phinney (1989) found that between fifty and sixty percent of the young people in each ethnic group could be classified as being at the unexamined stage of ethnic identity development. When she and her colleague followed up a sample of the subjects from the original study three years later, they found evidence of a progression in most of the subjects (Phinney & Chavira, 1992). In addition to this longitudinal evidence, there is cross-sectional evidence for this progression (Phinney, 1992), but more research is needed, as the sample sizes for the longitudinal research were small and most of Phinney’s research has been carried out on ‘minority’ communities in the United States (the word ‘minority’ is placed in inverted commas because in some of her research, it was the white students who were numerically in the minority).

At different points in the process of developing ethnic identity, individuals will be more or less committed to the culture of their ethnic group and to the dominant culture. LeVine & Padilla (1980, cited in Wallen, 1992) suggest that the
two axes, commitment to own culture and commitment to dominant culture, combine to give four categories of 'culturation', bicultural, acculturated, unacculturated and marginal (see Fig 1 below). This bears a very close resemblance to Hutnik's (1991) quadri-polar model of ethnic identity. The axes in her model represent degrees of identification with ethnic group and majority group, with the four quadrants respectively; assimilative, acculturative, dissociative and marginal.

These different categories are postulated to have different implications in terms of people's use of services, with established services being deemed appropriate for bicultural and acculturated individuals. However, there is no agreed consensus on the direction of the implications, indeed Wallen argues that 'all minority clients can benefit from mental health services that recognise their unique position and experience' (p292, 1992).

![Diagram of cultural commitment](image)

**Figure 1. Model of cultural commitment (Levine & Padilla, 1980, cited in Wallen, 1992)**

In relation to counselling services, the earlier conceptualisations suggest that the relationship between ethnic identity and use of services were as follows: The degree to which a person feels affiliated to their cultural group ('cultural affiliation' (Helms, 1985 cited in Coleman et al, 1995)) overlaps with their ethnic identity formation and is thought to have a bearing on their perceptions of and preference for a culturally similar counsellor. The closer the cultural affiliation,
the more likely that the individual will prefer a culturally matched counsellor and will judge the counsellor to be more competent or credible.

Subsequent research suggests that the relationship is not a simple one. In the USA, Yeh et al (1994) examined the relationship between the ethnic match of the therapist and client (children and adolescents) and service outcome (measured in terms of drop-out of treatment, number of sessions attended and functioning score at discharge). They found a positive association for adolescents, but not for children and a differential pattern according to ethnic group (with African-American adolescents more likely to drop out if their therapist was not ethnically matched than adolescents from other ethnic groups). There are a range of possible mediators for these associations, such as the degree of parental involvement, level of ethnic identity formation and broader social and historical factors, such as a history of social disadvantage and discrimination experienced by African Americans and the black consciousness movement.

Atkinson et al (1990) have found that students who used a counselling service represented the whole range in terms of cultural commitment/affiliation, but of those that did not, the main reasons given by students for not attending were related to their degree of cultural commitment. Thus, the more ethnically identified they were, the more likely it was that they would choose the lack of an ethnically similar or culturally sensitive counsellor as the main reason for not seeking counselling.

In the light of the above model (Fig 1), one would hypothesise that it is not only the individual's commitment to their ethnic group that would be of relevance, but also their commitment to or identification with the mainstream culture. Other dimensions may also be of importance. Fujino et al (1994) have found that both ethnic match and gender match (and the combination of the two) influence outcome of therapy for Asian-American women.

The writings of people in the area of transcultural therapy often highlight the lack of ethnically similar or culturally sensitive therapists as a reason for the underuse of services by people from ethnic communities. However, a meta-analysis of studies directed at the importance of ethnically matched or sensitive therapists suggests a more complex picture (Coleman, 1995). Coleman points out that ethnic identity or sensitivity is usually made salient in these studies, but if
you ask people to generate a list of attributes they would like to find in a therapist, the therapist’s ethnic identity is not a significant factor.

It may be that the importance of having an ethnically matched therapist will vary according to how the person seeking professional help understands their own distress. If they see it as relating to issues that only someone from their own culture will understand (in terms either of how the distress arose, what is maintaining it and the kinds of ‘solutions’ that might be applicable), then it may be important to see a therapist of the same ethnicity. This may be irrelevant if the problem is construed differently.

There are several ways that ethnic identity might relate for example to the Practice Oriented Framework of service use. The process of ethnic identity development may give rise to conflict within the family, especially when an individual is rejecting of the family culture (or aspects of it, such as dress, food or codes of behaviour relating to relationships with boys), which may in turn lead to a need for services. A person’s ethnic identity will affect their choice of social groups and meeting places, which (if these are outside the mainstream or dominant culture) may result in a lack of knowledge of services and access to them. Likewise, intent to use services may vary according to the value systems and rules of the culture with whom the person is identifying themselves. These issues are likely to be of particular relevance to teenagers who have been born and brought up in a mixture of mainstream and ‘minority’ cultures.

However, as has already been stated, ethnic identity should not be thought of as fixed or rigid. In a qualitative study of Asian women in London, Woollett et al (1994) found that the women’s constructions of ethnic identity were fluid and domain-related. This may be even more true of the teenagers referred to above, where they will have been exposed to representations of different cultures for most of their lives.

Much of the above discussion of ethnic identity is based on an acceptance of the construct of ethnic identity and its applicability to a range of cultures. It should be remembered, however, that the concept of ‘identity’ is euro-american in origin, as are most of the tools with which the various dimensions of identity and its development are measured. Thus it reflects an individualistic focus, which may not map directly on to the ways in which people from non-western cultures
conceptualise their development.

1.2.8 Broader perspectives
The research that has been reviewed suggests the importance of a range of levels of influence on the concepts discussed, from the individual (or personality), through interpersonal, social, cultural and historical (eg. migration history). A useful way of viewing this is within an ecological model, such as Bronfenbrenner’s (1979). One of the implications of this range of levels is that the concepts are themselves very complex, which may explain some of the variation and lack of conclusiveness in the findings of research into them.

As has already been mentioned, much of the research has used large samples and either an experimental or survey methodology (ie. broadly empiricist). Another framework to lay alongside this is social constructionism. Social constructionist enquiry is interested in how people make their world understandable, how they describe, explain and account for the world they live in (Gergen, 1985). Within this paradigm, ‘knowledge’ or understandings are seen to be socially negotiated and therefore change over time (eg. our changing understanding of what constitutes ‘childhood’) and between cultures (eg. concepts of ‘self”).

These socially negotiated forms of understanding are very important in social life as they allow for certain actions but work against others. For example, our understanding of ‘madness’ (a concept whose meaning has changed over time even within western culture) will lead us to behave in certain ways in relation to people labelled as ‘mad’ (or lead us not to label at all). Likewise, each culture defines ‘self’ differently (and there are even different definitions, reflecting different philosophical and professional traditions within a culture) and the ways in which a positive sense of self is maintained will be culturally defined (Kagawa-Singer & Chung, 1994).

Another important framework is that of ‘cultural psychology’ as opposed to ‘cross-cultural psychology’. The latter comes out of experimental social, cognitive and personality psychology (Much, 1995) and the bulk of its activity has been to explore the application of models developed (usually experimentally) on certain sections of Euro-American populations to other ‘cultures’. In other words, the Western population is taken as the ‘norm’. Cultural psychology draws on a range of ideological and theoretical frameworks from psychology, sociology, ethnology...
and philosophy. At its core is the interplay between the individual, society and culture (Kakar, 1982 cited in Much, 1995), with the focus of research activity being the patterns of meaning (personal, social and cultural) within particular contexts.

These paradigms would lead to different kinds of questions about help-seeking (and service use) and ethnic identity. They would be questions about the meanings of such concepts to certain people, within certain contexts and how this influences their behaviour. For example, the focus would be less on the ‘actual’ structural barriers to service use, and more of peoples’ understanding and perceptions of these and how they react to them. Clearly, this paradigm also has implications for possible methods of enquiry. It does not reject large samples, but includes methods that are sensitive to nuance and depth. As Gergen points out, these do not increase the ‘objective validity’ of the concepts (Gergen, 1985), but explicitly focus on subjective meaning.

1.3 Research Topic and Questions

The research reviewed above shows clearly that people from ethnic communities do not use mental health services in proportion to their population sizes and it puts forward interesting hypotheses as to why that might be. The models arising out of psychological research focus on the individual, especially their cognitive processes. These are expanded to include social or cultural factors, but often only so far as they influence cognitive phenomena such as attitudes and beliefs. People’s behaviour is seen as contingent upon what they think just before they act, thus minimising the social and cultural context.

Some of the more recent health behaviour models are much more explicit about the role of culture in how people think about health, and it would seem reasonable to extend this to ‘mental health’, especially for cultures where the mind-body distinction does not operate so forcefully. They also address aspects of the interaction between the individual and the professional and the Pre-Adult Health Decision-Making Model brings into focus the importance of peers and parents in adolescents’ health decisions.

Approaching from a different, more structural angle, the Practice Oriented Framework provides a useful way of conceptualising the underuse of services in terms that can be more easily addressed by service providers. However, the main
parts of the model need further specification in order to be more usefully applied to particular communities, be they 'ethnic' or other forms of social grouping.

Taken together, these models and the research upon which they were based would lead one to hypothesise that the seeking help from professionals is likely to be complex and related to several layers of influence (personal, interpersonal, social and historical), and therefore may be different for people of different ages, gender and ethnicity. So far this has been inadequately explored and whilst there has been some recognition of the implications of these issues on service development, the complex interplay of factors has rarely been acknowledged.

What is often absent in the research that has been the groundwork for this (and other) framework(s) are the perspectives of people from ethnic communities themselves (see Sassoon & Lindow, 1995). A way of addressing this might be to ask people from a particular ethnic community how they understand the process of seeking help from (mental health) professionals, what does it mean to seek professional help and how does this relate to knowledge, access and intent? This could give some insight into how the different layers of influence might be organised within individuals.

One source of information would be people who have used psychological services, and who could give retrospective reports of the process of referral and intervention. The benefits of this would be that the information would be grounded in actual experience, although the re-telling of the experience would involve a reconstruction of the events and emotions, which might well be strongly influenced by the outcome of the experience. The disadvantages of this approach would be that it would involve contacting again (the small number of) people who have used the service, which has ethical implications. Also, the views of those who never use the service are not reached and information on service accessibility would come only from those who had overcome the problems associated with it. Valuable though this information would be, they would be a highly selected sample.

Common to much research on race and culture and mental health has been a failure to differentiate between different ethnic communities (Roberts & Cawthorpe, 1995). In some studies, black and Asian people are grouped together (eg. Roach, 1992), others either give figures for black and Asian subjects separately
(eg. Atkinson et al, 1990), or focus on one or other group (eg. Ananthanarayanan, 1994; Webb-Johnson, 1991). It is unusual, though to find research that differentiates between the different Asian communities. One exception is the research carried out in Bolton by Ahmad et al (1994) into eating attitudes among Caucasian, Hindu and Muslim adolescents. They found significant differences according to religious orientation, with the Muslim adolescents forming the most distinctive group and offer explanations relating specifically to their cultural practices and constructions of gender and body shape.

Different communities are likely to have different socially negotiated meanings, relating to their different social and economic histories (including migration patterns) and their religious beliefs. In relation to mental health, whilst Asian perspectives on the mind and body tend to be lumped together and contrasted with western ideas, there may be differences between Muslim and Hindu understandings (as there are for the roles of women in the two religions (Ahmed, 1992 cited in Imam, 1994)) and these should not be confounded. This research will therefore concentrate on a particular ethnic community, the Pakistani Muslim community in Derby.

The research into help-seeking has suggested that the type of (psychological) problem has a bearing on how people go about seeking help for it (see section 1.2.5). It certainly makes intuitive sense that one’s construction of a problem will influence what one does about it. For this reason it would seem sensible to focus on the seeking of professional help for a particular psychological problem. The incidence of eating disorders amongst Asian teenagers is causing concern, and eating disorder generally have attracted a great deal of media attention (making it an area that most people know something about). Eating disorders would therefore be a good choice for a focus of discussions into help-seeking.

Given that ethnic identity (and in particular, cultural commitment or affiliation) seems to have some bearing on mental health service use, and that adolescence is seen as the main period for ethnic identity development, it would also be fruitful to explore how teenagers relate ethnic identity to professional help-seeking.
These then are the research questions:

1. How do Pakistani Muslim teenage girls understand seeking help from a mental health professional for an eating disorder (i.e. why and how people seek help and what does it mean to do so)?

2. How do Pakistani Muslim teenage girls understand the relationship between ethnic identity and seeking help from professionals?

The study aims to gain an understanding of the perspective of a fairly circumscribed group of people on seeking help from mental health professionals. It was recognised that such teenagers are likely to have very little direct experience of mental health services and therefore would be talking about a hypothetical situation. This might mean that the research would be tapping constructions of mental health services that reflect the perspectives of social structures to which they belong (peer group, family, Asian community), rather than constructions arising out of direct personal experience of mental health services. However, the two cannot be teased apart as personal experience is embedded in social structures. It should also be remembered that this relatively uninformed position is the most likely starting point for teenagers who need to access services and should therefore be of interest to clinicians and service planners.
2.0 METHODOLOGY

2.1 The qualitative paradigm

In the introduction to their book, 'Rethinking Methods in Psychology' the editors (Smith, Harre and Van Langenhove, 1995b) identify a sense of 'historical moment' (p1) indicated by the emergence of new methodologies, 'qualitative' methodologies, which move away from positivistic and experimental paradigms that have dominated psychology for so many years. The surge of interest can be seen in special editions of journals, dedicated to qualitative enquiry (eg. The Psychologist, 8 (3), 1995; Journal of Counselling Psychology, 41 (4), 1994 and Changes, 14 (3), 1996), but the very fact that they are 'special' issues indicates that they are yet to be fully incorporated into mainstream psychology. It was only three years ago that Harper & Warner (1993), then newly qualified clinical psychologists, wrote that 'by far the most significant difficulties in creating a space for this kind of research within clinical psychology are related to issues of history and politics' (p76).

Historically, psychology has sought to ally itself with the natural sciences and therefore has utilised methods considered to be 'scientific'. It is based on the assumptions that an objective world exists 'out there' (Osbeck, 1993) that is made up of objectively defined facts, that the causal relationships between these facts can be established using the hypothetico-deductive method and that the researcher is independent of this process (Creswell, 1994; Henwood & Pidgeon, 1992). The privileging of the collection and statistical analysis of numerical data has resulted in this paradigm being given the label 'quantitative'.

There has been discontent with this approach to the study of human activity since the end of the nineteenth century (Henwood & Pidgeon, 1995), the arguments being that it is based on an outdated version of natural science, (ie. Newtonian physics), which has been replaced by a physics of a much more 'chaotic' universe (Osbeck, 1993), and it makes the discipline very narrow (Smith et al, 1995b). An alternative paradigm ('qualitative') is that which assumes that 'reality' is subjective, multiple and context dependent, that research should focus on the generation of hypotheses through a process of induction and that research is inevitably value-laden (as is the researcher). Qualitative methods take a naturalistic or contextual approach and privilege the meaning of experience and...
behaviour.

The constructionist paradigm underlying qualitative methods argues that we do not experience the world directly, rather we ‘construct’ our own experience through a process of meaning-making. The meanings we construct reflect the immediate context, our personal biography and the social and cultural context. Thus the main sources of ‘data’ are what people say or do in real life settings and the accounts they give of this. In other words, what is studied is that which is made socially available (Harper & Warner, 1993).

Within the qualitative paradigm, a range of new methodologies have developed that draw on various theoretical strands from psychology and other social sciences. The three main strands are phenomenology, ethnomethodology and symbolic interactionism.

Phenomenology has its roots in the beginning of the twentieth century and is broadly concerned with an individual’s perception or account of an object, rather than the object itself (Smith, 1996). It is argued that neither the objective nor the subjective world can be described, only the world as experienced by the subject, thus the object of enquiry is the description of the phenomenon, as experienced by the person (Baker et al, 1992). The goal of phenomenological research is to uncover the essential structure of the phenomenon experienced and an example of this can be seen in the work done by Giorgi (1995). In attempting to investigate the experience of learning, he began with an extremely open-ended question, asking people to describe situations in which they have learned. From these concrete descriptions, through a systematic process of analysis of the implicit and explicit psychological meanings, he drew out underlying psychological structures of ‘learning’.

Ethnomethodology has been concerned with attempting to explicate the methods through which meanings are achieved in everyday activities. Discourse analysis (eg. Potter & Wetherell, 1987 cited in Potter & Wetherell, 1995) has drawn on ethnomethodology (as well as linguistics) and is concerned with what people do with their talk and writing, as well as the resources they draw on (Potter & Wetherell, 1995). Verbal reports are regarded as behaviours themselves and therefore it is not deemed necessary to go beyond the statements to seek relationships with other behaviours (Smith, 1996). An example of a piece of
discourse analysis is Wetherell and Potter’s (1992, cited in Potter & Wetherell, 1995) study of racist discourse in New Zealand, based on interviews with white New Zealanders.

Symbolic interactionism has its roots in sociology and social psychology and is influenced by phenomenology. It focuses on the meanings individuals ascribe to events and the symbols they use to convey meaning, arguing that these should be the central concern of social scientists. Meanings develop through social interactions but can be changed by a process of reflection and interpretation. Likewise, meanings can only be accessed through a process of interpretation. Unlike discourse analysis, methods that draw upon symbolic interactionism are interested in content of discussions (in other words, what people think and believe about the topic under discussion) (Smith, 1996). Language is the window into the inner life of the person (Denzin, 1995) and therefore discussion is one of the main routes of enquiry.

Examples of methods that have drawn on symbolic interactionism are Interpretative Phenomenological Analysis (IPA) (Smith, 1996) and Grounded Theory (Glaser, 1978; Glaser & Strauss, 1967 cited in Strauss & Corbin, 1990). Both are concerned with gaining an insider’s perspective into the phenomenon being researched, while acknowledging that the process of research is dynamic and will be influenced by the way the researcher experiences the world. However, while IPA’s main aim is to represent an individual’s (or a set of individual’s) view of the world, Grounded Theory aims to explain a given social phenomenon in the form of a theory.

2.2 Choice of methodology

The research described in the introduction used a range of methodologies, most being quantitative. Exceptions are the studies carried out by Fatimilehin & Davis (1995) using focus groups (qualitative) and Roach’s (1992) street survey (a mixture of qualitative and quantitative).

The choice of methodology depends on the goals of the research. One important dimension is whether or not the aim is to verify existing theory or to generate new theory (Rennie et al, 1988; Strauss & Corbin, 1994). The research by Atkinson et al (1990) described in section 1.2.7, asked the participants to choose reasons for
not making use of the counselling service from a set of predefined and mutually exclusive categories. The choices made were quantified and reported as percentages. This did not allow participants to generate new categories that might have better expressed their reasons, nor to explain the relationship between categories (or between the categories and other aspects of their lives).

The researcher's interest was in discovering new themes and relationships between themes, rather than verifying old ones. Although it was recognised that existing theories about the reasons that people from ethnic communities are under-represented as users of psychology services can help our understanding (and therefore influence service development), it was felt that there was room for research that goes beyond looking at why people do not use the service, to how people think about mental health services. Their thinking will inevitably be embedded in the social and historical context of the participants in the study and influenced by the researcher's perspective, making it an ideal area of research using methods that deal explicitly with these dimensions. As Orford (1995) points out, qualitative approaches are suited to the study of complex social phenomena.

The centrality of 'meaning', be it personal, social or cultural, to qualitative methods also makes it particularly appropriate (and attractive (Orford, 1995)) to practising clinical psychologists, as a large part of the clinical endeavour focuses on the meaning people ascribe to what they experience. Some therapeutic approaches have drawn heavily on social constructionism and are very much concerned with the creation of new meanings within people's lives (for example the narrative approach based on the work of Michael White, 1989).

Another reason why a qualitative method would be appropriate to the aims of this study is this paradigm's emphasis on the voice of those who participate in the research. This is particularly important when studying groups whose voice is rarely heard, such as people from ethnic communities. Denzin (1995) says of today's social interactionists (who have been influenced by feminist critiques of social interactionism) that they 'speak always to persons who occupy powerless positions in contemporary society' (p57). As well as being a clear statement of their position, this statement illustrates the way in which values are made explicit by researchers.
As the interest in this study was more to do with the content of the interview material and the social and personal meanings expressed within it, rather than the ways in which it is talked about, discourse analysis was rejected as a method. It seemed more appropriate to use a method whose roots were in symbolic interactionism. However, the researcher also hoped to go beyond the representation of the ‘insider’s view’ to develop some sort of conceptual framework, therefore grounded theory was chosen.

2.2.1 Grounded theory

Grounded theory (Glaser, 1978; Glaser & Strauss, 1967 cited in Strauss & Corbin, 1990) is a method that is increasingly being used in psychological research and would seem to be appropriate for a range of reasons:

* It is a general methodology for generating theory (i.e. it goes beyond description)
* It is more systematic than many other qualitative methods
* It focuses on content of data rather than structure
* It forces researchers to stay close to their data (using the techniques of ‘constant comparison’ and ‘theoretical sampling’, explained below)
* It requires researchers to search systematically for multiple perspectives
* It recognises that researchers cannot escape their subjectivity, but encourages them to avoid its effects by, for example, making their own assumptions explicit.

Grounded Theory was developed within sociology out of a dissatisfaction with existing procedures, which tended to generate large scale theories. These yielded little in the way of testable propositions and Glaser and Strauss believed that they did not offer a deep understanding of the complex social phenomena that they were aiming to explain. It was felt that it would be more useful to develop ‘middle range’ or substantive theories that explained a specific area of empirical enquiry. From these ‘local’ theories, more all-embracing systems of understanding would emerge.

Although the approach was developed within sociology, it was believed to be useful to researchers across a broad spectrum of disciplines, including psychology (Strauss, 1987), who had an interest in the complexity of the social world.
As with many qualitative approaches, the process of research is cumulative rather than sequential. Essentially, the data set is initially broken down, examined and compared with other parts of the data set and then is re-ordered through categorisation and the linking of categories according to their relationships with each other. In this way, patterns emerge from the data, rather than being imposed upon it. However, the researcher moves back and forth from the data to emerging theoretical schemes, collecting more data where necessary, so that data collection is influenced by the outcomes of the emerging analysis (Rennie et al, 1988). This is in stark contrast to quantitative approaches, where data collection and analysis are kept separate.

The role of previous knowledge in this process is not agreed upon. Some researchers argue that pertinent literature should not be read until the grounded theory has been developed (Rennie et al, 1988), in order that the emergent theory should be grounded as closely as possible in the data, rather than influenced by existing frameworks. However, others (eg. Morse, 1994; Strauss & Corbin, 1990) argue that to do this is to risk reinventing the wheel. Previous literature should be used to justify the research (for example, in terms of gaps identified) and to provide a theoretical context for the research. The existing knowledge can be used both as a template for comparison, allowing the researcher to recognise what is new and interesting in their own research, and to offer a range of ways of looking at social phenomena. In this study, relevant literature was read before and during the process of research, for the reasons mentioned above.

Specific ways in which the data was managed and analysed are given below.

2.3 Data management and analysis

The interview transcripts were analysed using primarily the Grounded Theory guidelines set out by Strauss & Corbin in their book, ‘Basics of Qualitative Research: Grounded Theory Procedures and Techniques’ (1990), but also drawing on the writings of other researchers who have used and adapted the method (Charmaz, 1995; Miller, 1995; Rennie, 1994; Frontman & Kunkel, 1994).

Analysis began with a phase of open coding, in which the researcher worked systematically through the data, generating an array of analytic concepts. This involved a line by line or phrase by phrase analysis of the data during which the
researcher gave each discrete incident, idea or event a name. This name or 'code' should be at a higher conceptual level than the word or words in the text, rather than simply a redescription, but it should keep as close as possible to the language used by the participant as possible, in order to preserve its meaning in context. For example, the following quote, "I think it'd take her quite a while to get sort of used to it herself. I think it would take her a while to understand actually what her problem is and to accept it and then, from then go to see what she can do to improve" was given the code 'acknowledging a problem'. See Appendix 1 for a list of initial codes and Appendix 2 for an example of coded transcript.

Other possible sources for names for codes are the researcher's own conceptual framework and the technical literature (Strauss & Corbin, 1990). The transcripts were worked through, with other examples of existing codes being noted and new codes generated. Codes were compared one against another ('the constant comparative method') in order to identify ways in which they were similar and different and how they might relate to each other. This is very different from traditional forms of content analysis, where pieces of data are allocated to predefined, mutually exclusive categories (Henwood & Pidgeon, 1992).

By asking questions of the data such as “What is this about and what phenomena does it relate to? What process is at issue here?” relationships between codes could be drawn out and linkages made at a higher level of abstraction. These are called categories. During this process, pieces of data that have been allocated to one code may be allocated to a different code or category. For example, "worries they would have... like letting parents down" 5.16 was initially assigned to the code 'family expectations'. But later it was reassigned to the category of 'assessment of the consequences of inaction.' As other pieces of data from the 'family expectations' code were also reallocated, the code itself was thrown out.

As with the codes, categories were compared, in order to identify relationships to each other (some categories were subsumed into a higher order category) and to ensure that they were mutually exclusive. The transcripts were also returned to in order to ensure that the categories fitted the data and to fill out or elaborate the categories in terms of its properties and dimensions, until the category was saturated. It can be seen therefore that this process involved both inductive and deductive processes.
Properties are defining attributes or characteristics of a category, and dimensions refer to the position of properties along a continuum. So for example, the sub-category, 'informal supportive relationships' has the properties of trust, shared understanding, relevant experience and taking it seriously, and the dimensions of duration (of relationship), closeness and gender.

In order to arrive at new theoretical formulations (rather than just describing the data or restating initial assumptions, Strauss & Corbin (1990) suggest a range of techniques to enhance what they call 'theoretical sensitivity' or 'the ability to "see" with analytic depth what is there' (p76). Theoretical sensitivity refers to a personal quality of the researcher in terms of her awareness of the subtleties of meaning of data. It may be developed during the period of the research, but also derives from personal experience, professional experience, the literature and the analytic process of interacting with the data. One strategy used was to repeatedly ask questions of the data (who? what? when? where? how?) in order to stimulate thinking about the possible properties and dimensions of categories. These questions also highlighted areas for which further data were needed.

Other strategies involved the making of comparisons in order to open up possibilities in the data. Examples of these are 'far out' comparisons (making comparisons with phenomena that are very different from that which is being studied), and the 'flip-flop' technique (turning the concept upside-down in order to think about it in a new way). These techniques were especially useful when the researcher felt stuck into a particular way of viewing the data. In this study, seeking help for an emotional problem was compared with seeking help for a mechanical problem with your car. This brought gender into focus, as well as questions about who is the 'expert' about the particular car/emotional problem being taken to the professional - the person who has driven/lived with it for the past two years, the passengers/people you live with or the professional who has worked with a range of cars/emotional problems?

Next was a process of axial coding in which connections were made between categories and their sub-categories. Strauss & Corbin (1990) suggest a framework, the 'paradigm model', to enable the researcher to think systematically about the connections between categories. This involved thinking about a phenomenon in terms of the conditions that give rise to it, the context in which it occurs, the strategies used to maintain it and the intervening conditions that have a
facilitating or constraining effect on those strategies.

The aim was to develop several main categories that were at a higher level of abstraction than previous categories, and ultimately to integrate these into a core category, around which all other categories are arranged. However, as Henwood & Pidgeon (1995) point out, this is a fairly ambitious goal for researchers starting out in qualitative research. Instead they suggest that such researchers focus upon and explore in depth a limited set of categories that are of particular relevance to the problem under investigation. In this study, there was a wealth of information on the teenagers' understandings of eating disorders. As this was not central to the research question about seeking help from professionals, it was only coded in terms of main themes. Where the teenagers made direct links between understandings of eating disorders and help-seeking, these were included in the more in-depth analysis.

Throughout the process of data collection and analysis, the researcher noted down ideas, thoughts and questions about the data ('memo's'). These were recorded separately from the transcripts and records of codes and categories and are there to aid the process of thinking abstractly about the data. However, they contained a reference to the transcript (or particular section of transcript) that stimulated the thought, so that they allowed the researcher to return to the data to check that their abstractions were linked to the research material (ie. 'grounded').

An example of one memo is:

3.4.96 Interview 7

Big dilemma - how can you access services that are culturally appropriate without the information travelling through your community and therefore having a negative impact on your family (either through general reputation, status, position of respect, or through specific things like a girl's reputation and therefore marriageability)? How do you even get to know where services are, let alone get to them? I've heard this being talked about in my clinical experience but it doesn't seem to be referred to in the literature.
Memo's are meant to capture thoughts and so are often preliminary and correctable. Their function is not to communicate ideas to an audience (Charmaz, 1995), therefore grammar and punctuation are less important than the meaning conveyed back to the researcher when he/she reads them.

Memo-writing lead directly into theoretical sampling. This refers to several processes. Firstly, as coding proceeds the researcher constantly refers to the relevant data in order to fill out the codes and categories. Secondly, it may involve only carrying out coding of sections of data relating to a particular category within which the researcher wishes to extend her theorising. Thirdly, analysis of early transcripts feed back into the research design, usually through a refocussing or expansion of the interview topics and further interviewing or re-interviewing.

The data management and analysis process described above was broadly adhered to, except that no further interviewing was carried out. Two other psychologists currently involved in grounded theory research helped with the process, taking part in some of the open coding and category development. This provided a check on the analysis (that it was ‘grounded’ in the data rather than being based solely on the researcher’s world-view) and introduced new ways of looking at the data.

2.4 Participant selection and access

The participants were female adolescents from one of the main Asian communities in Derby city, which is Pakistani.

2.4.1 The local context

Services in Derby for children and adolescents with eating disorders

Derby city has no specialist services for children and adolescents with eating disorders. The two main generic services are the Child and Adolescent Psychology service and Oaklands, the Child and Adolescent Psychiatry service, both of which cover the whole of southern Derbyshire. Young people might also get referred to the Sexual Abuse Unit if it is relevant. The route to referral is through GP’s, school nurses or doctors, education welfare officers, educational psychologists, paediatricians, social workers and other mental health workers in
the statutory and voluntary sectors.

In a recent postal survey of all of the 304 GP's in Southern Derbyshire (response rate, 59.5%), the majority said that they saw between one and five patients (children and adults) with eating disorders per year (Goss et al, 1994). It is not clear whether or not these are new cases. The majority of GP's refer such patients to community mental health teams (or the child and adolescent services). A large minority (34.6%) either treat the patient themselves or refer them to a Practice Counsellor (if available). The GP's reported that, compared to working with an average patient, they find they have to spend more time working with a patient with an eating disorder (or their support network).

For children and adolescents, routes to referral to mental health services tend to be more varied, but many rely on the recognition of a problem by an adult. As has been seen in the literature on help-seeking by adolescents, they are very unlikely to seek professional help and may not even turn to their parents for support (see section 1.2.5). This means that parents and teachers are likely to have a difficult, but important role in identifying distress in the adolescents with whom they are in contact.

**The Pakistani community in Derby**

Derby City has a population of approximately two hundred and nineteen thousand people (all figures provided by the Equal Opportunities Department of Derby City Council, taken from the 1991 census). Of these, approximately ninety percent describe themselves as white, with the Asian population being the next largest group at approximately six and a half percent. This puts Derby city above the national average in terms of its Asian population, but behind other cities in the Midlands, such as Leicester and Birmingham.

The Asian population is composed of approximately two fifths who identify themselves as Pakistani and three fifths as Indian (Bangladeshi's make up 0.1 percent of the city’s population). The three main religious groups represented are Muslims, Sikhs and Hindus.

The bulk of the Pakistani population live south and south west of the city centre, forming a community with its own shops, banks and places to eat. Several of the community centres in these areas cater for the local Pakistani community and the
city also has an Asian community centre, a Multicultural community centre and a relatively recently opened Pakistani community centre. These provide a range of social, art and leisure activities, with some times or clubs set aside exclusively for women.

2.4.2 Gender
All participants were female. There were several reasons for this. The concern over eating disorders and suicide amongst young Asian women (see section 1.2.2) meant that information about this particular group would be of particular clinical interest. In addition, eating disorders are more common amongst females than males (Levine, 1987), therefore young women are more likely to have come across them, either through personal experience, or through the media (e.g. teenage magazines), and to have thought about them. Also, the researcher is female and an assumption was made that being of the same gender would facilitate discussion (or at least, not hinder it). The Pakistani culture has clear rules about the mixing of people of different genders, which this arrangement did not infringe.

2.4.3 Age
Adolescence is usually roughly divided into early (10-14 years), middle (15-17 years) and late (18-early 20's) (Feldman & Elliott, 1990). This research included young women in the middle adolescent age band, (1) because they are likely to be more autonomous than younger adolescents and are therefore likely to play a more active role in seeking help for themselves (rather than relying on their parents or other adults) to initiate the process, (2) because they are likely to be further along the line in terms of their ethnic identity formation (see section 1.2.7), (3) because they will probably be more able to think about and express their thoughts on what are complex and potentially hypothetical issues and (4) because the middle adolescents are more likely to be provided for by the child and adolescent services.

All the teenagers\(^1\) who participated were in year 11 of school and were between 15 and 16 years of age.

---

\(^1\) The word 'teenager' will be used to describe the participants, in preference to 'adolescent' as this was how the young women referred to themselves.
2.4.4 **Ethical approval**
Before the fieldwork began, the research proposal was put before the ethics committees of the University and the Trust in which the researcher was on placement. It was given ethical approval by both committees.

2.4.5 **Access**
The researcher attempted to meet the teenagers through community groups and organisations. The reason for choosing this route first came from the understanding that the context of interviews has an effect on both its process and content. Interviewing within the buildings of a community venue might make certain topics more salient (e.g. the rules of conduct of the local community) than others (e.g. how school deal with teenagers' distress). However, there were very few activities organised specifically for female Asian teenagers. Contact was made with one group, but it was very small (on average, six or seven teenagers a week) with the young Asian women mainly in their early teenage years and with Asian teenagers from a range of religious backgrounds. The organiser (a Sikh woman) was very keen to be involved in the research, but was finding it very hard to recruit teenagers from the Muslim community to her group.

Community groups and organisations tend to centre around shared interests and therefore might result in a biased sample being contacted. Schools have the benefit of access to people with a range of interests, who are (usually) on-site in the day time.

Once it was realised that access via the community route was likely to prove problematic, head-teachers at two schools (Schools A and B) in the area of greatest concentration of the Pakistani community were contacted in order to ask permission to carry out the research in their institutions. Both schools were sent an outline of the research and an invitation for further discussion with themselves and any other staff who might have an interest (e.g. staff involved in pastoral care, school nurses and doctors, school counsellors). Neither school took up the offer of further discussions (probably reflecting how busy the staff teams were), nor did they pass it before the board of governors, but both willingly agreed to take part.

It was stressed that involvement of participants would be on a purely voluntary basis and schools would be offered feedback on the outcome of the research. In
addition, if participation in the research led to the identification of needs for psychological input, participants would be offered the opportunity of being referred on. In the event, this did not arise.

Both schools were willing to be involved, but the time-scale in which the interviewing could be carried out was restricted by mock exams and the onset of Ramadam. The deputy head-teacher at one school was unhappy for the teenagers to be interviewed at lunchtime (the only time available) over Ramadam, when they would be fasting during daylight hours. He was concerned not to be disrespectful of this religious practice. In the event, some interviewing did take place during Ramadam, but only after the views of the teenagers who had already been interviewed had been canvassed as to whether or not they would have been happy to have been interviewed at that time and with the full agreement of those to be interviewed.

2.4.6 Participant selection
Participant selection was arranged differently at the two schools, in line with the schools' wishes. At School A, the deputy head-teacher approached pairs of teenagers who fitted the research criteria, told them in brief about the research and asked them if they wanted to participate. He said that he aimed to include a range of teenagers in terms of their ability to express themselves verbally, but he did not employ any systematic way of doing this, so they were a highly selected sample. None of the teenagers he approached declined to take part.

At School B, the language support teacher spoke to a few of the Pakistani teenagers she knew and asked them to gather together their Pakistani friends and acquaintances in year 11 (15 and 16 year olds) and to come to the library on a particular morning. At that meeting, they were introduced to the researcher, who described the project and the opportunity was then given for them to think about it and meet again if they wanted to be involved. Those that wanted to participate formed themselves into pairs and arrangements were made for the interviews. This group were therefore much more self-selected. They were part of friend- and kinship networks and thus may also have been more homogeneous in terms of their life experiences.
At both schools, participants were given a letter for their parents (see Appendix 3), which gave parents the opportunity to refuse their daughter permission to take part. The letters were in both English and Urdu. Given the ages of the teenagers, they were entrusted to deliver the letter and notify the researcher or the deputy head-teacher at School A if permission was refused. At School B, some of the teenagers returned signed letters (indicating parents refusal), but there was no way of knowing whether or not parents had actually refused or if it was that the teenagers themselves had not wanted to be involved and had asked their parents to sign the letter (in spite of efforts to stress that it would be purely voluntary).

2.4.7 Data collection

Interviews of participants were semi-structured, using an interview guide (see Appendix 4) and a vignette of an Asian girl with an eating disorder (see Appendix 5) to prompt discussion about the role of ethnic identity and help-seeking from professionals. Participants were interviewed by the researcher.

A semi-structured approach was used as it was thought to be appropriate to the nature of the research questions. These aimed to explore a complex issue, that might have elements that were personal to the participant, therefore the flexibility and possibility for a conversational style offered by a semi-structured interview seemed to fit better than a structured approach. It was also consonant with the theoretical positions outlined in the section on methodology, that discussion gives a window onto people's psychological reality and that meanings are negotiated within a social context.

The interview guide was developed in order to address the research questions and drew on themes from the literature. Initial questions were used to establish a rapport with the participants (Smith, 1995) and to set a context within which the participants could think about seeking professional help. The questions in the interview guide were put in a logical order, but this was not rigidly adhered to, thus allowing for the exploration of areas relevant to the research questions, but not immediately apparent from the literature.

As far as possible, questions were open-ended. This was both in order to discourage 'yes/no' answers and allow the participants to talk about their thoughts and feelings, and also to avoid imposing the interviewer's world-view.
on answer's given. A stance of ‘active enquiry’ (Morse, 1994) was adopted by the interviewer, encouraging participants to elaborate on their statements and explain as far as possible the assumptions behind them, while attempting not to make them feel under pressure or judged.

The vignette was written by the researcher, about a Pakistani teenager who was described in such a way as to imply a strong identification with her culture (based on the researcher’s reading about and direct knowledge of the Pakistani culture). She was also described as having the main symptoms of anorexia nervosa. It had been intended to provide the teenagers with two vignettes, one of a young woman who had a strong cultural identification, the other who was more ‘westernised’. However, in the piloting of the interview with a group of white teenagers and a group of younger Pakistani teenagers, it became very apparent that this would be unwieldy and too time-consuming. The vignette of the more ‘traditional’ teenager was chosen in order to prompt discussion about the role of the ethnicity in help-seeking.

Participants were interviewed in pairs, partly for their own comfort, but also to generate discussion of multiple perspectives. This certainly seemed to occur, with some pairs disagreeing with each other, and some building on each others ideas in a way that might not have occurred had they come singly. The drawback of having more than one person can be that one of the pair dominates the discussion. This happened with one pair from School A who did not know each other very well, in spite of efforts to draw the quieter teenager into the process. It can also lead to participants being unwilling to express socially ‘unacceptable’ views. The fact that some of the teenagers debated ideas suggests that this was certainly not the case in all interviews.

At the end of the interview the participants were asked if they had any questions they would like to ask. Most took the opportunity to ask either for information about eating disorders and how to get help for them, or questions about the research and my academic and professional background.

Interviews took place at school in the lunch hour, in small rooms where there was some privacy (in two of the interviews, we were interrupted by a teacher coming in and collecting some materials and on both occasions the tape-recorder was turned off and the interview resumed only when the teacher had left the
room). Interviews lasted approximately forty-five minutes and were tape-recorded (with the participants' permission). It was explained to the participants that the interviews were confidential and that there would be no feedback to the teachers, except in the form of the final report, in which individuals would not be identified by name or school. The interviews were transcribed by the researcher and anonymised to avoid identification of the participants.

2.4.8 Multi-group Ethnic Identity Measure

In order to be able to describe the participants in terms of their ethnic identity, they were asked to take away and complete the Multi-group Ethnic Identity Measure (MEIM, Phinney, 1992, see Appendix 6). This is a measure of ethnic identity and other-group orientation, that has been used with young people in the United States. It was developed in order to provide a way of assessing ethnic identity in a range of populations (previous measures tended to be population specific).

It consists of twenty-three questions that are rated on a four point scale from 'strongly agree' to 'strongly disagree'. Fourteen of the questions assess ethnic identity and six assess other-group orientation. The other three are forced-choice questions about the ethnicity of the respondent and that of each parent (see below).

The two main constructs, ethnic identity and other-group orientation, are independent and have been found to be reliable for American high school students (aged 14 to 19 years) and college students (aged 18 to 34 years) from a range of ethnic groups. In the MEIM, ethnic identity is made up of three components, affirmation and belonging, ethnic identity achievement and ethnic behaviour. Correlations among these components was lower for the high school students than for the college students, and therefore they were not used in this study.

The MEIM includes an open-ended question to elicit a statement of self-identification, or ethnic label, and forced-choice questions about the respondent's ethnic group and that of their parents (i.e. their ethnicity). Slight adaptations were made by the researcher to the list of options for the respondent's ethnicity (questions 21-23) to make it more relevant to a British context.
2.4.9 Number of participants
As has already been explained in the section on methodology, the emphasis in qualitative research is on conceptual rather than numerical analysis, the aim being to produce an account that has depth. The numbers of participants reported in published qualitative research varies enormously. Currie (1988) interviewed seventy-six women, McCracken (1988) suggests eight or fewer. In this research, ten pairs of teenagers were interviewed. Ideally, further interviews would have been carried out to explore in greater depth concepts that were emerging in the analysis of the data, but this was not possible within the time constraints of the research.
3.0 RESULTS

The results will begin with a description of the sample in terms of their age and scores on the Multi-group Ethnic Identity Measure, followed by a description of the main categories that emerged from the grounded theory analysis.

There were two research questions driving the analysis, the first concerning Pakistani teenagers' understandings of seeking help from a mental health professional, the second concerning their understanding of the relationship between ethnic affiliation and help-seeking. As will be seen, their thoughts on the role of ethnic identity permeated many dimensions of the issues raised and therefore have not been artificially teased out into a separate section.

3.1 Age of participants

Of the twenty teenagers interviewed, ten were fifteen years old and ten were sixteen years old.

3.2 Multi-group Ethnic Identity Measure (Phinney, 1992) Scores

Fourteen (70%) out of the twenty questionnaires were returned. From those, thirteen of the teenagers labelled themselves as 'Pakistani' and one as a 'British Muslim'. The ethnic groups to which they said they belonged were 'Pakistani' (n=9), 'Muslim' (n=2) and 'British Muslim' (n=1). Two of the teenagers who returned the questionnaire did not respond to the question.

Table 1, overleaf, shows the mean Ethnic Identity and Other-group Orientation scores (the two scores shown to be reliable for fifteen and sixteen year olds, see section 2.4.7). See Appendix 7 for raw data.
The scores suggest that on average the teenagers in this study have a strong sense of their ethnic identity (maximum score = 4), stronger than the black and (south-east) Asian Americans in Phinney’s (1992) study (see Appendix 8 for Phinney’s original data). This may reflect the nature of the Pakistani community in Derby, which itself has a strong community identity. Some of the girls spoke of how their lives outside school were closely bound up with their family and if they did go out, it was with family members. They would also go to the houses of their Pakistani school friends, but many had fairly strict time limits on how long they could stay. Several talked about regular trips to Pakistan made by themselves and family, suggesting continued links with the country in which their parents were born.

They are also strongly oriented towards the mainstream culture (mean = 3.29), in which they have grown up and gone to school. Apart from school, two of the main interfaces between themselves and the mainstream culture are teenage magazines (which many said were a source of information on eating disorders) and television. Several of the teenagers also mentioned during the interviews that they ate a range of foods, including typically British (fish and chips) and food which is distinctively Asian (chapatti). All wore ‘modest’ clothing at school and when reading the vignette, some commented that they would never be allowed to wear skirts. It was not clear whether or not this was something they wanted to do and some of the teenagers talked proudly of the beauty of Pakistani dress.

The high scores on both Ethnic Identity and Other-group Orientation places the teenagers within Levine & Padilla’s (1980, cited in Wallen, 1992) ‘bicultural’ category (see section 1.2.7 of the introduction).

<table>
<thead>
<tr>
<th>Table 1. Mean Ethnic Identity and Other-group Orientation Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>number</td>
</tr>
<tr>
<td>---------------------------------------------------------------</td>
</tr>
<tr>
<td>Ethnic Identity</td>
</tr>
<tr>
<td>Other-group Orientation</td>
</tr>
</tbody>
</table>
3.3  Meanings of Seeking Professional Help

For the teenagers, the meanings of seeking help from professionals were many and varied and could be broadly divided into those that were symbolic and those that were concerned with the actions and strategies that flowed from the symbolic meanings. The two most powerful symbolic meanings were that help-seeking would lead to exposure to judgement by the Pakistani community (and all its ramifications for the individual and her family) and would raise issues about parental participation in the help-seeking process. Also important, but less clearly articulated, were the constructions the teenagers had about the client-professional interaction.

Interacting with the three main categories were two more sets of the teenagers' ideas, firstly about the conditions that would be necessary to ‘take the first step’ towards getting professional help and secondly their beliefs about what a professional could offer.

In this results section, the categories and their subcategories are listed below and then will be described and illustrated using the words of the teenagers. The three main categories (sections 3.5, 3.6 and 3.7) will be described first as they set the context for thinking about ‘taking the first step’ and interconnections between categories will be made throughout.
3.4 List of categories and sub-categories:

3.5 'The community.. what they going to say?' (Fear of exposure to community judgement)

3.5.1 being talked about

3.5.2 community construction of ‘problem’ (including meanings of ‘eating disorders’)

3.5.3 community construction of help-seeking behaviour

3.6 'Keep it in the family' (Decisions around involving or excluding parents)

3.6.1 parent-child responsibilities

3.6.2 parent-child relationship

3.7 'Knowing where to start' (Construction of client-professional interaction)

3.7.1 talking about yourself

3.7.2 power imbalance

3.7.3 ‘knowing where to start’

3.8 Taking the first step

3.8.1 identifying a need

3.8.2 informal support

3.8.3 severity of problem

3.8.4 assessment of consequences of inaction

3.9 Beliefs about professionals/professional role

3.9.1 ability to ‘help’

3.9.2 source of expertise

3.9.3 role as advice-giver
3.5  'The community - what they going to say' (Fear of exposure to community judgement)

Attempting to access professional help is seen as a process that carries with it the risk of people in the local Pakistani community (other than family and close friends) and peers finding out about what the individual is doing, and by implication, why she is doing it. The individual therefore becomes a topic of conversation and ultimately an object of judgement by the community and to a lesser extent, peers.

3.5.1 Being talked about

There are a range of ways that people can find out (ie. there are several conditions which might lead to such exposure), such as the professional, to whom the teenager goes, giving the information to others, the teenager telling or asking information from someone in the Pakistani community who passes this on, or being seen to go somewhere associated with emotional problems.

"...you wouldn’t really go to your doctor because your doctor knows your family innit and then he could tell your family, parents or someone" 6.11

"Wouldn’t want anyone to know ‘cause then they’ll spread it out, then everyone’s find out..” 6.6

"People would talk"

"That could pressure you in to not going if you were thinking of going” 3.7

The Pakistani community was construed as being particularly interested in the behaviour of its members and in discussing it with other members of the community. Information was described very powerfully as 'spreading' (see quotes above and below), a process that, once started, was outside the control of the individual.

"...everyone knows everything about everyone. Probably the local gossip this would be” 1.10

“‘Cause as the community knows they will start talking about you”

“Spreading about..” 5.8

2 6.11 refers to the interview number (6) and page number (11) respectively
Being talked about seemed to be unpleasant in itself, but it was fear of the consequences, in terms of the community’s judgements about an individual having an emotional problem or seeking professional help, that were most clearly described by the teenagers. The anticipated consequences are a change in the standing of the family and the individual in the community, and the respect accorded to them.

"The respect they have from the community, they might think that they might lose the respect from other people" 9.10

"... but if they hear something really bad from us they say, ‘look our back... like background was really good and look into the future, what have you done?’ " 5.8

The above quote illustrates that a change in the family’s standing within the community affects the family’s past (reflected in the word ‘was’), present and future. Some teenagers described the impact on the family’s future in terms of marriage prospects (negotiating the system of arranged marriages was an important issue for many of the teenagers interviewed).

However, although community judgement is very influential, there is another social grouping that is important to the teenagers - their peers at school. The anticipated consequences of being seen to have a problem are being teased and ridiculed (and by implication, ostracised).

"They don’t want it to be anyone else’s business"

"They might treat her differently and pick names, nick names" 2.7 3

The teenagers in one interview told a very vivid story of a girl at their school to whom this had happened. Their understanding was that it was the teasing (in which they took part) which eventually lead to the girl deciding not to attend her counselling sessions. One could hypothesise that the teasing was because of the stigma of having an ‘emotional problem’, or simply because a person is ‘different’ from their peer group in some way, at an age when group identification is very important.

3 Where there is no gap between quotes, the quotes followed on from each other in the interview
One of the conditions which can intervene in risking exposure is the location of the service. In the above story about the girl receiving counselling, a key feature was the place she went for counselling, namely the school's 'Pupil Care Base', which had a clear meaning, with stigma attached, to pupils in the school.

"also it was during school time, the teachers knew about it and everything and everybody else knew that when she actually went into that room obviously, it was the Pupil Care Base, so obviously." 10.19

Other conditions are timing (i.e. when you use it - see quotes above and below) and whether or not the person you see is from the Pakistani community or an 'outsider'. A person outside the community is assumed to be less likely to pass information into the community network.

"She'll have to find a suitable time... 4 she may have to miss school for a day and go there instead so that no-one else finds out" 2.7

In other words, access, a concept widely used in literature on service use, was perceived as a problem mainly in so far as it increased the risk of the community and/or peers finding out that you had an emotional problem or were seeking professional help (see 'Keep it in the family' for further discussion of conditions under which access may be difficult).

3.5.2 Community constructions of emotional problems

The cultural and social context of seeking professional help is a community and peer group in which seeking professional help signifies having a 'problem'. Before describing this sub-category, the teenagers' understandings of eating disorders will be delineated, but as this was not part of the main analysis, it will not be illustrated with quotes.

Although at times the teenagers in this study were talking generally about seeking professional help for emotional problems, the focus of the discussions was eating disorders (usually understood by the teenagers to mean anorexia and bulimia). These (eating disorders) had a range of meanings for the teenagers, which were connected with decisions about seeking professional help. Overleaf are the main themes that emerged.

4 Three dots mean that some text has been omitted
Control - eating disorders were seen either as in the person's control ("she didn't want to eat") or out of it (characterised by phrases such as addiction to dieting and inability to hold down food). A third possibility was a process in which the individual had initially chosen to cut down on food or to vomit, but she had then gradually lost control over her actions.

Body image - although some of the teenagers thought that a teenager might begin to control her eating because of an accurate assessment of her body size (ie. being 'too fat'), typically they thought people with eating disorders had a misperception of their body size ("they think they're fat") or attractiveness. However, several teenagers saw them as an expression of an overconcern with appearance.

The causal conditions were seen as being at a range of levels. At the intrapersonal level were notions of poor self-esteem, especially in the domain of attractiveness, overvaluing of self and 'stupidity'. Interpersonal processes could be the wish to be attractive to boys, comparison with media representations of women (white and Asian), being bullied or rejected or socially isolated, or being bereaved. At the level of the family was conflict, either between parents, parents and children or in the wider family (uncles, cousins). This might have an effect through direct involvement or through worry about the conflict between others. Cultural conditions were described as relating to unhappiness with arranged marriages (or plans for this), the community putting pressure on the family, which is experienced by the individual, and 'being westernised' (ie. having more opportunities to mix with boys and wearing clothes which expose more of your body, both of which were thought to contribute to a concern with appearance). Other social conditions mentioned, but not clearly explicated were poverty, being a teenager, school pressures and the availability and wastage of food in Britain.

It can be seen that the teenagers had rich ideas about eating disorders, which contrast with their perceptions of the community's and their peer group's constructions of emotional problems (see below). Eating disorders were seen variously as an illness (potentially fatal), a protest, an expression of distress, an attempt to be socially acceptable and a bid for attention. Some of these connected with the notion of seeking professional help, but others implied different kinds of solutions, such as addressing the issue of unhappiness with an arranged marriage, for which professional help might not be seen as relevant.
The participants in the study said that eating disorders were a topic that they rarely talked about at home or with their peers (although one pair commented that, knowing that they would be participating in the study, they had discussed it for the first time with their peers). The main sources of the above understandings were television (usually soap operas, but some documentaries and news items) and teenage magazines. As the teenagers interviewed saw it, this gave them a different and more informed perspective on eating disorders than their parents or grandparents.

The teenagers understood the community and their peer group to assign two principal meanings to emotional problems, 'madness' and 'badness'.

Madness is constructed either as an affliction (therefore not necessarily permanent) or a personality trait that is applied to the individual. The idea of being seen to be 'crazy' arose most frequently in the context of peer reactions to someone seeking help from a professional.

"and we kind of let it out that, 'oh look, she's... you know, something's wrong with her, she's a freak'... and that kind of discouraged her, she didn't want to see that person again" 10.19

"yeah, from school friends they might think you're some kind of mental freak or something, if you're going to have to see someone to talk about something" 4.9

Badness or being judged to be a bad character, concerns going against the moral codes of the Pakistani Muslim community and can consequently bring shame onto a family. This involves the family losing the respect of the community. Symptoms associated with the problem (eg. not eating) and the meanings connected with it (eg. wanting to impress a boy) can bring shame, as can getting help outside the family. Shame was talked about as a feeling experienced by an individual or group of individuals (eg. a family) and also as something done to an individual or group by others,

"everyone will ashamed your parents" 5.8
3.5.3 Community constructions of help-seeking

Seeking professional help was understood to mean that a person had an emotional problem and therefore brought with it the related constructions and consequences. However, the action of help-seeking was also perceived to have practical hazards relating to being judged to be behaving unacceptably. An example given by one of the teenagers was of a young woman seeing a male professional. People seeing this might view it as unacceptable, given the potential in this situation for the development of a relationship between them.

Strategies for dealing with this are being chaperoned or seeing a family doctor, but the risk of other people finding out still remains.

In addition, the teenagers thought that certain kinds of professional help (talking therapies) are seen by community members as being for 'western' people and inappropriate for Asian people, although their own views might be different.

"Yeah, but if you get counsellors and that sort of thing then it would be big, whereas western people think it's just OK, just normal... It's like going to doctors or anybody like that, just talk to someone, but in Asians it's a bit different"

"I think it's [counselling] OK, it's normal" 6.8

How then do individuals and families cope with the practicalities of seeking professional help in the context of their fears of exposure? The main strategies for the individual are either to keep the information about difficulties they are having, or help they are getting, totally secret or to be very selective about who they involve. Those who might be told are either close friends or family members. Families also take control of the information, as can be seen in the second quote below.

"...cause some people might think like, they might tell someone else, so they might keep it to themselves" 7.5

"They [parents] probably be over-protective and say, 'ah, you know, keep it in the family'" 3.12

Words in square brackets have been added by the researcher
The consequences of this might be that help is not sought, both because information control precludes it or because the teenager is unable to access information about her own difficulties and where she might go for help. However, there are ways in which teenagers feel they could access information anonymously, and under these conditions, get help. The media plays an important role in providing such information. For example, teenage magazines, in which there are problem pages and helpline numbers are given. This relies upon the teenager identifying herself with the people or ‘condition’ described.

Gender is clearly an important dimension of exposure to community judgement. It affects whether or not and individual is an object of scrutiny, the meanings given to certain behaviours that might be associated with having a problem and with professional help-seeking and the strategies open to the person. For example, a boy going out alone would not risk labelling in the same way as a girl. This seemed to be the case particularly with eating disorders as some of the symptoms (eg. amenorrhoea) have a bearing on the individual’s child-bearing capacity and therefore marriageability, or imply that she may be pregnant and therefore must have had pre-marital sex. There were several accounts of sisters and sisters-in-law ceasing to have periods for short times and the concern this created for families.

3.6 ‘Keep it in the family’ (Decisions around Parental participation)

When asked what teenagers could do to get help with an eating disorder, many immediately said that they should or could talk to family and/or friends. However, on further discussion, the issue of parental involvement turned out to be more complex than it had seemed at first.

Parental involvement was described by the teenagers as being partly a function of socially and culturally constructed ideas about parents’ responsibilities to their children (and vice-versa) and partly a function of the relationship between the teenager and their parents. Questions about parents’ involvement in the seeking of professional help include the possibility of both active decisions in relation to parents/family (to include or exclude them) and also a passive stance in which the decision is seen to be out of the hands of the teenager.
3.6.1 Parent-child responsibilities

There was an expectation amongst some of the teenagers that they would essentially have no choice about involving their parents, because of other people's interpretation of the role of parents in the lives of their children. Parents would find out any way from the professional (especially GP's) from whom help was sought or from people in the community who had found out (through mechanisms explained above).

"...you wouldn't really go to your doctor because your doctor knows your family innit and then he could tell your family, parents or someone" 6.11

"Because some ladies or teenagers, they don’t know their GP that well... they wouldn’t just go up to them and say 'I've go this', they might feel scared that they might tell their parents so... they get scared sometimes" 9.5

As can be seen from the above quotes, one strategy to deal with the belief that parents would be informed is not to seek professional help.

The teenagers also talked about parental involvement as being concerned with cultural expectations to do with respecting family and parents.

"But for a westernised person, they don’t really have to tell their parents what’s the problem, ‘cause they could just take their friends along... it would be alright, parents don’t even have to know about it. Whereas with this girl her parents will have to know about it." 1.10

"It's too out of order, innit, you don't listen to your family." 6.7

"I just think family comes first, they have a right to know" 4.6

As can be seen from the first quote, the notion of duty to parents is seen as being irrelevant to westernised or white teenagers, who are perceived as being free to do what they want and go where they like. This was one of the main points of tension between the mainstream culture (in which the teenage years are seen as a time of increasing autonomy and independence from parents) and Pakistani culture that the teenagers discussed in this study. However, some of the teenagers also felt that Pakistani girls have much closer relationships with their mothers than white girls. It was not clear from the interviews where these ideas
come from, and as can be seen in section 3.4.2, in terms of seeking professional
help, closeness is only one dimension of a supportive relationship.

Certain hazards were highlighted by the teenagers as being associated with not
involving parents, such as the meanings that the teenagers thought parents
might ascribe to what they see their daughter doing (going out, coming back late)
and how the parents make sense of secrecy.

"'Cause she can't go to the doctors without her parents knowing, if they're
going to ask her, why do you want to go to the doctors, so what will she
say?" 9.11

"If she doesn't tell her parents about it, think she goes.. if she tries to hide
it, they probably take it the wrong way, they probably think she's doing
something bad or doing something else" 1.9

The sense of the teenagers feeling monitored was strong in many of the
interviews and was closely bound up with culture and gender. Many of the
teenagers described how they were only allowed to go out in the evenings under
very specific conditions, and the anxiety felt if they thought they might be late
getting home. Their understanding of the monitoring revolved primarily
around the issue of minimising the possibility of mixing with members of the
opposite sex. Unaccounted-for time away from family, school or other
responsible people (eg. older siblings) was potentially time to be with boys and the
teenagers felt that hiding their actions increased parents' suspicions that their
daughters were engaged in this type of activity. The teenagers often expressed the
feeling that their parents did not trust them:

"That's true, yeah, they can't exactly trust girls as well as they trust boys"
1.12

"The first thing that come to their mind is that she's probably want to
impress boy or something, you can get into trouble.. white people, they're
alright, just let them off" 9.10

The strategy of excluding parents (or 'going behind their back') also has with it the
risk that parents will find out from other people in the community, which would
be both shameful and hurtful.
“that the other people find out before the parents and that’s why the parents get so much hurt.. when they find out that this has been going on behind their back” 5.11

Parents were also seen as having a facilitative role in the accessing of professional help,

“... but if she told her parents, they’re going to be more than happy to help” 1.9

“... just tell your mum so that she wouldn’t tell anyone and then she’ll tell you what to do and tell the doctor or something like that” 6.7

as well as providing emotional support in the form of a close and understanding relationship (see section 3.4.2).

3.6.2 Parent-child relationship

The importance of the relationship between teenager and parents, was discussed mainly in terms of the impact of a poor relationship. This was seen as one of the reasons for excluding parents from the process. If the relationship was poor, then support would not be forthcoming and therefore parents would be excluded.

“I'd never tell my mum 'cause I don't get along with her, like I can't talk to her in a proper way... or even my father, I can't or my brothers but it's just my sister, but my mother, I can't, I'm apart from her, I'm not really close to her..” 5.7

“My sister would [influence her to get professional help], but I don’t think it would be my parents because I don’t get on that well with them” 9.6

For some, an individual's relationship with her parents was seen to be independent of ethnicity. Others saw relationships as being bound up with cultural practices, either in ways that mitigated against closeness between parents and children, or such that relationships (especially between mothers and their daughters) were seen to be closer than in ‘westernised’ or white families.

As can be seen from the above quotes, sisters (usually older sisters, and the teenagers may also be using ‘sisters’ to mean close cousins) can be an alternative
form of support, as can the anonymised forms of help mentioned above, such as a help-line.

"I think it would be best like a helpline, where the parents don't find out."

9.11

This also avoids other people in the community finding out, a concern for both the teenager and their parents that was discussed earlier, but whose influence affects many aspects of the process of help-seeking. A strategy parents might use to deal with this is preventing the teenager from seeking help outside the family ('keep it in the family').

"... in Islam you know, people they're too scared of their parents to talk about... to other people, that if someone else might find out they'll be... it won't be good for the parents that people talk about them... they'll be talked about, that's what parents don't like"

9.9

"... the parents might think getting help from someone else would be a bit wrong"

"Well, if she went to someone male then the parents might worry it would go wrong... they'll think more of the problems behind getting help, 'cause it's a male and a female and it could cause problems for the parents"

4.10

If teenagers believe that parents hold these views then they might be reluctant to engage their parents in the process of help-seeking and therefore may either limit their help-seeking to their peers or try to cope on their own. The last quote also illustrates the close connection between the conduct of the teenager and the position of the parents in the community and throws some light on why parents might want to 'keep it in the family' (i.e. exert control over the who knows about the help-seeking).

Parents might also be excluded because of a concern that they would over-react. This seemed to be both about protecting the parents from too much worry and the teenager protecting themselves from added anxiety by minimising their difficulties.

"She'd [mother] probably start worrying and that's the only reason I wouldn't tell her" 5.7
".. parents would get worried.. parents would be really worried... and make a really big thing out of something small" 1.5

"It's just like in the soap programmes, sometimes you get like a person having a few problems and things like that and the next thing the parents or somebody suggests you should go to a psychiatrist or something.." 10.16

Yet again we can see the role of the media in the teenagers' thoughts about seeking help from professionals.

In summary, thinking about seeking professional help raises questions about involving parents in the process, some of which are connected to cultural constructions of the parent-child relationship, others to more personal and individual meanings. It raises dilemmas for teenagers growing up in a mainstream culture which reifies individuality and a family culture which may be very cautious about seeking help outside either the family or the community. The strategies that the teenagers saw as being open to them had a function of both protecting their parents from shame and hurt and protecting themselves, for example, from additional worry. However, some of the teenagers acknowledged variation within the community and that parents and the community were changing in ways they believed to be beneficial to themselves.

".. some parents just want everything to be that they want it but some other parents listen to their children and agree with them or something like that. 'Cause most parents are going.. turning more westernised" 6.8

3.7 **Knowing where to start** (Constructions of client-professional interaction)

The teenagers had ideas about what happens when an individual goes to a professional (client and professional talk to each other) and about the imbalance in the power relationship between client and professional. They also had notions about what would be required of them in the interaction, which gave rise to fears of not living up to these and being judged to be ignorant. From their accounts, it seemed that the media were an important source of these 'scripts' around the client-professional interaction.
3.7.1 Talking about yourself

The main activity in a client-professional interaction was seen to be ‘talking about yourself’. This was set within the context of a social construct that ‘talking helps’, although it was not an idea that all the teenagers agreed with, as the following quote illustrates.

“... I don’t tend to discuss my problems ‘cause I keep a lot to myself, I know that’s a bad thing ‘cause I’m supposed to talk about my problems ‘cause it’s supposed to make you feel better, or something.” 4.6

The content of the ‘talking’ could be quite general (anything, yourself) or more specific (how you feel, what’s happening to you or your problems). The process could be one in which the teenager is being active (e.g. explaining and telling) with the professional taking a more passive role of listening, and/or the professional might be directing the interaction, for example by encouraging the teenager to talk about something in which they, the professional are interested.

“They will be interested and they will listen to you as well” 9.7

“I think they would be sensitive or thoughtful... easy to talk to really” 6.13

However, the other teenager in interview 6 felt differently.

“Might lead you on about your family, you know, they might like, just sitting there talking about your problem, they go into your family, how you get on with your parents and all that, start asking you personal questions” 6.13

This quote illustrates one of the fears associated with talking to and interacting with professionals, which relates to the power that professionals are perceived to hold.

3.7.2 Power of the professional

The power of the professional was mainly construed as an ability to make the teenager do something or stop doing something.

“And then they’d force you to eat your meals or something” 1.7

“... they will be more um influencing you to stop the thing” 9.7
This may reflect the teenagers ideas about authority figures in general. But the professional was also seen as having much more extensive powers, extending over the individual's personality.

"They just change you, change your person, change you as a person" 6.12

This last idea apparently derived from a popular soap opera, in which one of the character's was bulimic. According to the teenagers, the outcome of this character's involvement with a psychiatrist was a change in her personality and the development of hate for her family. These were clearly very powerful images for the teenagers.

3.7.3 Knowing where to start

Although the teenagers had some sort of script about what might go on when they met a professional, they were anxious about their own role in the process. They talked about having to enter the situation armed either with knowledge about their own problem or about the 'rules' of the interaction.

"... I think, if there were some leaflets they might want to read, read them first to find out a bit more about their problem, then actually go to see somebody who can help them, 'cause if they know more about it then they feel more secure, in a way, feel more confident about it, than if they didn't know anything about their problem" 3.7

"I would be nervous probably.. if I never.. if I wanted to talk to someone like a doctor or nurse.. I don't know where to start from" 5.9

Behind this second quote (and additional comments made by other teenagers) is the idea that there is a starting point, but not knowing what that is puts them at some sort of disadvantage, for example, it may result in them being judged unfavourably.

"... talking to someone who knows a bit more than us, they'd probably say, look they don't even know about these kinds of things, every-day things" 1.4

It may be that the need for prior knowledge and a script about the client-professional interaction arises partly from the power imbalance and is one way of recreating balance and taking some control, but as has already been discussed,
acquiring information is a procedure that risks other people finding out and probably talking about you. As has been mentioned earlier, many of the teenagers said that eating disorders were not a topic they discussed, therefore it is unsurprising that they should feel uncertain about what might be relevant information in a consultation with a professional.

3.8 Taking the first step

The fear of being exposed to judgement by the community and peers and the consequences that a negative judgement could have on the teenager and their family means that for these teenagers, accessing professional help was seen as a risky enterprise. For some, there were also questions to consider about whether or not to involve parents. These two dimensions to help-seeking do not go away once help has been sought, they run alongside and influence the whole help-seeking process.

The category of ‘taking the first step’ includes phenomena that the teenagers believed necessary to be in place for them to access services. These are that the teenager needs to have identified a need, that the problem is severe and that not seeking professional help will have negative consequences for the teenager. Teenagers also felt that they needed support from people around them.

It was recognised that ‘taking the first step’ could be very difficult, but that it would not necessarily remain that way.

“If I was there I wouldn’t have any worries talking to a psychologist”
“Yeah, when I was there, but actually getting off my back and.. it’s very hard, that’s the first step”

3.8.1 Identifying a need

A need for professional help could be identified by the teenager herself, by others and jointly with others (family, peers and professionals). It could be a process of active construction or one of labelling. An example of the process of active construction is given overleaf.
"Or she could tell the doctor that she's feeling really cold all the time and then he could ask her if she's on her periods or not, then she could tell him the full thing." 6.18

Of course to get to the doctor in the first place, the teenager and/or her family will have to have noticed something different or worrying that needs explaining and that, in their view, falls into the realm of the general practitioner.

The teenagers understanding of eating disorders incorporated the notion that some people might not acknowledge that they have a 'problem', but that acknowledgement was a step in the direction of getting help.

"I think it'd take her quite a while to get sort of used to it herself. I think it would take her a while to understand actually what her problem is and to accept it and then, from then, go to see what she could do to improve" 3.9

The above quotes illustrate how problem acknowledgement is seen as a process and that acknowledgement may be private and/or public. In the case of the top quote, the intervening condition that might result in someone not 'admitting' their problem to others was a fear of people's reactions, so it can be seen that identifying a need is closely bound up with fear of exposure to judgement by the community and peers.

The process of identifying a need is also influenced by another aspect of the person's expectations of its outcome (in addition to it being a route to help), which is that they will 'hear the worst'. In other words, they may find out that what they thought was not very serious is in fact something to worry about.

"No, I think very few would actually go to the doctor, they probably like to hide it... 'cause they'd probably tell their parents and make it to be more serious than the girl or person wants to feel it is"

"They probably don't want to find out they're really ill, than what they really think they are, 'cause they're just worried" 1.5

"... she doesn't want to know what she's got... that she's anorexic" 8.8

In the latter quote it seems to be the meaning of the label 'anorexia' that makes having the label so anxiety-provoking, and may result in teenagers preferring to deny the extent of their difficulties, rather than address them. However, the label
was also seen as a means to accessing specialist services.

"If the person knows that they got a problem and they know what it is they can actually go out and... find help, but if they don't exactly know they should go to a social worker or doctor or something" 10.13

There are tensions between the processes teenagers might use to identify a need (through talking to friends, family or professionals) and both the fear of information about them spreading and the reluctance of some of them to involve their parents.

3.8.2 Informal supportive relationships

In talking about where teenagers with eating disorders might go for help, friends and parents were often seen as the first port of call in terms of sharing their concerns, checking out the seriousness of their difficulties and providing support in accessing professional help.

There were several important properties of these supportive relationships which allowed for open communication:

Trust

Trust is a rich concept, concerned partly with whether or not the person can be trusted not to pass information on to other people, either within the school or outside the family, but is also to do with respect, shared understanding and relevant experience. It was usually conceptualised as arising from other dimensions of the relationship, such as 'closeness' or it reflected a lack of connectedness with the family (and hence a low probability that information would find its way back).

"I'd rather talk to someone who's an outsider who's from your own religion, 'cause then at least that person wouldn't tell anyone and they wouldn't know you properly, at least you could trust them." 6.10

"I think talking to your friends"

"Someone who you close to or something, that's like the first start and then.."

"Or one of your relatives who you're close to who you could trust" 10.14
Shared understanding

Shared understanding has several properties. One seemed to organise itself around having a shared history and familiarity.

"They [family] know all about me and I know everything about them so if I was just to talk to a friend they might say something wrong to me" 4.6

"You’re known each other longer, you understand each other more, and if it was someone you didn’t relate to as you did with you best friend I don’t suppose they’d understand much, they’d probably just say ‘go and see a doctor’ or whatever, whereas a friend knows.. if you’re.. like we’re close, like she’d know what I was going through or she’d be able to help me with it more.." 3.6

One link made between a shared history and trust was that time gives you a chance to gain evidence of a person’s trustworthiness and even to test them out.

"..’cause some might tell other people and it might go round the school.."

"You should test them out ‘cause from you’re seven to you’re eleven you know from right to wrong and you know which friend is good and which friend is bad"

"Not good to trust or to trust" 5.6

The other dimension of shared understanding concerned the role culture in the teenager’s life. A shared appreciation of this contributes to the teenager feeling understood, it eases communication and means that any suggestions made or advice given will ‘fit’ with the context in which the teenager lives.

"Everyone [in peer group] has different ideas but then they understand what each.. like where we come from, the background and then they tell you to do something which connects with you family as well.." 6.9

"It’s like, in Derby mainly social workers are like Asians and you probably could talk to them openly about it, ‘cause they might understand what you’re going through and like if it’s a family problem or marriage problem they might know what’s happening" 7.9

However, there was variation between the teenagers who took part in the importance given this, with some seeing it as more relevant to their parents’ generation.
Taking it seriously
Having your concerns taken seriously and being respected was important and her assessment of its likelihood influenced whether or not a teenager would actually approach another person. In the first of the following quotes, the teenagers were discussing the possible thoughts of someone who is concerned that they might have an eating disorder.

“They [friends] won’t care, they won’t do anything.”
“They’ll probably laugh at me, they probably say, ‘oh it’s nothing, you know, go away’” 1.4

“People got to take you serious, you know and if you know that person take you serious, then do things, if you know they’re not then just.. you have to just go to another person you know will respect you..” 5.11

The reasons people might not take you seriously are not caring for you and not having time for you, but it was also seen as a strategy used when people don’t know how to help you.

“If that has happened in their family they don’t know what to do, they just say, ‘oh look, you get over.. you get over with it’ and nothing will happen” 5.9

In this way it is linked with the next property of a supportive relationship.

Relevant experience
In relation to informal support (ie. not professional), relevant experience depended very much on the interplay between gender, ethnicity and the nature of the problem. Eating disorders were seen as a problem experienced by young women and therefore more likely to be understood by women. Some of the symptoms associated with eating disorders (eg. amenorrhoea) were also seen as topics about which it was only appropriate to talk to other women. However, eating disorders were also seen as primarily a ‘western’ problem and it was assumed that women who had not been brought up in Britain would have little experience and therefore understanding of them.

“.. ‘cause.. the parents [from a more westernised family] know more about this, more than Asian families do, so they could help get some help” 8.9
"I think it would be better if she talked to her mum, 'cause about her periods.." 6.18

"I think someone, and Asian person, woman, should learn what eating disorders is and then tell these older women about it, so if us lot do have problems like this, we can go to our mums who know a bit about it. 'Cause we can't go to her 'cause she knows nothing about it.." 1.12

"If they're [sisters] older they've been through everything, anyway" 3.10

There is tension between the desire to turn to mothers for help and support and the belief that they may not understand what you are talking about. If you have no sisters who can provide the support, then you may be forced to go outside the family and risk being seen to be behaving improperly.

Most of the above properties of supportive relationships were discussed in relation to informal sources of support, but the issues of gender appropriateness, being taken seriously, relevant experience and shared understanding were also related to professionals at various points in the interviews (though not extensively enough to warrant separate discussion).

3.8.3 Severity of the problem

If the teenager was going to risk exposing herself to judgement by the community, take her problem outside the family, and overcome fears about seeing a professional (see sections 3.3 and 3.5), it would be a last resort. This was seen as being because her parents couldn't help her, she was physically very ill or she could see no other way out.

".. she could probably go [to the GP]
She's a Muslim though"
"yeah, I know"
"Why would she go to the GP then?"
"There's nothing else that she could do apart from talk to her friends" 6.17

"If like the parents or family were really worried about her, telling her that she's too thin, but she can't talk to them about it then she might want help" 2.6
"If she become really ill then, you know, when she's really weak then go and see someone for help" 3.9

3.8.4 Assessment of the consequences of inaction

Another dimension of the decision as to whether or not to seek professional help was an assessment of the consequences of not seeking help. The potential consequences were in a range of domains - physical health, academic achievement and more generally 'future options'. The most powerful of these seemed to be damage to physical health. This may reflect a hierarchy of concern or it may reflect the teenagers understandings of the main consequences of anorexia and bulimia.

"Kind of like, something might go wrong if you don't stop" 9.6

".. families tell her it's the right time for you, because you're losing too much weight and you know.. tell her what could happen, if she loses.. like she could get this disease or could.. (die) or become anorexic... You know, you want to live your life, become something, not weaken it..."

"She might want to go to college or university and become something whereas her health problems are in the way and she can't do it" 5.13

"If she was to think about what she's got ahead of her, the future... then she got to make sure that her future plans were good, do she probably would go to see a doctor or something" 4.11

One teenager, who had made herself vomit in the past because of concerns about her weight and appearance, described how the media played a role in her changing her actions.

".. but then looking at these um advertisements and um in magazines they say that people could get really ill and could die, so that's how I stopped" 9.2

The flavour of these quotes is a mixture of being motivated by fear and of caring about your future, either for yourself or for your family, as illustrated by the next quote.

"..worries they would have...like letting parents down" 5.16

68
3.9 Beliefs about professionals/professional role

In terms of professionals, most of the teenagers had only had contact with GP’s and nurses. One teenager said that she had never even been to see a doctor, while another had had social contact with a social worker. Therefore, for most of them, the main sources of information about ‘professionals’ were other people (friends, family, relatives) and the media (TV and magazines).

“Like on TV nowadays, going to the doctor and things like that, they make it look so... so sort of scary like that’s the last thing you would want to do” 3.13

Three main kinds of beliefs or constructions were discussed - professionals’ ability to help, professionals as a source of expertise and their role as an advice-giver.

3.9.1 Ability to help

Believing that a professional could help was, for some, a precursor to accessing professional help. Conversely, if that belief was absent, it would be less likely that help would be sought.

“’Cause there’s a lot of people who are suffering from eating disorders and they might say that, like they had this problem and they went to see a... went to seek professional help and ?? about that, so that might encourage her” 8.7

“That he [GP] can help you with this thing that.. you’ve got eating disorder and want to stop it and he can help you.. that’s what would make you go to see one” 9.5

“...she might think they’d be thinking ‘what’s she doing here?’ and they can’t do anything to help me” 1.8

“She’d probably think it was stupid... and that you didn’t need help from them” 7.11
It is not only the beliefs of the teenager that are important, but also her family and parents,

".. sometimes if you want to yourself go and get professional help... sometimes they [parents] might not know exactly know what's wrong with you, probably think that you're (confused) and they might think that, oh, it's a waste of time to go" 10.20

and this last quote also illustrates how the belief depends on the construction of the problem. If there is a match between how the problem is seen and what the professional can provide, then help may be sought.

3.9.2 Source of expertise

Accessing expertise is about why you might go to a professional rather than an informal source of help and can be seen as the 'professional' version of 'relevant experience' (a property of supportive relationships).

"People that are qualified in their work, nurses or doctors"

"Who have got some qualifications and you know, have been.. have had some.. it's mostly that you should go to the qualification people that go credit, yeah, experience" 5.8

3.9.3 Role as advice-giver

One of the main roles of the professional is seen to be to give advice, tell the teenager what to do. In other words, this is the main form in which they expected to access the professionals expertise.

"Or she might go to a doctor and ask him if she's anorexic or ask him to tell her about anorexia, tell him what she's been doing and then he could give her advice" 6.17

"Yeah, like tell us.. tell them that.. give them good advice.." 5.8

Although again, the kind of advice a professional might give needs to relate to the constructions of the problem.

"I don't think the doctor's actually give you that sort of advice that you need.. it's just like medical advice that they basically give, but sometimes you need more than that" 10.14
The beliefs that professionals could help in a way that informal sources of help could not were seen as contributing to a willingness to seek professional help, but they were described as being lower in priority than issues to do with the community, parents and the requirements of the interaction between the teenager and the professional.

In summary, the interaction between the community, family and individual is crucial to an understanding of how these teenagers were thinking about seeking help from a professional. This was expressed very clearly by two teenagers when they said the following,

"It [the community] puts pressure on the family and then the family, the family puts pressure on you."
"but mainly on the individual"
"yeah because then you think 'oh you've let down your family"
"and know you've done something wrong when you shouldn't have"
"and that hurts you know, let down your family, because there's a lot about respect and that in the community" 10.9

Communication about emotional distress also has to be seen in the above context. It is mediated by gender, ethnicity and the nature of the problem. With professionals there is an additional issue of the nature of the interaction between teenagers and professionals and the fears associated with this.
4.0 DISCUSSION

In the first part of the discussion, the research findings will be considered and related to the literature described in the introduction. Following the tradition of much qualitative research, areas of research that were not addressed in the introduction will also be drawn upon, the reason being that their relevance emerged as the study proceeded. The order of the discussion will broadly follow that found in the results section. The contribution of the research findings to existing theory will then be summarised and the role of ethnic identity in the seeking of professional help will be considered. The second part of the discussion identifies some of the limitations of the study and then goes on to propose some clinical implications arising from the research findings.

4.1 Discussion and interpretation of the main findings

It emerged from the interviews that seeking help from professionals was seen by the Pakistani teenagers who participated in the study to be a complex phenomenon, incorporating several closely interacting levels of organisation in their lives. The most important of these were the Pakistani (Muslim) community, their peers, the family (as a social construct) and their relationships with family members and peers. Because they had had little contact with mental health services, the teenagers ideas about the role of these services in seeking help from professionals were less clearly articulated, but powerfully expressed (and could therefore reasonably be assumed to be influential).

While much of what the teenagers had to say about the structures and social processes in their community has been written about in other bodies of literature (eg. Joly, 1995; Ballard, 1994; Lewis, 1994; Wilson, 1978), the ways in which these articulate with seeking professional help for emotional distress has rarely been addressed. Indeed, in most of the books referenced above, little or no mention is made of mental health.

4.1.1 Community and peers
Perceptions of what the Pakistani community might think, say and do were a major concern for the teenagers. Their concern was not just for their own reputation, but also for their family, in terms of the position held by the family in the community. The construction by which the individual and family are linked
is ‘izzat’. This is variously defined as honour, pride and self-respect, but the way in which it is applied means that it acts essentially as a male construct (Wilson, 1978). The upholding of izzat of family and community rests on the female members of the family (Khanum, 1992), therefore it is women who can place izzat most at risk. The behaviour of boys and men is not considered to be so strongly related to izzat (Raza, 1993). This offers an explanation for the teenagers experience of feeling less trusted by their parents than their brothers. It may not be that parents trust them less, but that there is more to lose if a girl contravenes the rules. Izzat serves as a measure of relative standing within the community (Ballard, 1994), hence the importance of not damaging it.

Sassoon & Lindow (1995) argue that respect within one’s own community is particularly important for populations that have experienced oppression from the wider society, and therefore already have a vulnerable status. The national (and international) context of this research is one in which the Muslim population in Britain, and especially Muslims in Bradford, have been given a high and somewhat negative profile as a result of the Salman Rushdie affair, the expression of opposition to the Gulf War and clashes between police and young Muslim men in Bradford. Sassoon & Lindow’s argument raises the question as to whether or not the Pakistani community in Derby experiences itself as vulnerable. Certainly, some of the teenagers in this study made unfavourable comparisons between what is available for them in comparison with what is available for Asian Muslim teenagers in cities with larger Asian Muslim populations. This seems to suggest that they see their community as not having the resources (and/or power) to provide the same facilities. While this is not the same as ‘vulnerability’, it may relate to it, in that having relatively less power in relation to the mainstream community than another Asian Muslim community, may be experienced as being in a vulnerable position.

The teenagers explanations of the kinds of judgements made by the community concerned beliefs that having an emotional problem would be construed as being ‘mad’ or having done something ‘wrong’. This was then seen to reflect on the family and would have the implications discussed above for both the family and individual. The nature of these implications (ie. how losing respect and being shamed is experienced by families and individuals) was not systematically explored in this study, but one implication that was spoken about was the effect on the marriageability of the individual.
Shaw (1988, 1994), in her accounts of a Pakistani community in Britain, describes the structural and symbolic importance of marriage in the community and how it relates a family's past, present and future. Pakistani communities are organised in terms of kinship networks called 'biraderi'. These are flexible entities in which people can be included and from which they can be excluded, and are maintained by a range of social processes, including marriage. This could be one reason that marriageability was picked out by the teenagers, another being the importance of this issue to teenagers growing up in a mainstream culture in which marriages are not usually arranged. They described it as an issue that they thought about more, now they were approaching school-leaving age, but that was being approached differently for their generation from how it was organised for their parents. They reported that, on the whole, Pakistani teenagers were being given more choice of marriage partner. However, this still had to be negotiated with parents, who were seen as holding most of the power.

The fear of community judgement gave rise to the contemplation of a range of strategies to manage help-seeking, in which controlling information about the need for services was paramount. Parents were also seen to have their own strategies for evading the judgement of the community, such as dealing with problems themselves or minimising them. The fact that the teenagers in this study said that they almost never heard of people within the community having eating disorders may be an indication of the effectiveness of the system of information control.

Peer judgements were also an important consideration for the teenagers in relation to seeking help from professionals. They were at an age during which there is thought to be very strong pressure to conform to the peer group norms (Heaven, 1994), hence a fear of appearing 'different'. Receiving professional help for an emotional problem is by no means the norm, and therefore may well result in the individual being excluded from the peer group. The exclusion (through teasing, bullying and social isolation) may also be understood in terms of the mainstream community values in which emotional distress and the seeking of help for it is stigmatised.

Although the teenagers in this study described vividly how such teasing went on at school by children from all communities, many maintained a view that seeking help from professionals (eg. counselling) was acceptable within the white
community. That the teenagers hold contrary perspectives may reflect the
different contexts in which they find themselves and has resonances of the fluid
and domain-related constructions of ethnic identity reported by Woollett et al
(1994). In one context, for example the family home, one perspective may be
more salient, while the school context brings to the fore a different perspective.

Anxiety about both community and peer judgement could be said to act as a
'barrier' to service use (see section 1.2.3 of the introduction), in that the teenagers
said that it might lead to them not seeking professional help (or discontinuing
any professional input they were receiving). It certainly fits into Hoberman's
(1992) category of 'psychological barrier'. However, this reduces what are very
social phenomena to the level of the individual. It could also fit into Wallen's
(1992) category of 'cultural barriers' (the cultures being respectively Pakistani and
youth/mainstream culture), which includes culturally-determined constructions
of 'mental health', although these were framed by Wallen more in terms of
actual differences rather than the interplay between these and the individual
(leading to anxiety).

In addition, it was not always the case that the teenagers said it would stop them
from accessing professional help, rather that it would necessitate certain strategies
in order to prevent people outside a fairly close circle of immediate family and
friends from finding out (see section 3.4.2). There were also circumstances under
which some of the teenagers thought they might seek professional help, in spite
of the above, for example, if they felt sufficiently supported and if 'things had got
really bad' (see sections 3.7.2 and 3.7.3).

4.1.2 Family
The role of the family and more specifically, parents, was given a high priority by
the teenagers in this study, something that is not addressed in many of the
models of service use and health decision-making. This can be partly explained
by the fact that many of the models were developed on the basis of research into
the behaviour of adults, but may also be a result of the models being largely euro-
centric, and therefore having a different perspective on the role of the family in
the life of the individual from that held by these Pakistani teenagers.

In thinking about seeking professional help, the teenagers in this study talked a
great deal about the issue of whether or not to include parents in the process of
seeking help, or indeed if they even had a choice. They discussed parental involvement in terms of duty to and respect for parents, as well as their relationships with parents. Also of importance were the parents' own beliefs about the ability of professionals to help (see section 3.9.1). Therefore, the issue of involving parents was less to do with 'decisions' made at the time about whether or not to involve parents, and more to do with cultural practices and the quality of existing relationships. In this way, the data in this area do not seem to fit the 'decision-making' models (eg. Langer & Warheit, 1992; Ajzen & Fishbein, 1980).

However, the data may throw some light on possible meanings of Langer & Warheit’s (1992) notion of a 'decision-making orientation', as it applies to this population (see section 1.2.6 for a discussion of the concept). The 'consistency' in who an adolescent refers to about her health decisions may result in part from cultural notions of duty or consistency in the quality of her relationship with her parents. The 'decision-making orientations' of the teenagers who participated in this study are a moot point, since they were not measured. There were certainly some teenagers who were clear that they would tell their peers, rather than involve their parents, and vice versa, but whether or not this reflected a consistent pattern is not known.

The different ways that the teenagers talked about the involvement of parents serves as reminder of the inaccuracy of stereotypes such as 'Asians look after their own'. Whilst there might be pressure to keep certain information and actions within the boundaries of the family or community, this was not always seen as the most appropriate place for them. Both Beliappa (1991, cited in Ahmed & Webb-Johnson, 1995) and Fenton & Sadiq (1993) comment how, for the Asian people in their research, the family was often not seen as a viable means of support at times of emotional distress. They report that a significant number of people wanted to talk to someone about their problems, but felt that there was no-one appropriate available, sometimes because the source of the distress was relationships within the family and role expectations.

The teenagers in this study reported several factors that could affect where they would go for help. In line with the research by Boldero & Fallon (1995), their construction of the problem influenced who they thought they would turn to within the family. Eating disorders were seen as a problem experienced and therefore understood by women, thus the teenagers said that they would turn to
mothers or older sisters. This choice was reinforced by the nature of some of the symptoms that they associated with eating disorders (eg. amenorrhoea), which were seen as ‘women’s business’. It also reflected the closeness of their relationship with their mother that some of the teenagers reported and about which other authors have written (eg. Wilson, 1978). However, eating disorders were also seen as a ‘western’ problem and it was believed that older generations were not informed about them, therefore older sisters and peers were sometimes seen as more appropriate sources of help or support than mothers.

While the influence of the community and family suggest that these teenagers hold a perspective in which emotional problems are placed in the context of their roles and responsibilities to family and community (Ahmad, 1990 cited in Imam, 1994), they also expressed some reluctance to involve parents. In spite of pressure to ‘keep it in the family’, some of the teenagers talked about getting help independently of family and community. This could be understood in several ways. It could result from the teenager having a poor relationship with her parents. It could also be construed as being a result of the teenager having a more individualised understanding of her problem, perhaps as a consequence of her experience in the mainstream culture, or it could be seen as the teenager attempting to achieve some autonomy from her parents. This is far from an exhaustive list and could be enriched by more detailed follow-up discussions with the teenagers who put forward this idea.

Although some aspects of excluding family were attractive to some teenagers, this strategy was seen to be fraught with risk. Risk that was bound up with religious and cultural values and practices. The main risk perceived by the teenagers was to be seen to be going somewhere alone or unsuitably chaperoned. In Islam, young women and men are segregated from an early age, in order to protect the purity and chastity of the women (Shaw, 1988), so to go out unchaperoned raises the possibility of spending time with members of the opposite sex. While this form of social control can be seen throughout the Islamic world, the teenagers interviewed are living within a mainstream culture with very different values and expectations. Some of them saw this as a reason why their parents kept tight control over them, but it is only part of the picture. As Shaw (1994) points out, illicit love affairs are often depicted in the romantic idiom of Asian songs and films, including those written centuries ago, they did not arise solely in the context of contact with other cultures.
Issues around relationships with boys were also found at the level of the meaning of eating disorders. A few of the teenagers saw eating disorders as a sign of a girl's over-concern with her appearance. If parents saw it that way, one could hypothesise that it might result in tighter social control, rather than the seeking of professional help.

However, the teenagers ascribed a range of different meanings to eating disorders, meanings that suggest that these teenagers have amalgamated both 'eastern' and 'western' understandings of this particular set of problems. It was said that eating disorders could be caused by low self-esteem, a concept which comes out of western psychology. But there was also a recognition of the role of conflict within the family and between family and community in the aetiology of eating disorders. While the language used to discuss the latter did not include the concepts harmony and balance (see Fernando, 1995a in section 1.2.3), there was a sense of a disruption of roles and relationships. Of course, conflict in the family as a cause of eating disorders is a theory found in European and American thought as well.

It is very difficult, and perhaps not particularly useful, to draw firm conclusions about the relative influences of family and community culture and the mainstream culture. It would seem to be more important to know something about the ways in which the teenagers understand their distress. However, the interviews were set up in such a way that the focus was on a western construct, 'eating disorders'. This is bound to have influenced the content of the interviews towards other westernised concepts. In addition, the source of most of the teenagers' information on eating disorders came from British and American sources (magazines and television). As one girl reflected, she thinks of eating disorders as a 'white' problem, but that is purely because the only people she sees or reads about in the media who have an eating disorder are white. This is despite the fact that eating disorders among Asian girls are a growing concern for clinicians (see section 1.2.2).

Nonetheless, the values and practices of the Pakistani community, as they are enacted at the level of the community, family and individual, are obviously a crucial factor in thinking about providing services for adolescent girls. Of importance are not just the values and attitudes towards services, but also those relating to families, women and emotional distress.
4.1.3 Client-professional interaction

To seek help from a professional also conjured up for the teenagers certain constructions of the client-professional interaction. Their ideas on this were based mainly on vicarious experience (except for their contact with GP’s), with some of the most powerful images (or ‘models’, in the language of social learning theory) coming from the television. One of the only models in the introduction that deals explicitly with the client-professional interaction is the Interaction Model of Client Health Behaviour, IMCHB, (Cox, 1982). The data from this study begins to elaborate important properties of the interaction for the teenagers interviewed, namely assumptions about the vehicle of interaction (talking), the power imbalance and the importance for the teenager of coming to the situation armed with prior knowledge and a ‘script’ for the interaction. All three properties raised anxieties for some of the teenagers, perhaps heightened by the fact that many of them envisaged meeting a professional without having previously spoken about eating disorders.

4.1.4 Taking the first step

The interviews revealed that seeking professional help was seen by the teenagers as a process that happens over time, something that was addressed by some of the health decision-making models (eg. the Pre-Adult Health Decision-Making model (Langer & Warheit, 1992) and the illness representation model (Leventhal et al, 1992)), but less so by the barrier models of health service use (eg. Wallen, 1992 and the Practice Oriented Framework (Yeatts et al, 1992)). However, the ways in which the teenagers talked about ‘taking the first step’ suggested having to get over a ‘hump’ or barrier, after which the process would be easier.

Along the lines described by Leventhal et al (1992), seeking help from a professional begins with a process in which a problem is identified and acknowledged, usually in conjunction with friends and/or family. It may be that the search for help goes no further, either because the individual or their family decide to deal with it themselves, or because the problem is denied by either party. One of the reasons given in this study for hesitating to access professional help was a fear of ‘hearing the worst’. This phenomenon has been described by Hackett et al (1973 cited in Helman 1995) on delay in contacting medical services after the first signs of cancer. They found that people who worried more about cancer tended to delay seeking help more than non-worriers and it was hypothesised that the reason for the delay might be to avoid hearing the fatal
diagnosis.

In this study, whether reporting a fear of hearing the worst was related to worrying more about eating disorders cannot be ascertained. It could certainly be hypothesised that fear of what an individual may hear from a professional could be related to what they already know about what they think they are suffering from. So for example, some of the teenagers understood anorexia to be a life-threatening condition, which could relate to a fear of being told that this is the label for what they are experiencing.

Having some form of informal support was also seen to be important by the teenagers. Whilst this is not particularly surprising, what was interesting were some of the properties of those relationships that the teenagers deemed valuable. Although the properties were applied primarily to parents and peers, they can inform what would be important in the teenagers' relationships with professionals as well, however, it should be remembered that this remains an assumption. Shared understanding was one such property, which incorporated a shared history and a shared understanding of the role of the person's culture in her life. This throws light on why cultural match and cultural sensitivity are important dimensions of a client-professional relationship for some people (see Atkinson et al, 1990). Shared understanding was not seen by all the teenagers as something exclusive to people from the same ethnic community, but many of them mixed mainly with other Pakistani girls, a choice which might revolve around aspects of shared understanding.

It could be argued that shared understanding only emerged because ethnicity was made salient in the interviews (see Coleman, 1995 in section 1.2.7), both by the difference in the ethnicities of the participants and the interviewer and by the vignette (prior to the vignette, ethnicity was not directly prompted, although it was followed up if raised by one of the teenagers). However, it was not the only property of importance to the teenagers, and it made sense in the light of their discussions about the significance of the community and their family. The property of shared understanding also expands the discussion by Leventhal et al (1992) on the importance of patient and professional sharing illness representations, to include shared understandings of broader aspects of culture and ethnicity and their impact on an individual's 'health behaviour'.

80
The properties of relevant experience and trust both raised dilemmas for the teenagers. Preferring to talk to someone with relevant experience greatly limits the pool from which they can choose their support, as it usually excludes mothers (who are thought to know little about eating disorders). The pool is already limited in some senses, by the perceived pressures not to go outside the family. However, older sisters provided one solution. On the other hand, professionals were seen as people with experience (perhaps by definition alone), but accessing them raised the issues discussed above.

Trust was understood in terms of 'closeness', a dimension that teenagers might not be expecting to find initially in a professional, but it also included an expectation that the other person would treat information given to them as confidential. However, because of their view of their own community as a structure within which news travels fast, it raised the issue of whether or not they could trust a professional from their own community. One teenager resolved this dilemma by saying that she would feel comfortable talking to a person with the same religious and cultural background, but who lived outside her community.

Again, these data expand some of the previous research, by specifying in greater detail the nature of factors that play a part in help-seeking for this particular group. For example, in the research into help-seeking by adolescents, social support is found to be predictive of help-seeking in some studies, but this is usually measured simply in terms of its presence or absence. The way in which it is measured may explain why it is not found consistently, as its presence may only be valued if it has particular properties.

Taking the first step was also perceived to be related to the severity of the problem, in so far as things had to be really bad before they would seek help, to a sense of what might happen if help was not sought and beliefs about what the professional could offer. All three suggest the kind of cognitive appraisal within a social context that is the foundation of the social cognitive models of help-seeking and health behaviour. They relate to some of Leventhal et al's (1992) dimensions of illness representations, namely the consequences of the 'illness' and the potential for cure or control.
4.1.5 Theoretical frameworks and models

How helpful then have the frameworks and models introduced at the beginning of this report been, and how much has the analysis of the interviews contributed to the frameworks?

Taken together, the models cover most of the levels addressed by the teenagers in the interviews, from the cultural to the intra-individual. But for the Pakistani teenage girls interviewed, their social (community and school) and familial context had a high priority that is not mirrored in most of the frameworks and models. Joly (1995), writing about Asian Muslims in Britain, says that “families and communities provide emotional and material support to their members... supply a focus of identification and create a base from which to interact with wider society”. (p2) The frameworks described place a greater emphasis on the individual and their cognitive processes, reflecting their theoretical and cultural origins in which rationality, logic and control are reified. This is not to say that the teenagers did not talk about cognitive actions such as assessing the consequences of their action (or inaction), but they were usually set firmly in the context of the social meanings of those actions. For example, not to get professional help might result in letting parents down in terms of plans they had for the teenager’s future.

The Practice Oriented Framework (Yeatts et al, 1992) can be used as an example. The four main components of the model are perceived need, knowledge of services, access to services and intent to use services. All of these were alluded to in this study, but in specific and context-dependent ways. For example, identifying a need was one of the properties of taking the first step, but this was largely seen as being achieved through a process of interaction with parents, peers or professionals. It related to the issue of knowledge in so far as parents were often perceived to have little knowledge of eating disorders and therefore what to do about them. For the teenagers, gaining access to services was understood mainly in terms of doing it without other people finding out. Thus the location of the service and when it could be accessed were seen to necessitate strategies organised around controlling information, rather than practical considerations, such as how long it would take to get to a particular service. However, it has to be noted that the teenagers knew very little about locally available services and how to access them. Had they tried, they might have placed a greater emphasis on the need for information about local services and the practicalities of accessing...
them. Relevant to intent to use the service were the family's and the individual's intentions, both of which operated within social structures, such as gender.

At this point, it may be important to be reminded that the 'social' does not just concern the Pakistani community, but also the school environment, in other words, 'youth culture' as it is expressed in schools (the role of school staff was notable for its absence in the accounts of most of the teenagers). Unsurprisingly, the role of peers was better represented in the frameworks arising from the work on adolescent help-seeking (see section 1.2.5).

4.1.6 Ethnic identity and seeking help from professionals

As a group, the teenagers who returned the Multi-group Ethnic Identity Measure scored high in terms of their ethnic identity and other-group orientation. In the main they identified themselves as Pakistani. Although their lives outside school were fairly restricted socially and in terms of leisure activities, something they bemoaned, they spent large parts of their day in the multi-ethnic environment of their schools and had access to magazines and television. One teenager commented on how different her behaviour was at school and how shocked her parents would be if they could see her. This was not described as a 'conflict' between home and school, rather two different ways of being.

Ballard (1994) described this as 'code switching', saying that British Asian children are skilled social navigators, adapting themselves to the different contexts in which they function. He argues that this can become difficult, not so much because of the different value systems underlying the two cultures, but because of the negative perception each culture has of the other. The teenagers interviewed described their own and their parents' negative constructions of 'western' values and practices. They also denigrated their own culture in terms of the rules relating to female teenagers and understanding of 'western' phenomena (eg. eating disorders), but did not talk about other people's negative attitudes toward the Pakistani culture. The word 'racism' was not mentioned. An obvious explanation of this is the influence of the ethnicity of the researcher (white British). This explanation is supported by the way that one teenager asked permission to make an unfavourable comparison between white doctors, whom she said do not listen, and Asian doctors, who she said functioned more like counsellors at times.
One aim in the study had been to explore the teenagers' understandings of the relationship between ethnic identity and help-seeking from professionals. As all of those who returned the questionnaire scored highly in terms of ethnic identity, they represented a fairly homogeneous group. When asked, after reading the vignette about a fairly 'traditional' teenager, what would be different about help-seeking for a teenager from a more westernised family, the teenagers often answered in terms of a white or non-Pakistani teenager and family. It was almost as if it was hard for them to imagine a more westernised Pakistani teenager.

The teenagers' understanding of the relationship between ethnic identity and seeking help from professionals was expressed both implicitly and explicitly. It was implicit in their constructions of help-seeking in which cultural values and practices were seen to be fundamental to the whole process. It was more explicitly articulated in terms of differences between themselves and their non-Pakistani peers. In relation to help-seeking the differences were the greater autonomy of white peers to access help independently of parents and without the fear of condemnation from their community. Also perceptions that, on the one hand, white girls could tell their parents anything about themselves and would not be concerned about issues of gender appropriateness, while on the other hand, they also had the option of telling their parents nothing. Additionally, the belief was expressed that white girls were more likely to suffer from eating disorders and therefore need to access services, but also that their parents would know more about eating disorders and therefore could offer more help to their children. These constructions were not shared by all the teenagers in the study. Some recognised as much variation within the non-Pakistani populations as within their own community, for example in terms of parental strictness and the quality of parent-child relationships.

The MEIM was given to the teenagers in order to describe the ethnic identity of the group, therefore, a systematic analysis of each individual teenager's ethnic identity score and their constructions of help-seeking was not carried out. However, although it too was not systematically analysed, reading of the transcripts reveals how the teenagers enact a range of identities, such as daughter, sister, female, teenager, Muslim, Pakistani and Asian, some of which come to the fore in certain contexts, but all of which have a continued influence on the individual.
In summary, the research has shown how help-seeking from professionals is seen as problematic for Pakistani Muslim teenage girls. It has highlighted the importance of looking at the issue as an interaction between different levels of organisation (see Bronfenbrenner, 1979), with the community, family, peers and parent-child relationship being particularly important for these teenagers. Their own individuality was given a much lower priority than would have been suggested by existing models.

Deciding about seeking help from a professional is not a matter of simple either/or choices, but requires the individual to address a series of inter-related issues. Of prime importance is the impact of the individual's actions on their family's position within the community. This is juxtaposed with a mainstream community in which teenagers are perceived to be relatively autonomous in their actions. Also to be considered are aspects of the process of communication between the teenager and professional, if and when they meet, and the anxiety teenagers anticipate feeling in such situations. However, it is important to be aware that whilst some of the issues raised are likely to be particular to this group of teenagers (e.g. the impact on the family’s position within the Pakistani community), some will be shared with other teenagers (e.g. ambivalence about involving parents) and with other young women (e.g. fears about discussing personal issues with male professionals), but it was not the aim of the research to make comparisons with other groups.

What arises from the above process of deciding are individualised strategies and solutions to social, as well as individual processes and structures. The strategies and solutions take into account the teenager's relationship with her parents and an assessment of the consequences of inaction, but it is recognised that they are not likely to be final solutions and may carry with them their own risks. Of concern to clinicians is that some of the teenagers thought that the impact of the 'problem' on their lives would have to be great before they would consider seeking professional help.

The research has also offered ways of making existing models relevant to the population interviewed, something that Denzin (1995) believes to be an important part of the work of social interactionists. As they stand, the models are either too narrow and individualised to be of use, or so broad that they cannot offer any specific recommendations.
4.2 Limitations and clinical implications of the study

Before the implications of the study and recommendations arising from it are considered, its limitations will be discussed as they provide the context in which the implications can be understood.

4.2.1 Methodological limitations

Limitations of the sample
The process by which participants were recruited into the study has been described in the section on methodology. For both practical and ethical reasons, the teenagers were self-selected to a certain degree. In school A, the deputy head-teacher played an important role in approaching teenagers, thus the sample is likely to reflect his biases in some way. While interviewing the teenagers from school A, it was not obvious what these biases might be as the teenagers covered a range in terms of their ability to express themselves verbally, their comfort with the interviewing situation and their knowledge of the subject. However, it is likely that he chose girls whom he knew (it is a big school) and who would conform to the 'rules' of the situation.

In school B, the girls were identified through their peer network. The effect of this may have been greater homogeneity in the thoughts and ideas of the participants. Having said this, there were times in the interviews when the teenagers openly disagreed with each other.

For ease of access, the participants were drawn from schools with large Pakistani (and other Asian) populations. This may have an effect on their ethnic identity and therefore their understanding of the role of ethnicity in seeking professional help. One could hypothesise that the degree to which an individual is in a 'minority' in a particular setting will affect the person's experience of his/her ethnicity. In terms of sampling, it would have contributed to the study to interview Pakistani teenagers in Derby from schools with fewer Pakistani pupils.

With the benefit of hindsight, it would also have been useful to know more about the backgrounds of the teenagers interviewed, for example, the area of Pakistan from which their parents migrated (urban or rural), how long their parents had lived in Britain and/or in Derby and their direct or indirect
experience of the mental health services.

Generalisability
Related to the issue of sampling is that of generalisability, or external validity. Because qualitative analyses are typically carried out on small, selected samples, the issue of how far the data can be generalised is problematic (Rennie et al, 1988). Some of the questions raised about the findings in this study are:
- How far do they relate to seeking professional help for other kinds of emotional distress?
- What can they tell us about Asian Muslim teenagers in other parts of Britain?
- How do they relate to the experiences of Pakistani teenagers who have used services or are actually experiencing emotional distress?

Authors from within the qualitative paradigm argue that generalisability is not the goal of qualitative research (eg. Leininger, 1994), but rather the aim is to produce in-depth understandings and knowledge of particular phenomena, that are transferable to another similar context. Certainly, one aim of this was to produce something that would be of use and interest to service providers and planners in Derby. However, it has to be remembered that it covered only a very narrow age band (the teenagers were fifteen and sixteen years of age) and they were exclusively female. The importance of gender in the teenagers' constructions of help-seeking make it likely that Pakistani teenage boys would have some different perspectives.

The fact that the study did not involve Pakistani teenagers who have used services has been explained in the introduction (see section 1.3), however, the findings would clearly be enriched by including such people and might throw light on other priorities and concerns.

The 'vehicle' for discussing seeking help from professionals was 'eating disorders'. In spite of the teenagers' limited direct experience of eating disorders, it proved a fruitful topic and illustrated the importance of the meanings of symptoms and labels in the process of help-seeking. It would be expected that there would be differences between the meanings ascribed to eating disorders and those ascribed to other expressions of emotional distress, but the general point that it is the meanings that are important would remain.
Validity
Validity is talked about in a range of ways within the world(s) of qualitative research, but the various conceptualisations are all based on the premise that there is no objective truth against which the research findings can be measured. Each piece of research is situated within a particular context and relates to the worlds of the participants, including the researcher. For this reason different criteria such as ‘credibility’, ‘confirmability’ (Leininger, 1994) and the ‘pragmatic standard’ (Osbeck, 1993) are proposed.

Some of the ways of ensuring these are built into the grounded theory method, for example, keeping close to the data through the method of constant comparison. Another, that was not possible in the time available for this study, is one part of theoretical sampling, in which analysis alternates with data gathering. This would have allowed the researcher to fill in gaps that were emerging in the accounts or enrich categories that had already emerged. An example of a gap that emerged related to the kind of information that was passed between people in the community. It was surprising to the researcher to hear that information about a person’s menstrual cycle would be known by people not living with her. This challenged assumptions about what would be considered ‘private’ but also explained a connection being made by the teenagers between the symptoms of eating disorders and the issue of marriage. The kind of theoretical sampling that took place in this study was the continued reading of relevant literature as the analysis proceeded. Light was thrown on the above issue in a book by Wilson (1978) where she described the transmission of information and other forms of knowledge through the close relationships between women in the extended family (‘biraderi’), including information about menstruation and sex.

‘Triangulation’, the collection of data from a range of sources, is another way that has been proposed to get a full account of a particular phenomenon. As parents were seen to be an important part of the process of help-seeking, this study could be strengthened by gaining the perspective of parents and indeed other community members or representatives. Family doctors were also frequently mentioned by the teenagers. Given their pivotal role in many referrals to the mental health system, further research is warranted in interactions between Pakistani teenagers and their GP’s, paying special attention to how the issue of confidentiality is handled. However, this was not possible within the confines of
this study, but a degree of triangulation was achieved through the reading of literature from a range of research bodies, with which there was found to be some consistency in findings.

Other psychologists were used in the research process to validate decisions made by the researcher, but another way in which this can be done is ‘respondent validation’. In other words, taking the findings back to the participants and including their feedback in the final product. Again this was not possible within the time available. It would have provided useful additional information, but as Henwood & Pidgeon (1992) point out, the information arises from a process in which power is unevenly balanced between researcher and researched.

Using the pragmatic standard, evaluation is based upon the degree to which good accounts or stories about the phenomena in question have been produced, in other words, it’s ‘usefulness to society’ (Osbeck, 1993). This is perhaps something that can only be assessed in the fullness of time.

The points above lead into the issue of how much of a grounded theory analysis was achieved. The time available had an impact on the richness of the data, in so far as it was not possible to collect more data. Had it been collected, it would have focussed on the emerging analysis, developing sub-categories such as ‘community construction of emotional problems’ (section 3.4.2) and ‘parent-child responsibilities’ (section 3.5.2) as these did not reach saturation. It would also have included the other possible sources of data mentioned above. In the event, only a partial analysis was achieved.

**Verbal reports as data**

Given the stance within the qualitative paradigm that there is no absolute truth ‘out there’, but rather that meanings are socially negotiated, verbal reports are not as problematic as they can be for quantitative research. None-the-less, there is an assumption that there is a relationship between what a person says and their ‘psychological reality’ (Smith, 1995b). However, as Currie (1988) reminds the reader, people’s descriptions of their thoughts should not be mistaken for a fully developed explanation. The job of the researcher is to ‘explain the explanations’. In this study it is particularly important to remember that the teenagers were talking about a hypothetical situation, but the fact that the themes and patterns that emerged were repeated in different interviews is an indication
of the strength of those meanings in their lives and one could hypothesise that they would remain important at times of distress.

Another concern of verbal reports, or more specifically, interview data is the possibility of respondents tailoring their responses to the situation and the researcher. The researcher tried to minimise this by asking open-ended questions and making them indirect rather than personal, for example, ‘what might a person your age think about ...?’. It would be naive, though, to assume that the interviewees did not construct their responses to fit the situation.

The other elements of the situation that are likely to have constrained the process are the ethnicity of the researcher (see below), the presence of a tape-recorder, the different styles of interaction used by the two parties, and possibly, the lack of any prior relationship. Conscious efforts were made by the researcher to address these. For example, confidentiality was promised and the researcher attempted to adopt a non-judgemental and curious stance. It was stressed at the beginning of the interview that, although the researcher would be asking questions, it was because she was interested in what they thought, and that there were no ‘right’ answers. Despite this, biases are inevitable.

Ethnicity of the researcher
A very influential dimension was the ethnicity of the researcher. Research by Shaeffer (1980, cited in Tizard & Phoenix, 1993) provides evidence that both black and white people tend to give different answers to questions that contain a racial component, depending on the race of the interviewer. It was expected from the outset that being white would have an effect on the process and content of the interviews. While the researcher being white was rarely mentioned, the comments by the participants on the importance of cultural sensitivity and a shared understanding of their culture by help-givers suggest that the silence on the issue was more likely to represent discomfort at pointing out differences between us, rather than the irrelevance of that difference. Wilson (1978) argues that Asian women being interviewed by a white woman might not believe that they would be understood and their openness would be affected by the shadow cast by a history of racism. It has already been mentioned (section 4.1.6) that racism was not raised in any of the interviews, and an explanation offered.
Another potential issue is the sensitivity of the subject, or aspects of it. For example, there was one occasion when, on being asked directly about the sensitivity of the topic, one of the teenagers said that she found it difficult to talk hypothetically about 'family problems'. This may have been discomfort at talking to a white researcher (and psychologist) about such issues, or it may have reflected a general rule that such issues should not be spoken about with strangers. On the whole, however, the researcher was struck by the openness of the participants.

**Researcher bias**

As with respondent bias, researcher bias is acknowledged as unavoidable. Something the researcher found particularly difficult in the interviews was to avoid imposing a construction of the individual in which mind and body are separate. This can be partly explained by the fact that within the English language, there are very few words and phrases that allow for the expression of more holistic constructions. However, there are ways in which researcher bias is addressed within the method. Researchers are encouraged to make transparent as much of their research process as possible, including their personal, theoretical and philosophical starting point. They also attempt to record their biases and assumptions as they proceed, in the form of memo's. These are repeatedly returned to and held up against the emerging analysis. The constant comparative method also aims to minimise bias by forcing the researcher to return to their raw data and check the 'fit' of their analysis, both by finding confirming evidence and negative cases. However, given the interpretive element of the grounded theory method, subjectivity is built in to the process, therefore different researchers coming to the same data are likely to emphasise different parts of it (Rennie et al, 1988).

In fact, as a piece of qualitative research, it could have been improved by a greater immersion of the researcher in the Pakistani community. In the way that the researcher dipped in briefly, it resembled some of the quantitative work that is sometimes criticised by qualitative researchers for being too superficial. The degree to which this would have been possible given the researcher’s age, profession and ethnicity is a moot point. Had the pressures of exams and Ramadan not been there for the teenagers, more time would have been spent explaining the research to the participants and meeting with them after the interviews to get feedback and follow up on some of the issues raised.
4.2.2 Clinical implications of findings

To quote Fernando (1995b), “The way forward for service development is unclear” (p211). The two main options he describes for providing mental health services in a multi-ethnic society being (1) a complete over-haul of the power of vested interests and the dominance of the medical model versus (2) chipping away at existing institutions, while creating separate services for different ethnic groups. Given the unlikelihood of the former, the clinical implications listed below will fall mostly within the boundaries of the latter. However, carrying out the research raised questions (still unresolved) in the mind of the researcher as to how far services can be realistically adapted and how far there is a need for very different kinds of services. Answers to these very large questions clearly need to come out of a dialogue between service providers, purchasers and the communities for whom services are being provided, rather than a single research project.

Having said that, the research findings have given rise to a range of implications relevant to Pakistani teenage girls that could be usefully considered.

* The Pakistani community plays a very important part in the lives of the teenagers and their families. Therefore, if there is to be any change in the use of services by Pakistani teenage girls, consultation should be carried out with key members of the Pakistani community and involvement of the Pakistani community in service planning and decision-making should be ensured. As Webb-Johnson (1991) points out, this is often absent in service development. Part of this process will necessitate the development of a shared understanding of emotional distress and a recognition and valuing of difference. Through this the goals of services and the means by which they are achieved could be achieved and also a shared understanding of the cultures represented. Through consultation, the acceptability of services to community, family and individual should be ensured. This may require additional consultation with people other than the usual spokesmen for the community, as they are usually men in authority and therefore may not be in a position to reflect the views of other community members (Ali, 1992).

* Child and adolescent psychology services should be active in finding out about how the needs of similar groups are met in other parts of the country with
distinct Pakistani communities, such as Bradford.

* A range of services, should be offered, reflecting the differences between families and the differences within families, in terms of relationships between parents and children. Given many adolescents' reliance on adults, particularly their family, services should allow families to play a pivotal role in planning, participating and guiding services (England & Cole, 1995). However, it is also important to provide the adolescents with the option of services in which the family is not involved.

* For the above reasons, there should also be a range of routes of referral, including self-referral.

* Services provided should stress confidentiality, as is done by Asian Family Counselling Service, AFCS (London & Bradford).

* Adolescents should be offered a choice in terms of the gender of workers with whom they will be involved.

* Adolescents should be offered a choice in terms of the ethnicity of workers with whom they will be involved.

* Given issues around access, resulting from the teenagers limited public mobility, outreach services should be developed. Moodley (1995) sees these as particularly appropriate for minority communities, who are more likely to lose out in existing structures. These could provide link-workers from the same ethnic group, but who are perceived to be independent of the community and who maintain confidentiality.

* Outreach services could be used to do preventive work with both adolescents and their parents. As well as providing education, this would be one way of reaching mothers and including them in the process of service planning. Outreach should monopolise on existing systems of knowledge acquisition and support between women within the community (see section on 'validity' in section 4.2.1) Again, it would necessitate the development of shared understandings of the phenomena under discussion.
* Links should be made between child and adolescent services and those services set up primarily for adults from ethnic communities or used by such adults. Given the close relationships described by some of the teenagers between themselves and their mothers, they are also likely to be at risk if their mothers are emotionally distressed.

* Given that schools and teachers were often not seen as sources of help, the role of schools is unclear. However, for those teenagers who do not want to involve their families, school may be one of the few alternatives for providing information and support in accessing other services. To do this schools need to address the stigma associated with emotional distress and set up confidential systems by which pupils can access support. They also need to employ staff from the Pakistani community or staff who are known by the pupils to have an understanding of the values and practices of the Pakistani community, with whom teenagers can discuss their difficulties or distress. The links between such staff and the Pakistani community need to be made explicit in order to address teenagers’ fears about information finding its way back to other community members.

* The media (mainstream television, teenage magazines, Asian television and radio networks) should be used to provide information, but care should be taken to ensure that it is seen as relevant to Pakistani teenagers. Information should be both about where to go and how to go about it, including what happens when a person or family comes face to face with ‘a professional’.

4.3 Conclusion

By giving a voice to the thoughts of a group of Pakistani teenage girls, this study has added to our understanding of the meanings they associate with seeking help from mental health professionals and the dilemmas this could raise for them if they had to seek professional help themselves. It also gives us insight into the strategies and solutions arising from the dilemmas.

The models and frameworks described in the literature review have chosen to focus mainly on ‘people’ or on ‘structure’, while this research addresses the relationship between the two. It challenges the notion that seeking professional help is purely a rational decision-making process and places it firmly in the
context of existing social and cultural structures and practices. The analysis revealed a complex interaction between different levels of social organisation, an interaction that needs to be addressed in thinking about how services might be better organised to meet the needs of Pakistani teenage girls.

The focus of the research has necessarily been narrow, but this has allowed it to explore issues relevant to a particular population and to consider implications, some of which are specific to the population involved and some relevant to other populations. The qualitative techniques used were well suited to the questions being addressed and would be valuable in any research following up the issues raised here about the meaning of seeking help from mental health professionals.
APPENDIX ONE

List of initial codes from 'open-coding'

1 - Friends help  
2 - Family help  
3 - Spreading the news  
4 - Counselling helps  
5 - Confidentiality  
6 - Advice-giving  
7 - Family first  
8 - Shared understanding  
9 - Family expectations  
10 - Secrecy  
11 - Making matters worse  
12 - Intergenerational differences  
13 - Changing parental attitudes  
14 - Parental strictness  
15 - Cultural differences  
16 - Intra-cultural variation  
17 - Cultural sensitivity  
18 - Anonymity  
19 - Trust  
20 - Relevant experience/expertise  
21 - Power of professionals  
22 - Positive qualities of professionals  
23 - Exclusion of parents  
24 - Role of media  
25 - Physical changes as motivator  
26 - Academic achievement as motivator  
27 - Professional help - last resort  
28 - Keep it in the family  
29 - How other people see you  
30 - Identifiable service  
31 - The unknown  
32 - Gender appropriateness  
33 - Community judgement  
34 - Respect for religion  
35 - Becoming an object of scrutiny  
36 - Naming the problem  
37 - Changing traditions  
38 - Physical before emotional  
39 - Acknowledging the 'problem'  
40 - Embarrassment  
41 - Shame  
42 - Taking it seriously  
43 - Interference  
44 - Intrusiveness  
45 - Support  
46 - Talking helps  
47 - Use of force  
48 - Knowing where to start  
49 - Taking the first step  
50 - Future options  
51 - Unavailability of professional help  
52 - Fear of consequences  
53 - Relationship with parents  
54 - Lack of culturally appropriate help  
55 - Knowing where to go  
56 - Over-reacting  
57 - I must be crazy  
58 - Deciding for yourself  
59 - Fear of ridicule  
60 - Indirect approach  
61 - Accessibility  
62 - Being labelled
APPENDIX TWO

Example of initial coding on part of Interview Five

Key:
* Words of teenagers are indented. The first teenager to speak is in plain text, the second in bold.
* [xxx] indicate someone speaking simultaneously with the main speaker.
* ?? denotes a word that could not be understood on transcription.
* ??? denotes a phrase that could not be understood on transcription.
* Handwritten numbers over sections underlined by hand refer to initial codes in appendix one.

They have different kinds of relationships with their children. [Yeah] Where else could teenagers could turn for help, do you think, for eating problems?

Probably magazines, mainly they write in them

But more our Asian girls wouldn't do that, they wouldn't write to [yeah]

They keep it in there, they keep it or tell their sisters or friends

They keep it or tell their sisters or friends, but they wouldn't ask like

'Cause they don't want the public to know, because our.. our religion

'Cause as the community knows they will just start talking about you

Spreading about

It will go all around and then your parents will.. everyone will ashamed your parents and you know, it just goes around the community and they don't.

some people might have respect for your feelings but some might not

'Cause our family, they got good pride in them, they got nice. good background and the.. the future that's coming, they want that to be good [that to be good] but if they hear something really bad from us they say 'look, our back.. like background was really good and look into the future, what have you done?' and they just like not nice people any more and that
So having a problem in the family could influence the future of the family [yeah]
Have you got any ideas where else you could go, um, where else people could go, not necessarily where they would go if they had an eating problem

30·
Hospital, I don't know, farm, these farm, um don't know what they called, um, farm

Right so that's like a sort of, um, clinic or [that's right, special clinic]

Doctor [doctor, GP doctor?] yeah or the nurse
Family doctor, you got the family doctor and the doctor's got a nurse, talk to the nurse

If you, if you had to go and see someone what would, who would you hope.. what would they be like? You know, you're saying perhaps nurse is it because it would be female or [yeah] would that be helpful.. what other things would be helpful if you had to go and see someone, what would you like?

6·
Them to be like? [yeah] Yeah like tell us.. tell them that.. give them good advice with whatever they say ?? They should like understand them more and..

What kind of people do you think would understand teenagers, Asian teenagers particularly?

60·
People that are qualified in their work [yeah] nurses or doctors
60· Who have got some qualifications and you know, have been.. have had some..
It's mostly you should go to the qualification people that got credit, yeah. experiences.

Mainly then at home because you know they can't, they can't, they don't.

If that has happened in their family they don't know what to do, they just say 'oh look you get over, you get over with it' and nothing will happen? but if you go to more experienced people they will like [try and talk you out..]
tell you 'go to this place, phone this.. call this line they might give you help [right]. But our family they just like say 'oh, get over it'.

What do you think friends can give you, what kind of help can friends give you?

They can.. listening is better than [better, yeah]. tell them to sort it out themselves.

encourage you, I think that's the best way

Encourage you to do what?

Like if you're not eating, try to encourage you to go to the doctors, to see someone
go to doctors, they could talk you in to that

Yes, so they might be a first step

Yeah and then the other professionals

If you had to go and see a professional who was to do with eating disorders or to do with these problems, as you say, problems with your mind or how your mind is affecting your body, what do you think you would think, what would you be thinking if you had to go and see someone? Would you be ??? or whatever?
I would be nervous probably [yeah, yeah] if I never.. if I wanted to talk to someone like a doctor or nurse.. I don’t know where to start from. Yeah that’s the main reason, yeah. It’s first that they got to look at you.. they got to know what prob.. if they look at you, then they could find out ?? cold, like if you got a red nose or cough and they know you got a cough, but with that like they can’t find out, you got big bags of clothes, and they can’t find out, you.. you have to explain it [yeah, explain it] to them, you can’t just sit back and let them say ‘what’s wrong with you?’ [maybe confidential, talk to them and tell them your problems] First step is hard to go somewhere, first step you have to take is really hard [yeah, you don’t know what’s going to happen, what if everyone finds out, you can’t take that first step, but if you took that first step [and then it’s easy] it’s like more steps it could lead to somewhere, better to the future.

What can help you take that first step, then, what do you think would be helpful to teenagers particularly?

It’s like someone’s go to push you [push you, yeah] or either not push you, either like is when time is right [time is right] for you, when it’s a right time for them, then they take the first step, not if someone’s like ‘you got to do now, you got to go today, I made appointment, that’s it, at ten o’clock you go’. It’s like they’re not ready, they’re like shock, ‘ooh.’ I told.. I told the doctor’, it’s not nice, it’s when I’m ready, then I should take the first step, not you making me for.. me to ready for first step.

So they’ve got to be quite sensitive to what you need rather than just put [what they think, yeah] their own ideas, yeah. Do you think, say if you knew someone who was going to see a.. someone who was helping them with their
psychological problems, the problems they had with happiness or whatever, do you think if you knew 'oh, she's going to see such-and-such', what would you think about them?

If someone had told, if someone had told your stuff to other people?

Well no, if someone said 'you see that girl there, she goes and she sees a.. she goes to see a [doctor] doctor, psychologist, whatever, what would you think about them?

I think it's good 'cause she's trying to get help where she can. She's not hiding it to herself, she's not taking it all on her own, at least she's confident or..

Yeah, but that girl who's saying that she's going to see the doctor and all that, it's like she's telling everyone, it could be in the school she's telling everyone or at home and it's like if it was me and someone was telling about me, something, I'm going to doctors or somewhere, I'll be like really shameful, if someone came up to me 'Oh, do you go to the nurse or are you anorexic or are you this or are you that', I'd be like 'who told you, who told you, no, no it's not true'. You got more scared then, like if you find out that somebody's been talking about you, you like 'that's it, I can't do any.. I'm not taking any more steps, that's it I can't?? 'cause everyone's find out and I'm leaving it in this, I'm not moving any more..

So there's a lot of shame associated with it [yeah], with going to see a professional, there'd be shame. Is it.. I wonder why peole feel shame, I wonder.. I mean I've got some ideas, I suppose, but what do you think, why do people feel shame?
I don't know, I mean, there is no reason, they're only trying to help you

Yeah, it's like they don't want anyone else to find out what problem you got, that's why they feel ashamed, just like.

What they do is if someone finds out from the community, what they're going to. They talk about you at home and then you know

Either if you find... if you like someone really close and they find out and like really shameful and like... they gonna ask you, 'why haven't you told me, because I'm really close to you' and you, like me, like you don't want anyone to find out what you got. Then telling everyone... because it's really hard to tell people... stuff, because it's... it's spread around [it's not shameful], it's spread around... some people don't want that

So it's that trust thing [might be shameful] it's like being sure... you've got to be sure someone will treat what you say with respect [yeah] not misuse it against you

People got to take you serious, you know, and if you know that person take you serious then do things, if you know they're not then just... you have to just go to another person that you know that will respect you, trust you and then... the other person that tells everyone what you got, what problems you got.

So could you ever turn to anyone else in the community for help do you think?

Teenagers nowadays, you can, because they are changing, the community is changing and... there are some people who don't change, some people who don't change.

Our community, especially our community, we haven't got like social clubs
or (yeah), or any ?? [?? clubs where girls can go] or either like er there's er I know there's this school where women that don't know English and they come, I know that much, but they haven't got stuff like us, for our teenagers or social club or learning club, learning how to sew, learning how to...

anything, but our community's a bit back...

even if you say like you want to go swimming and you want to take some exercise or something and er they might be even doing it themselves but

they'll just spread the word around 'look at her doing this, she's doing this, or doing that' or try to make you a bad character and themselves as a good person, [right] even though they might be doing something worse than you.

It hits you when like.. it's like.. your family, like, if you're doing something, and your family doesn't know all the rest of the community knows and it hurts the parents and the mother when er if they find out at the end, that's why you shouldn't like.. girls and the boys don't try to like do stupid things that other parents... that the other people find out before the parents and that's why the parents get so much hurt.. when they find out that this has been going behind their back.

Right so do you think it's important to make sure parents know first [first yeah] before the rest of the community [yeah]
Dear Parent,

As part of my Masters degree in clinical psychology I am carrying out a piece of research investigating Asian teenagers' knowledge of eating disorders and their attitudes towards seeking help from health professionals.

The Headteacher at Derby Moor Community School is happy for me to carry out the research at his school. I plan to interview 10-16 teenage girls in pairs and their contribution to the research will remain anonymous.

Please could you complete the slip below if you are not happy for your daughter to be involved and return it in the envelope provided.

Yours faithfully,

Emma Meldrum

Name of child: ...........................................

I do not consent to my child’s participation in the research project.

Signed: ..............................................
APPENDIX FOUR

Interview Guide:

Part A: Knowledge and constructions of eating disorders and meaning of seeking help from mental health professionals:

- Have you come across 'eating disorders'?
- Where have you come across them?
- What does 'eating disorders' mean to you? (prompt - what words/images come to mind)
- Why do you think some teenagers have these problems? (prompt for multiple perspectives, eg. family, friends, school, community, media)
- If teenagers have these kinds of problems, what can they do about them?
- What will influence them in what they do? (prompt for range of possibilities, eg. type of problem, family circumstances/attitudes, access to services, knowledge of services, peer reactions)
- If you had an eating disorder, what would you do?
- If you had to go and see a mental health professional, what would it mean to you? (prompt - what words/images come to mind)

Part B: Meaning of seeking help from mental health professionals and its relation to 'ethnic affiliation'

Vignette A ‘Traditional’ Asian teenager

- What do you think about the vignette?
- Would she seek help, and if so who from and why?
- How would she feel about seeking help from a mental health professional? (prompt - some people feel worried, relieved..)
- What would encourage her to seek professional help?
- What would discourage her from seeking professional help?
- Would she encounter any problems seeking professional help?
- Would she have any worries about seeking professional help?
- Would it make any difference if she came from a more ‘westernised’ family?
APPENDIX FIVE

VIGNETTE A

Naseem is 15 years old. She lives in Derby with her parents and two sisters (one older, one younger). She describes herself as Pakistani, and is proud of her ethnic/cultural background. At home she wears shalwar kameez and at school she is allowed to wear long trousers under her skirt. She does not have a boyfriend and is expecting her parents to arrange her marriage.

She’s doing well at school and her parents and teachers expect her to get good grades in her GCSE’s, but she is not yet sure what her future plans are. She has a few good friends, all Pakistani, but recently has seen less and less of them. This is partly because she goes straight home after school and does exercises in her room. Her aim is to burn off calories, as she feels fat, however, her friends and parents have noticed that she has lost a lot of weight over the past few months and is looking thin and gaunt.

Naseem describes herself as ‘obsessed’ with food. She prepares all her own food very carefully, eating only low fat foods in small quantities. She prepares (non-Western) meals and makes sweets and biscuits for her family, but doesn’t eat them herself, saying that she doesn’t feel hungry. When she isn’t doing school work, she pores over cookbooks and food magazines and every morning, she lies in bed planning what she is going to eat that day.

Naseem’s periods have stopped and she has notices that she always feels cold (especially her hands and feet). She weighs herself at least twice a day and feels very happy when she has lost a pound or more. If she has put on any weight she feels full of despair and hates herself, and will try to eat less the next day.

Naseem is beginning to worry about herself. She knows she isn’t really ‘fat’, but she still wants to be thinner and has a horror of putting on any weight. She has heard of the term ‘anorexia’ and thinks the description might apply to her.
APPENDIX SIX

THE MULTIGROUP ETHNIC IDENTITY MEASURE

Phinney (1992)
adapted for use in Britain by Meldrum (1995)

In this country, people come from a lot of different cultures and there are many different words to describe the different backgrounds or ethnic groups that people come from. Some examples of the names of ethnic groups are Indian, Pakistani, African-Caribbean, Chinese, Irish and White British. Every person is born into an ethnic group, or sometimes two groups, but people differ on how important their ethnicity is to them, how they feel about it, and how much their behaviour is affected by it. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in:

In terms of ethnic group, I consider myself to be _____________________________

Use the numbers given below to indicate how much you agree or disagree with each statement.

<table>
<thead>
<tr>
<th></th>
<th>4 Strongly agree</th>
<th>3 Somewhat agree</th>
<th>2 Somewhat disagree</th>
<th>1 Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>I have spent time trying to find out more about my own ethnic group, such as its history, traditions and customs</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>I am active in organisations or social groups that include mostly members of my own ethnic group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>I have a clear sense of my ethnic background and what it means for me</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>I like getting to know people from ethnic groups other than my own</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>I think a lot about how my life will be affected by my ethnic group membership</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>I am happy that I am a member of the group I belong to</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>I sometimes feel it would be better if different ethnic groups didn't try to mix together</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>I am not very clear about the role of my ethnicity in my life</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>I often spend time with people from ethnic groups other than my own</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>I really have not spent much time trying to learn more about the culture and history of my ethnic group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>I have a strong sense of belonging to my own ethnic group</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I understand pretty well what my ethnic group membership means to me, in terms of how to relate to my own group and other groups</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Strongly agree</td>
<td>3 Somewhat agree</td>
<td>2 Somewhat disagree</td>
<td>1 Strongly disagree</td>
<td></td>
</tr>
<tr>
<td>------------------</td>
<td>------------------</td>
<td>---------------------</td>
<td>--------------------</td>
<td></td>
</tr>
<tr>
<td>13 In order to learn more about my ethnic background, I have often talked to other people about my ethnic group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14 I have a lot of pride in my ethnic group and it accomplishments</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 I don’t try to become friends with people from other ethnic groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16 I participate in cultural practices of my own group, such as special food, music or customs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17 I am involved in activities with people from other ethnic groups</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 I feel a strong attachment towards my own ethnic group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19 I enjoy being around people from ethnic groups other than my own</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 I feel good about my cultural or ethnic background</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Write in the number below that gives the best answer to questions 21 to 23

21 My ethnicity is
1 Indian
2 Pakistani
3 Bangladeshi
4 African-Caribbean
5 Chinese
6 White British
7 Irish
8 Mixed parentage
9 Other (please describe) ________________

22 My father’s ethnicity is (use numbers above) __________

23 My mother’s ethnicity is (use numbers above) __________
APPENDIX SEVEN

Multi-group Ethnic Identity Measure scores for Ethnic Identity and Other-group Orientation.

<table>
<thead>
<tr>
<th>Participant number</th>
<th>Ethnic Identity</th>
<th>Other-group Orientation</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2.79</td>
<td>3.67</td>
</tr>
<tr>
<td>2</td>
<td>3.64</td>
<td>3.00</td>
</tr>
<tr>
<td>3</td>
<td>3.71</td>
<td>3.67</td>
</tr>
<tr>
<td>4</td>
<td>3.14</td>
<td>2.67</td>
</tr>
<tr>
<td>5</td>
<td>2.50</td>
<td>3.67</td>
</tr>
<tr>
<td>6</td>
<td>3.07</td>
<td>3.67</td>
</tr>
<tr>
<td>7</td>
<td>3.79</td>
<td>3.67</td>
</tr>
<tr>
<td>8</td>
<td>3.86</td>
<td>2.83</td>
</tr>
<tr>
<td>9</td>
<td>3.71</td>
<td>3.17</td>
</tr>
<tr>
<td>10</td>
<td>2.64</td>
<td>3.50</td>
</tr>
<tr>
<td>11</td>
<td>3.57</td>
<td>3.00</td>
</tr>
<tr>
<td>12</td>
<td>2.57</td>
<td>3.33</td>
</tr>
<tr>
<td>13</td>
<td>3.64</td>
<td>3.00</td>
</tr>
<tr>
<td>14</td>
<td>3.00</td>
<td>3.17</td>
</tr>
<tr>
<td>mean</td>
<td>3.23</td>
<td>3.29</td>
</tr>
<tr>
<td>SD</td>
<td>.48</td>
<td>.34</td>
</tr>
</tbody>
</table>
APPENDIX EIGHT

Original data from research study by Phinney (1992) using the Multi-group Ethnic Identity Measure:

Mean Ethnic Identity scores for high school students (mean age = 16.5 years):

<table>
<thead>
<tr>
<th></th>
<th>mean</th>
<th>SD</th>
<th>n</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Asian</td>
<td>2.92</td>
<td>.49</td>
<td>134</td>
</tr>
<tr>
<td>Black</td>
<td>3.04</td>
<td>.49</td>
<td>131</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2.91</td>
<td>.49</td>
<td>89</td>
</tr>
<tr>
<td>White</td>
<td>2.42</td>
<td>.51</td>
<td>12</td>
</tr>
</tbody>
</table>

Whole sample mean scores

<table>
<thead>
<tr>
<th></th>
<th>mean</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic Identity</td>
<td>2.94</td>
</tr>
<tr>
<td>Other-Group Orientation</td>
<td>3.15</td>
</tr>
</tbody>
</table>

Other-group Orientation scores were not reported in Phinney (1992) for each ethnic group.
REFERENCES


Ananthanarayanan, T (1994) Epidemiology of mental illness among Asians in the UK. British Journal of Hospital Medicine, 52 (10), 500-506


Dolan, B; Lacey, H & Evans, C (1990) Eating behaviour and attitudes to weight and shape in British women from three ethnic groups. *British Journal of Psychiatry, 157*, 523-528


Shaeffer, N C (1980) Evaluating race of interviewer effects in a national survey. Sociological Methods and Research, 8, 400-419


Williams, R (1983) Keywords: A vocabulary of culture and society. London: Fontana Press


Wilson, Melba (1994) Mental health and Britain's black communities. Kings Fund Centre

Wilson, Mona & MacCarthy, B (1994) GP consultation as a factor in the low rate of mental health service use by Asians. Psychological Medicine, 24, 113-119

