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Exploring the experiences of parental attachment and familial reputation in the Indian Hindu population.

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by

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Overview

This thesis portfolio comprises three parts: a systematic literature review, an empirical paper, and appendices. The thesis explored the experiences of family reputation and parental attachment within the Indian Hindu population in the UK.

Part One: Systematic Literature Review

The systematic literature review explored how stigma of mental health diagnoses is experienced within ethnic minority populations. The review utilised the NICE quality checklist with an additional question from the CEBM checklist to determine the quality of chosen papers, which were then thematically synthesised. Findings highlighted the Context of Mental Health Stigma, Determinants of Mental Health Stigma, Effect of Mental Health Stigma. Subthemes included the causes and experiences of mental health, the impact and understanding of MHD, views on help seeking, and maintaining factors of MHD's.

Part Two: Empirical Paper

The empirical paper explored the experiences of family reputation and parental attachment. Nine participants engaged in semi-structured interviews with transcripts being analysed using social constructivist grounded theory. Findings highlighted the origin of family reputation, the maintenance, and consequences of it on parental relationships as well as how future generations aim to change its impact.

Part Three comprises the Appendices.

The appendices contain relevant information to the systematic literature review and the empirical paper. It includes a reflective statement of the research process, an epistemological statement that reviews the epistemological position of the researcher and relevant materials used in the research.

Total word count (including tables, figures, and references, excluding appendices): 25,897.

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Part One – Systematic Literature Review

This paper is written in the format ready for submission to the Journal of Advances in Mental Health. Please see Appendix C for the Guideline for Authors".

How is Stigma of Mental Health Diagnoses Experienced in Minority Ethnic Populations.

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Abstract

Objective: In Global Majority (GM) cultures, stigma of mental health difficulties (MHD) impacts individuals and families and reduces access to support. This paper aims to understand the experience of stigma in relation to mental health diagnoses within GM cultures.

Method: Qualitative Literature was systematically searched using APA PsycInfo, Academic Search Premier, Medline, CINHAL Complete and APA PsycArticles between October and November 2022. Eleven of 3029 articles met the inclusion criteria (qualitative data researching mental health stigma in minority ethnic groups). Data were synthesised using Thematic Synthesis.

Results: Findings were organised into three themes and six subthemes. The main findings explored: Context of Mental Health Stigma, Determinants of Mental Health Stigma, Effect of Mental Health Stigma. Subthemes included the causes and experiences of mental health, the impact and understanding of MHD, views on help seeking, and maintaining factors of MHD's.

Conclusions: Stigma of mental health diagnoses can reduce GM cultures uptake of mental health services. It highlights cultural challenges internally (stigma and shame) within cultures and externally (systemic barriers to accessing support) from existing models of healthcare. Further research into cultural adaptations in minimising stigma and increasing uptake of mental health help seeking is recommended.

Keywords

Stigma, Mental Health, Ethnic Minority, Qualitative

Introduction

Recently, the term ‘global majority’ (GM) has been adopted to be used as an alternative to terms more commonly used such as ‘ethnic minority’, ‘person of colour’, or ‘Black, Asian and Minority Ethnic (BAME)’ in the hopes of challenging a white majority perspective. The term ‘GM’ brings light to the 85% of the world that constitute the group (Campbell-Stephens, 2021). Within Western countries such as the UK, US, and Australasia, the ethnic majority is White (Australian Bureau of Statistics, 2022; US Census Bureau, 2020; England and Wales census, 2021; New Zealand 2018 Census, 2020) so typically models of healthcare are tailored toward the majority population making it more culturally insensitive (Nair & Adetayo, 2019; Tucker et al., 2015). Despite this, people of a GM background, particularly of African Caribbean heritage, are more frequently diagnosed with mental health conditions every year than their white counterparts (Grey et al., 2013).

It has been found that many GM groups have faced external barriers in accessing mental health care services, particularly in Western countries (Bansal et al., 2022) which was exacerbated during the COVID-19 pandemic (Germain & Yong, 2020). This has resulted in some groups being less likely to seek help and more likely to face social consequences following episodes of crisis. Inevitably, this causes poorer health outcomes for this group, for example, more likely to be detained under the Mental Health Act (1983; Bansal et al., 2022; Grey et al., 2013). Groups such as African Caribbean people are up to eight times more likely to be given a severe mental health diagnosis, and five times more likely to be detained under the Mental Health Act (1983) than the White population in the UK (NHS Digital, 2022). Despite this they have less access to psychological interventions to reduce distress (Grey et al., 2013; Glover & Evison, 2009). It is argued that healthcare, particularly in the UK functions within a White structure affecting the way in which diagnoses, and individual experiences in GM groups are understood (Bansal et al., 2022; Fernando & Fernando, 2004). Fernando (2004) highlights how this affects how people view help seeking from services. The research draws attention to the importance of increasing professionals’ cultural humility, reflexivity and recognising one's own unconscious biases when assessing mental health (Fernando, 2004) to reduce the impact of a diagnostic structure developed in a Eurocentric paradigm.

Individuals of the GM also face internal barriers to help seeking. Discussion and experience of mental health difficulties (MHD) is still commonly disapproved of within GM groups, (Mahmood et al., 2021) limiting engagement with mental health services prior to a crisis (Grey et al., 2013; McCann et al., 2018). Research has found varying stigmatising attitudes within GM groups toward people with MHD's with mental health concerns resulting in blame attributed to individuals for MHD's for 'contracting a disorder' (Corrigan et al., 1999; Corrigan & Watson, 2007; Corrigan & Kosyluk, 2014, p. 155; Weiner, Magnusson, & Perry, 1988). In comparison to the White population, the GM group can perceive someone to be more likely to cause harm and therefore require separation from the group (Corrigan & Watson, 2007; Eylem et al., 2020). Members of a GM population can therefore respond with more anger or refuse offering help and avoid people with MHD's socially (Corrigan et al., 2003; Corrigan et al., 1999, 2000; Corrigan & Watson, 2007). Additionally, GM communities often value and rely on family support much more than White groups due to the collectivist nature of their cultures (Snowden, 2007). This can further hinder GM individuals in admitting MHD's and therefore to seek help. Studies have found that GM family members believe that their relationship to a person experiencing MHD's should be kept a secret due to this bringing shame to a family (Corrigan & Watson, 2007; Ohaeri & Fido, 2001; Phelan et al., 1998; Phillips et al., 2002; Shibre et al., 2001). This can be known as courtesy stigma which is the 'process by which family members of the individual with MHD also experience similar social devaluation' (Moses, 2014 p.155)

To date, there are no systematic qualitative literature reviews exploring the experience of stigma of mental health within GM populations. This may be due to limited qualitative data in the area due to a reluctance to disclose and discuss MHD's in the population (Kreps, 2017). The implication of this literature gap is that it can facilitate the ongoing misunderstanding of GM experiences and maintenance of existing Eurocentric structures of healthcare services and psychological intervention. This means that GM communities continue to receive care that is not person-centred or culturally considerate. The objective of the current study was to understand the experiences of stigma in relation to mental health diagnoses in the GM population in order to answer the review question "how is stigma of mental health diagnoses experienced in minority ethnic populations". The review utilised a qualitative methodology to understand and synthesise first hand experiences of stigma towards MHD. The majority of current literature focuses on 'double stigmas' such as mental health alongside racial disparities, the implications of mental health stigma in GM groups within healthcare, or are quantitative studies examining correlations within stigma. There was not yet research exploring the experiences of those directly impacted by the stigma towards them, exclusively due to their mental health from other members of the GM community. As the term GM is emerging, this review has utilised the term ethnic minority to ensure all relevant research is included.

Methods

Search protocol

A systematic search was implemented accessing the following databases: APAPsycInfo, MEDLINE, CINHAL Complete, Academic Search Premier, APA Psych Articles through EBSCOhost. The databases chosen all published peer-reviewed psychological research holding relevance to the research question of the review. The databases were searched from 2003-2023 as research in this area increased from 2003, perhaps due reports published in 2001 and 2002 addressing and defining racial disparities in the utilisation of mental health services (Cook et al., 2007; Nelson, 2002; Office of the Surgeon General (US) et al., 2001). The following search terms were chosen through dissection of the research question and identifying all relevant variations of the words, they were:

(stigma* or shame or discriminat* or prejudice*)

AND

(minorit* OR ethnic* OR racial* OR race OR global majorit*)

AND

(diagnos* OR label*)

AND

("mental health" or "mental-health" or "mental illness*" or "mental disorder*" or "psychiatric illness*" or anxiet* or depress* or schizophren* or "well-being" or "well being" or distress*)

Limiters included: English Language, Peer Reviewed Journal, Academic Journals and, Full Text. These limiters were applied after the search.

Inclusion and Exclusion Criteria

Table 1: Overview of the inclusion criteria and rationale for papers chosen.

Inclusion criteria	**Rationale**
Language: English	The researcher can read and understand English fully minimising the risk of misinterpretation the text.
Population: Groups who identify as being part of an ethnic minority group	This review focussed on ethnic minority groups to understand and explore their experiences of stigma towards mental health diagnoses as a review had not been previously conducted.
Population: Groups who have been given a mental health diagnosis	To understand community stigma towards mental health diagnoses groups who had

	received a mental health diagnosis were included.
Study design: Qualitative	To provide rich data in understanding the lived experience of minority groups who have received a mental health diagnosis and the stigma from the community they have received.
Study type: Full text, peer reviewed academic journal	This review aimed to look at peer reviewed empirical research which includes collecting data on psychological phenomena based on research questions, and reporting on the findings of sound quality.

Table 2: Overview of the exclusion criteria and rationale for papers removed.

Exclusion criteria	**Rationale**
Language: non-English	Translation services were not available though it is recognised that this would increase risk of misinterpretation and misunderstanding.
Population: individuals who identify as members of the LGBTQIA+ community	This review aimed to understand the experiences of ethnic minority groups with a mental health diagnosis. Therefore, this review excluded those of the LGBTQIA+ community as they have a unique set of additional circumstances that are not in focus of this review.

Population: groups that have been diagnosed with neurodevelopmental diagnoses	Neurodevelopmental diagnoses were considered more medical as well as having different causes, explanations, and treatment.
Population: groups that do not have a mental health diagnosis	Papers that focussed on groups who did not have a mental health diagnosis were excluded as it was not in line with the research question.
Population: groups that do not identify as members of ethnic minority groups	Research focussed on people from ethnic minority
Population: research focussing on the experience of systems around someone with a mental health diagnosis	Papers that focussed on the experience of those around the diagnosed individual were excluded as this review aimed to understand first hand experiences.
Content: research that does not report on stigma	This review aims to explore and understand the experience of stigma of mental health diagnosis. Any papers that did not report on stigma were excluded.
Content: research that focuses on racial or ethnic discrimination and stigma	Papers that focussed discrimination as a result of race or ethnicity rather than a mental health diagnosis, were excluded as it was not in line with the research question.
Study design: quantitative data	This review aimed to collate and understand first hand experiences of ethnic minority groups which quantitative studies would not provide.

Study type: studies not published in peer-reviewed journals. Papers that are abstracts, literature reviews, meta-analyses, commentaries, letters, editorials, reports, conferences, grey literature, case reports, opinion articles and book chapters	This review aimed to focus on exploring original and primary research. Papers which are not published in peer reviewed journals may lower the quality of the studies selected.

All papers were screened by title and abstract before being read. Any papers that did not meet all inclusion criteria or met a minimum of one exclusion criteria were removed alongside duplicates (n= 361). The most common reasons for exclusion of papers initially was that the papers did not report exclusively on mental health stigma, that papers researched the impact of MHD on systems around the individual experiencing it, and experiences of those identifying as a member of the LGBTQIA+ community. All reference lists of papers selected from databases were searched for additional relevant papers that fit the inclusion criteria. A final sample of 11 papers remained (see Figure 1: PRISMA Flow Diagram – Summary of the selection process).

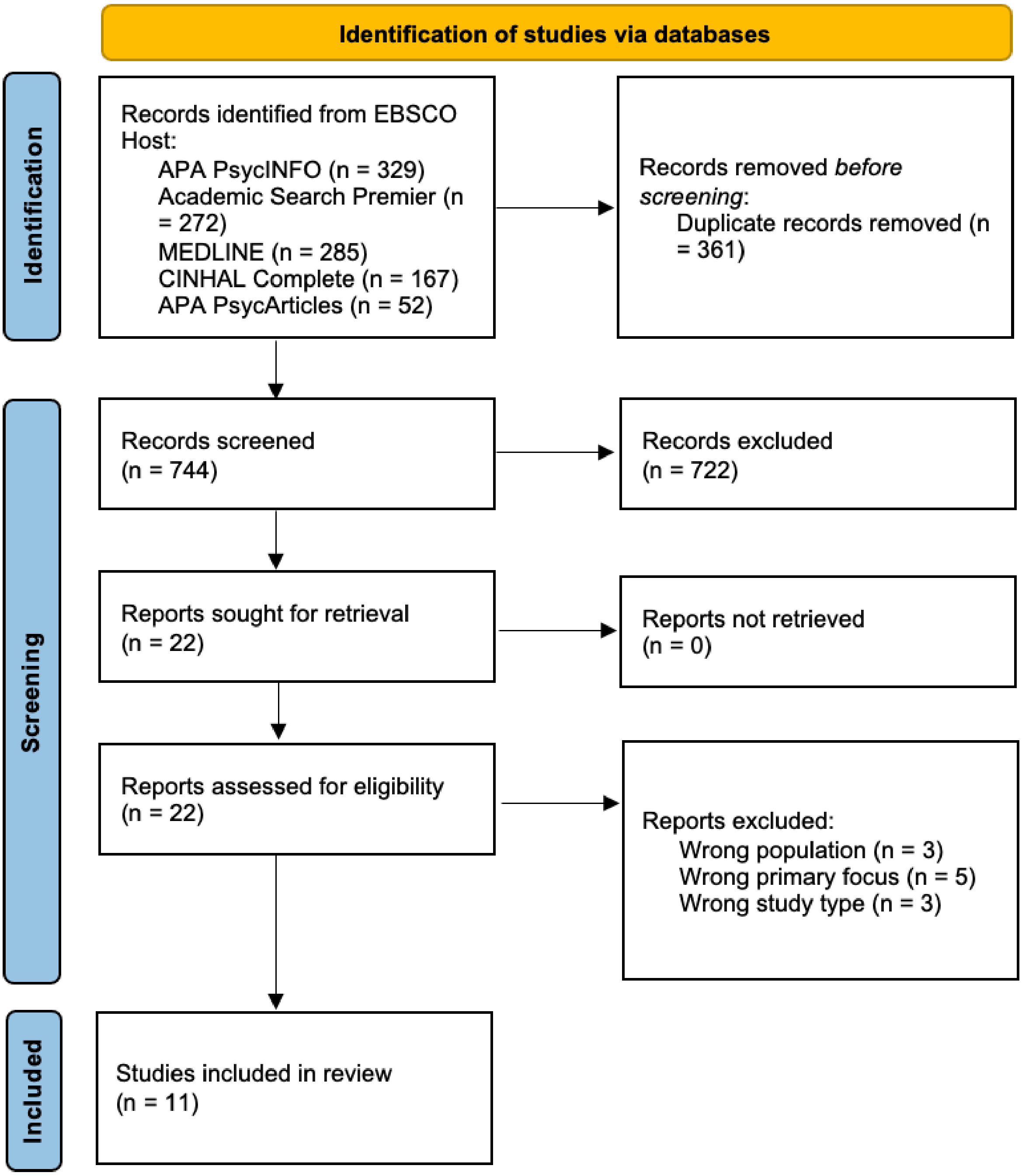

Figure 1: PRISMA (2020) Diagram – Study of the selection of papers process

Data Extraction

Relevant data from each paper was extracted into a table. Headings included:

- Study Title
- Author(s) and year of publication

- Location of the study
- Methodology
- Information about the participants
- Key findings (See Table 3)

Quality Assessment

The National Institute for Health and Care Excellence (NICE) quality appraisal checklist was used to assess the quality of each study (NICE, 2012) with one additional question added from the Centre for Evidence – Based Medicine (CEBM, 1997; See Appendix D). This question asked if the findings of this study are applicable to clinical settings which may help to increase clinicians understanding of stigma of mental health diagnosis in minority ethnic groups Therefore, the researcher felt the additional question of 'Are the findings transferable to other clinical settings?' would be relevant to consider. These checklists were chosen as they thoroughly assessed quality and validity across different domains such as, relevant theory, study design, data collection, trustworthiness, ethics, and analysis while utilising a simple but effective scoring system. Alternative checklists were considered such as the Critical Appraisal Skills Programme Qualitative Studies Checklist however, it did not seem as thorough, nor did it consider researcher bias in detail. The checklist scored each paper based on how well they met the quality criteria (See Appendix E for the summary of quality assessments). If the paper met most or all of the criteria, the checklist assigned '++', for studies that met some of the criteria, but the conclusions would not be impacted were assigned a score of '+'. If a study met few or none of the criteria, the study would score a '-'. The highest, median, and lowest scored papers were shared with another clinician to independently re-score using the same checklist to ensure that the process was reliable. Variations in scoring were debated until consensus was reached with clear rationale, ultimately the primary researcher made the final decision taking alternative perspectives into consideration.

It was recognised that the researcher's upbringing as a female of Indian heritage with close cultural community links within a western environment, might influence cultural assumptions that impact the interpretation of findings and codes reported in the papers such as minimising different gender expectations and exaggerating the importance of reputation. Having grown up in this cultural community, the researcher has experienced stigma toward mental health diagnoses and negative impacts of it on individuals and families. As the researcher is in Clinical Psychology training, they also hold strong views in normalising MHD's and against stigma towards diagnoses, recognising the impact it can have on mental health service users. Despite this, the researcher aimed to remain neutral during the literature review process and held regular supervision with both ingroup and outgroup members of the target population. Keeping a reflective journal also assisted in identifying and minimising this influence.

Data Synthesis

Thematic synthesis (Thomas & Harden, 2008) was adopted to analyse the data collected from the papers. This method enabled themes to be identified across the literature and be coded, then grouped, drawing upon thematic analysis techniques.

Stages of Thematic synthesis (Thomas & Harden, 2008)

1. Line by line coding of the results from each study.
2. Create descriptive themes from the codes to summarise findings across studies and identify the meaning of each code group.
3. Develop analytical themes to interpret the descriptive themes considering the review question.

Results

Overview

Overall, eleven studies were selected for review. The studies explored the personal experiences of stigma of mental health diagnoses within GM groups. These papers were published between 2006 and 2018 with four papers using focus groups and seven adopting interview methodologies.

Six studies recruited participants from the United States of America, four recruited from the United Kingdom with the remaining one recruiting from Iran. All studies reported data about the ethnicity, and approximate age of participants. The analysis methods varied across studies but all produced themes within their data. Each paper explored stigma and understandings of mental health while barriers to help seeking emerged through analysis. A detailed summary of each study is presented in Table 3 below.

Table 3: Detailed summary of each study

Author and year	Location	Method	Participants	Key findings	Quality rating
Alvidrez, et al. (2008)	Black adults-referred to community-mental health services in-San Francisco.	Semi structured interviews Statements identified, and thematic categories/ subcategories developed. Chi-square tests examined potential age and gender differences	- Public-sector Black African American - Age ranged from 25–60, - Mental health consumers. - Self-report of psychiatric diagnoses or symptoms. - Approx. 75% currently receiving outpatient mental health treatment, mostly in community mental health programs. - 88% had received treatment in the past.	Four themes: - Exposure to stigmatizing beliefs. - Stigma as a barrier to seeking mental health treatment. - Stigma as an ongoing treatment experience. - Strategies to deal with stigma.	++
Bernstein et al. (2007)	United-States of America (USA)	Ethnographic method based on 12 step Spradley's Developmental Research Sequence. - Ethnographic face-to-face interviews conducted in Korean; - Ethnographic record was constructed from data - Duration: length participant was willing to speak (45–90 minutes). - Each participant interviewed one to seven times, (total of 55 tape-recorded interviews)	- 17 Korean immigrant women (scored mild-to-severe depression the Hamilton Depression Inventory Scale). - 24 to 69 years (mean 46) - 3 to 33 years (mean 15.8) living in US. - 13 married participants, two separated and two unmarried. Seven had one child, one had two children, five had three children, four had no children. Five were housewives, Five were business owners, four were employed, one was on disability, one college student, and one was unemployed. seven participants had mild depression (scored 7–17), five had moderate depression (scored 18–24) and five were severely depressed (scored 25–36).	Four themes: - Emotional entrapment - Shame and failure as women - Disappointment and failure to live a normal life. - Emotional restraint, somatic, bodily, and metaphoric expressions	+

Black et al. (2011)	Urban senior-centre in a north-eastern-city primarily serving African American elders. USA	Data collection: single two-hour interviews. Analysis: analysed transcripts through data review, sorting, and coding for themes (Mischler, 1986; Silverman, 2001).	- 60 African American equal men and women with varying levels of health and functional status. - Aged 60+ - The majority was single, (53%), with at least a high school education (88%).	<u>Three themes identified:</u> - Depression and Identity - Expressions of Depression - Resolutions for Depression,	++
Campbell & Mowbray (2016)	USA- -	Face-to-face interviews Analysis: Thematic	- 17 Individuals who identified as Black or African-American experienced symptoms of depression - Variety of locations community and mental health services - Aged: 21 to 57 - 12 participants diagnosed with depression by a mental health professional, 5 self-diagnosed. - 16 with a minimum of high school degree, and one participant finished in the eleventh grade.	<u>Three themes:</u> - Race/culture-specific aspects of depression experience - The impact of stigma - Pushing back against the stigma	++
Conner et al. (2009)	Urban,-largely low-income-African American-community	4 focus groups (9-12 participants in each). Semi-structured focus group, 90 min approx. Analysis: Thematic	- 42 African Americans - Recently experience of major depressive episode (self-reported) - Recruitment: community based primary care centre. A medical diagnosis of depression was not necessary.	<u>Six themes identified:</u> - Perceptions of depression: - The unique experience of being African American that contributes to depression:	++

	Eastern US city		- Aged 60 to 93 (average age of 65 years old) - Largely women (84%) who had been widowed. - High school education (79%), 48% retired or unemployed. - Experienced recurrent episodes of depression. 33% sought mental health treatment, 22% sought mental health treatment within the last 6 months.	- Seeking treatment as a last resort: - Myths about treatment for depression: - Stigma associated with seeking treatment for depression: - Culturally appropriate coping strategies	
Dejmana et al. (2010)	Public urban healthcare centres. 3 areas of Iran: Tehran, Ilam, Tabriz	- Explorative research design. - Data analysis: Content analysis - Purposive sampling - Gendered focus groups: more comfortable. - Interviews primarily conducted in Persian; Kurdish and Turkish were interpreted by trained researchers (observers) translated by bilingual knowledge. - 1.5-2 hours and ended data saturation reached	- Twelve focus groups; equal men and women (38 each) - Fars (Tehran) 26 (13W/13M) - Turks (Tabriz) 27 (13M/14W) - Kurds (Ilam) 23 (12M/11W)	Three themes: - Naming the illness - Cause of the condition - Control of illness	++
Knifton (2012)	UK communities in Scotland of Pakistani, Indian, and	- Focus groups. - Purposive sampling - Lasting 90 minutes and two hours.	- 10 focus groups conducted with 87 participants. Variation in age, gender, and faith. - Translators provided accommodate everyone.	Four themes: - Beliefs and stigma associated with mental health problems. - Perceptions of mental health treatment and services	+

	Chinese-heritage	The focus group data were analysed systematically - Analysis: ‘focusing factors’ (Silverman, 2004) Grounded theory.		- Effectiveness of an existing national anti-stigma campaign - New Approaches	
Lavender et al. (2006)	Yoruba, Bangladeshi and White British—living in Southwark, South London.	- Semi-structured interviews, using vignettes describing depressed individuals. - Purposively sampling in age, gender, duration of residence in UK, and educational achievements. - Transcribed interviews analysed using Atlas TI, and partly using grounded theory.	- 20 Yoruba, 20 Bangladeshi and 20 White British people, recruited from primary care. Approx. equal gender split - 18 to 80 years of age, with varying educational achievements. - All the Bangladeshi people were Muslim. - The Yoruba were mostly Christian. - About half of the White British group was Christian	<u>Four themes:</u> - Causes of depression - Stigma of depression - Coping with depression - Is the person ill?	++
Mantovani et al. (2016)	South London	- Semi-structured interviews with faith groups lasting between 45 and 60 min. - Interpretative design. - Purposive convenience sampling - Transcripts uploaded into qualitative data analysis software (NVivo) - Analysis: Thematic	- 26 men and women of African descent involved with Christian faith-based organisations - involvement with outreach intervention programme to promote mental health in minority communities. - Participants were aged between 24 and 75 years	<u>Four themes:</u> - Sociocultural beliefs about mental illness and the production of stigma - Social consequences of stigma mental illness - ‘Silencing’ mental illness and avoidance behaviour impacting on help-seeking. - The reproduction of stigma in faith communities	++

				impeding/delaying help-seeking	
Matthews et al. (2006)	West side Chicago	- Seven focus groups conducted by a trained moderator. - Approx. two-hour semi-structured discussion - Immediate post-session debrief to summarise and identify findings. - Analysis: Thematic	- African Americans predominantly lower income - Self-identified ethnic identity, - English speaking, 18+ - Average age 52 (range 29-85), 74% female, 57% college educated, 52% employed outside the home, 44% Personal/ family history of mental illness. 37% reported “ever received counselling or therapy for an emotional mental health problem”	4 themes identified: - Definitions and explanatory models of mental health: - Culture and mental health: - Mental health service use: - Strategies for increasing access to mental health services	++
Wagstaff et al. (2018)	Assertive Outreach Teams in the West Midlands, UK.	- Semi-structured interviews - Analysis: Interpretative phenomenological analysis, - One research interview was repeated the participant was too mentally unwell in the first interview to be considered reliable.	- Participants were service users considered the most disengaged from mental health services. - 7 male participants (diagnosed schizophrenia), a history of disengagement from services and described ethnicity as ‘black’.	Three themes: - “People just keep hounding me”, - Antipathy to Medication, - Choice and the value of services, - Stigmatisation and identity.	++

Thematic Synthesis

The reviewer followed the thematic analysis guidance set out in Thomas and Harden (2008) whereby themes are identified across qualitative papers drawing upon frequently used techniques of thematic analysis techniques. Appendix F presents an example of line-by-line coding from Black et al., (2011) and Appendix G illustrates how subthemes were created from these codes. The research question of 'how is the stigma of mental health experienced within minority ethnic cultures?' can be understood through four analytical themes outlined in Table 4; 1. Context of mental health stigma, 2. Determinants of mental health stigma and 3. Effect of mental health stigma.

Quality assessment of the papers chosen:

In summary, the quality assessment of the papers chosen, demonstrated good standard of quality. Each study utilised rigorous analysis methods which were relevant to the aims of the study and were transferrable to other clinical settings. However, throughout the papers, there were frequent failings to report on the role of the researcher and ethical considerations which means that the relationship between the participants and researcher may not have been considered, as well as minimal transparency regarding how research was explained and presented to participants. At least four papers selected did not report on whether they had considered ethical issues nor did they discuss consent or whether they had gained ethical approval.

Overall, all but one paper scored '++' stating that the quality of the research and findings were adequate based on the NICE checklist. One paper scored '+' due to insufficient reporting of data collection methods, contexts of the data collected through direct quotations from participants, exploration of alternative explanations and discussion of ethical issues. This may make it difficult to analyse the richness of the data as there was an underrepresentation of participant voices and experiences. Despite this, all other areas were sufficiently detailed and described so it did not impact the overall findings of the study. No studies were removed based on quality as they all scored '+' or higher.

Furthermore, all but one study was conducted in western countries (six from the United States and four from the United Kingdom). While each country adopts different models of healthcare, GM groups are considered the minority population within these countries. As such models of healthcare are not tailored to their cultural needs as has been found. This may not be the case for Iranian participants describing their experiences in Iran. As the participant group selected for the study were members of the majority population within the country, it is more likely that the model of healthcare adopted meets their cultural needs. The findings of this study highlighted this as papers conducted in the Western countries highlighted help seeking barriers in internal (stigma and understanding) factors and external (distrust towards healthcare professionals and cultural needs being met), whereas the Iranian study found similar internal barriers to help seeking, but attitudes towards healthcare professionals and services were more positive.

Table 4: Outline of derived analytical themes

Broad themes	**1. Context of Mental Health Stigma**	**2. Determinants of Mental Health Stigma**	**3. Effect of Mental Health Stigma**
Subthemes	1.1. Causes of MHD	2.1. Impact of MHD	3.1. Views on Help Seeking
	1.2. Experiences of Mental Health Stigma	2.2. Understanding MHD	3.2. Maintenance Factors

1. Context of Mental health Stigma:

Throughout this synthesis, it is important to consider the context of mental health stigma within GM groups as it allows for greater understanding of the stigma as well as cultural barriers that may be faced. This includes what people of a GM background believe causes MHD and the current experiences of mental health stigma.

1.1 Causes of MHD:

Many ethnic groups believed that MHD were a result of supernatural causes such as demon possession, the devil, and 'a paradigm of evil' (Black et al., 2011 p. 652; Mantovani et al., 2017). With Nigerian and Asian participants believing MHD were caused by 'curses, black magic, evil spirits, and the misdeeds of ancestors' (Knifton, 2012 p. 293; Lavender et al., 2006 p. 653). Additionally, participants from African descended faith communities in the UK believed that a choosing a lack of faith in God could cause mental health distress (Mantovani et al., 2017), an idea which was most strongly held by religious leaders (Matthews et al., 2006; Black et al., 2011).

Biological, emotional, cognitive, social, and physical 'vulnerabilities' (Lavender et al., 2006 p. 654) to MHD were discussed. Biologically, Iranian participants stated that 'internal factors' such as emotion, cognition and hormones caused people to be more vulnerable to depression (Dejman et al., 2010). Iranian participants also believed specific personality traits were considered a 'weakness' causing MHD's while Hindu, Sikh and Muslim participants believed that mental illness was inherited through families (Knifton, 2012). Participants described MHD as a weakness or a sign of being 'crazy', which was considered to be a 'white people' trait, unaligned with their own culture and experiences (Alvidrez et al., 2008 p. 880, 881; Black et al., 2011; Campbell & Mowbray, 2016; Conner et al., 2010).

African American (AA) elders also reported potential physical causes to MHD in that they could be caused by physical health problems themselves (Black et al., 2011), particularly age-related physical difficulties like mobility deterioration (Conner et al., 2010). Participants from various cultural backgrounds stated that they would accept a doctor's diagnosis of a MHD (Lavender et al., 2006) but would not be able to recognise characteristics of MHD's thinking them normal (Conner et al., 2010) so would delay seeking help (Alvidrez et al., 2008). South Korean participants believed that their body could recognise when there was an emotional difficulty and created physical pains (Bernstein et al., 2008). It was these physical symptoms that were identified in AA groups when asked to share how they could recognise MHD such as feeling empty, weight change and fatigue (Bernstein et al., 2008; Conner et al., 2010), however this could lead to confusion between mental and physical health. Despite this, MHD were considered less than physical illnesses, this alongside existing stigma of MHD prevented participants from recognising their mental health needs (Alvidrez et al., 2008; Mantovani et al., 2017). This led to the belief that some MHD were considered 'severe' and impossible to remedy (Knifton, 2012 p. 292).

The most prominent belief was that MHD was caused by stressful social factors like economic status, social isolation, and pressures within relationships and responsibilities (Conner et al., 2010; Knifton, 2012; Matthews et al., 2006). Loss and death were described as a social cause within African descended participants as the breakdown of relationships were thought to cause MHD (Black et al., 2011; Conner et al., 2010; Lavender, Hussain-Khondoker & Jones, 2006). Relational stresses within Bangladeshi and Iranian participants included family and marital pressures with AA elders reporting that caregiving and custodial issues can contribute to financial, emotional, and physical demands (Black et al., 2011; Conner et al., 2010; Dejman et al., 2010; Lavender et al., 2006). Similarly, gender related stressors were named in Iranian and AA female participants as women described struggles with discrimination, a societal need for dependency on men and feeling shame when personal information is shared about them (Black et al., 2011; Dejman et al., 2010). African descended faith groups within the UK cited 'moral failings' from the person experiencing MHD as they are unable to conform to the expectations of society (Mantovani et al., 2017 p. 376). Wider social factors such as racism and immigration were also discussed as causes for MHD. Iranian participants stated that war could cause anxiety, and difficult immigration processes would also create additional stressors such as language barriers and inadequate accommodation (Dejman et al., 2010; Knifton, 2012). Alongside this, participants from various ethnic backgrounds named their experiences of racism, prejudice, discrimination, and increased violence as a result, as a factor in developing MHD (Conner et al., 2010; Knifton, 2012).

1.2 Experiences of Mental Health Stigma

The papers described how MHD are often and intensely stigmatised in various ways (Knifton, 2012). African descended participants in the UK explained how the stigma associated with the MHD is more impactful than the MHD itself and so becomes a significant barrier to help seeking (Mantovani et al., 2017; Matthews et al., 2006).

Stigma towards MHD existed across generations and has become embedded within GM cultures as a shared experience between cultural groups (Campbell & Mowbray, 2016; Knifton, 2012). Despite this, it was thought that Black American groups may experience heavier stigmatisation from other members of their group than one might from different cultures (Campbell & Mowbray, 2016). Stigmatising beliefs about MHD's are thought to be perpetuated by the various understandings of causes as they can often lead to shame and blame of an individual, such as experiencing MHD as a 'punishment from God' (Campbell & Mowbray, 2016; Knifton, 2012 p. 292); Lavender et al., 2006). These beliefs are integrated into cultural environments and conversations making symptoms and discussion of MHD 'taboo' subjects, evolving into internalised and individualised stigma (Campbell & Mowbray, 2016).

Stigmatising beliefs about MHD were found to impact a range of areas including understanding of MHD, sharing experiences of MHD with support networks, communicating feelings, and one's sense of self. A lack of understanding of MHD was found to prevent Black mental health consumers from recognising they had mental health needs, therefore acting as a barrier to help seeking and engagement with services (Alvidrez et al., 2008; Wagstaff et al., 2018). The taboo nature of MHD caused individuals to hide their mental health needs as they considered it 'inappropriate' to discuss them with their support networks seemingly out of fear that they would be seen as 'shameful', 'crazy', or 'a burden' (Alvidrez et al., 2008 p. 879, 880; Black et al., 2011; Campbell & Mowbray, 2016; Conner et al., 2010; Matthews et al., 2006). This fear was supported as participants of African descent stated that family members understood MHD to be a 'weakness' and so when MHD are discussed, they are kept within the family and hidden from the wider community (Alvidrez et al., 2008; Conner et al., 2010 p. 272). Stigma has also affected how people of a GM background communicate their feelings in a more general sense. South Korean participants were described to communicate their feelings metaphorically or somatically due to 'moral responsibility' and shame (Bernstein et al., 2008 p. 397; Matthews et al., 2006) while African descended participants felt the stigma of MHD was so strong it was considered 'demonisation' and thus damaging to the individual and their community to disclose it (Campbell & Mowbray, 2016; Mantovani et al., 2017 p. 379; Matthews et al., 2006). The impact stigma had on sense of self was recognised across numerous cultures. Participants from traditionally Asian countries felt that disclosing MHD caused them to feel they were inadequately fulfilling their societal and moral responsibilities leading their communities to view them as a 'failure' or 'socially inept' which is magnified in the cultural focus on marriage (Bernstein et al., 2008 p. 398; Knifton, 2012). AA elders and Black participants similarly felt that disclosure of MHD would lead to discrimination and social isolation (Alvidrez et al., 2008; Campbell & Mowbray, 2016; Conner et al., 2010; Matthews et al., 2006). The stigma could be internalised affecting their perception of themselves, with participants of African descent describing feelings of shame and self-criticism leading to anger and depression affecting their perception of themselves.

Stigma of MHD and shame experienced by individuals and their families was found to be a key barrier to seeking help to manage MHD's in addition to the social stigma experienced once one is involved with mental health services (Alvidrez et al., 2008; Campbell & Mowbray, 2016; Dejman et al., 2010; Knifton, 2012; Mantovani et al., 2017; Matthews et al., 2006; Wagstaff et al., 2018). Not only this, but stigma of MHD maintained a long-term impact on individuals and families who had experienced MHD, particularly for African descended participants living in Western cultures.

"If somebody within their family has gone mentally ill, it's a shame, and they rather push that person out of the way and don't talk. So, you have that thing that you bring that kind of stigma

with you. If somebody goes mentally ill in your family you don't talk about it really. If it goes wrong in a family, something is wrong with that [whole] family, so, you shut that person away. It's this big, denial, and it has been from the whole cultural thing (AM06, African Caribbean)." (Mantovani et al., 2017 p. 378)

2. Determinants of Mental Health Stigma

This theme refers to the impact MHD can have in GM cultures as well as the communities understanding of MHD.

2.1 Impact of MHD

MHD within GM populations can reportedly result in social isolation and judgement. African descended participants described experiencing social isolation and separation particularly from family as they would often avoid individuals with MHD or refuse to accept that MHD signs were present (Alvidrez et al., 2008; Mantovani et al., 2017). AA elders explained that this feeling of isolation acted as an antecedent to feelings of depression (Conner et al., 2010). Black participants differentiated between social rejection, which was less concerning and ostracisation which instilled fear due to judgemental responses from community members when seeking help for MHD (Alvidrez et al., 2008). As such, cultures believe individuals should not express emotions outwardly causing people with MHD to feel the need to 'accept and endure' their pain (Bernstein et al., 2008 p. 397).

"I'm not the only one, I mean, people they got nowhere else to go, nothing to do, the sad people, funny people, and they go round other people's houses and they just come unstuck" (Bubbles, Wagstaff et al., 2018 p. 163)

When an individual has disclosed MHD's, it can impact their identity and perceived role in the community particularly as a woman. Across cultures, women hold responsibility for their family, they are expected to be the 'matriarch' supporting the family yet a 'self-sacrificing, obedient, devoted and submissive' partner (Bernstein et al., 2008 p. 398; Campbell & Mowbray, 2016). A mental health diagnosis can threaten their perceived ability to do so therefore considering her to be an unsuitable marriage partner (Bernstein et al., 2008; Dejman et al., 2010; Knifton, 2012; Lavender et al., 2006). Assumptions are made about their identity such as being 'dangerous and less intelligent', being 'gossiped about', and treated as though they had a problem (Alvidrez et al., 2008 p. 875, 883; Campbell & Mowbray, 2016; Knifton, 2012 p. 288). Participants held the belief that their family would not understand their MHD so would consider them 'a burden' (Conner et al., 2010 p. 270) and would therefore 'taint' their family reputation (Knifton, 2012 p. 292). These marks of difference were described to 'stain' the person at any stage of recovery (Mantovani et al., 2017 p. 377).

Reputation of the family and the wider culture in response to a mental health diagnosis was reflected on. People experiencing MHD, particularly younger individuals were thought to share responsibility more heavily with their family, therefore impacting their family reputation (Alvidrez et al., 2008). This was thought to reflect negatively on the whole family, particularly if a member or family name holds significance in the community, therefore seeking help was often deemed inappropriate (Alvidrez et al., 2008; Mantovani et al., 2017; Wagstaff et al., 2018). To maintain the reputation, families resorted to hiding the MHD (Knifton, 2012). Black participants believed that failing to maintain reputation constantly would cause the family or community to not be considered in the 'wider whiter world' (Campbell & Mowbray, 2016 p. 263).

"I think that my perception of or my experience of being a Black woman in a department full of White people, one of my fears was that I wouldn't be taken seriously as a student if it was widely known that I was depressed. Or there would be a perception that I can't perform to the best of my

> *ability or get things done. And I think my experience as a Black woman colors that perception of the situation for me. I think I didn't want it to be another strike, so to speak, on my record. And I feel like they might be able, or certain people might be willing to give Suzie [laughs] White grad student more leeway than they would me automatically, so for me coming in talkin' about I'm depressed, and I need special concessions, I think I just thought that I wasn't likely to get that. In fact, I thought that people might just look at me as I'm just incompetent and don't belong here." (Kamille*; Campbell & Mowbray, 2016 p. 262)

Participants reported feeling that their feelings would be invalidated and ignored both within the wider society as well as their support networks. Campbell and Mowbray (2016) stated that black participants could feel pressured by research praising Black Americans strength to maintain good mental health, particularly as they have coped with traumatic stressors historically, thus maintaining the pressure to uphold their community's reputation in the whiter world.

Considering this, Alvidrez et al. (2008) stated that nearly all participants who had sought mental health help had found techniques to cope with their need for support as well as negative responses from community members surrounding this.

2.2 Understanding of MHD

Understandings of MHD within GM cultures is thought to change across the lifespan (Black et al., 2011; Campbell & Mowbray, 2016) but could be separated into psychological, spiritual, social, and medical understandings (Knifton, 2012; Lavender et al., 2006). It was widely found that a lack of understanding around MHD is what created and maintained stigma towards it (Matthews et al., 2006).

The primary psychological understanding was that individuals have control over developing MHD's by focussing on negative thoughts (Black et al., 2011). Spiritual understandings led to AA elders often refusing to believe the existence of MHD as it is shaped by an individual's sense of self and belief system constructed from life experiences, their perception from others and God's perception of them (Black et al., 2011). African descended participants therefore felt that on one hand Black people should have the capacity to cope with difficulty due to their resilience and faith in God (Alvidrez et al., 2008), while AA elders believed that depression was considered separate from the individual so should be treated using religion and meditation (Black et al., 2011). Solely spiritual treatment to MHD from pastors highlighted the lack of understanding GM cultures could have toward MHD (Mantovani et al., 2017).

Medical understandings of MHD were shared within the papers. Participants shared their reluctance around taking medication as a form of treatment for MHD's as there was often lack of understanding around them. Black participants who had received care for schizophrenia shared that they were often not made aware of the reason for being prescribed medication or the purpose of it (Wagstaff et al., 2018). Additionally, AA elders held the belief that medication such as anti-depressants were addictive 'street drugs' so refused to take them (Conner et al., 2010 p. 272).

> *"I saw myself as a skeleton, rag clothes with holes; it's more like body wrap rather than clothes thrown over this skeleton hanging in air, bony skeleton swinging around in the wind, that's my image of self. Living is difficult, it's like I was stripped, penniless, empty shell and nothing left in me."* (Bernstein et al., 2008 p. 399)

3. Effect of Mental Health Stigma

This theme describes how stigma affects help seeking behaviour and maintains MHD.

3.1 GM Views on Help Seeking for MHD

Barriers to accessing help for MHD were described in all of the papers selected for this review. Stigma, a lack of understanding of treatments, cultural inappropriateness of existing services, and the existing emphasis on spiritual practices have all been described to prevent help seeking for MHD.

Stigma associated with MHD and treatment seeking outside of the community and family was reported across generations (Knifton, 2012). It consistently acted as a barrier to seeking help with it being considered more important than the MHD itself, causing people to hide their MHD and not seek help (Alvidrez et al., 2008; Campbell & Mowbray, 2016; Conner et al., 2010; Dejman et al., 2010; Knifton, 2012; Mantovani et al., 2017; Matthews et al., 2006). Within many cultures, seeking help was viewed negatively and considered a sign of weakness (Alvidrez et al., 2008; Conner et al., 2010) due to its effect on the family's reputation, participants expressed fear of damaging their family's reputation should they seek individual help for their MHD (Alvidrez et al., 2008; Mantovani et al., 2017). Due to this, and that participants felt they would be treated differently after seeking help (Alvidrez et al., 2008), many people did not accept that they had mental health needs, believing that their self-reliance prevented them from experiencing MHD (Black et al., 2011), therefore did not require external support for it (Conner et al., 2010).

> *"My friends and members of my church and even the people that—my neighbors—I really didn't want them to know that I was going to seek mental health, because I always felt like they would think that, "Oh, well she's crazy. Don't have her come over anymore. Something wrong with her. Better be careful around her." (N, 58 year old woman; Alvidrez et al., 2008 p. 883)*

A lack of understanding of current mental health treatments was also thought to be a barrier to accessing or seeking out help for MHD. MHD did not carry the same weight as physical health difficulties so limited the understanding people had of themselves (Alvidrez et al., 2008; Conner et al., 2010; Mantovani et al., 2017). Additionally, participants over 60 expressed rejecting medication as they were already prescribed some for physical health difficulties (Conner et al., 2010).

Many participants expressed negative beliefs about the effectiveness of mental health treatments as they felt it was not culturally applicable outside of the White population (Conner et al., 2010; Matthews et al., 2006). This created barriers in accessibility to services (Alvidrez et al., 2008; Conner et al., 2010; Matthews et al., 2006). Despite this, participants did not believe that easier access would increase help seeking behaviours in cultural groups (Knifton, 2012). As such, participants felt that seeing a doctor or psychologist should be considered a last resort if risk increased significantly (Dejman et al., 2010; Knifton, 2012). There were many reports of a distrust of health care professionals and a lack of effectiveness due to the belief that individuals will be teased and invalidated through the immediate prescription of medication or referral to an asylum (Campbell & Mowbray, 2016; Knifton, 2012). Black participants who had accessed treatment for schizophrenia described a lack of control and understanding in their prescription and consumption of medication stating it as the primary reason service users disengage or are deterred from mental health support (Wagstaff et al., 2018). There were conflicting statements about the helpfulness of medication (Lavender et al., 2006; Matthews et al., 2006) but participants did describe changes that should be made to increase cultural appropriateness within services. They felt that healthcare professionals should integrate the use of service users' families due to the systemic nature of their values and networks (Lavender et al., 2006), this may also assist in the language barriers present (Knifton, 2012). Participants felt that interpreters may not only bring problems around confidentiality but also that they may not be able to accurately communicate a service user's feelings (Knifton, 2012).

At present, culturally accepted coping methods for managing MHD including psychological, social, spiritual, and medical approaches (Black et al., 2011; Conner et al., 2010; Lavender et al., 2006; Matthews et al., 2006). Iranian participants stated that they would accept a diagnosis from a doctor though medication should be thought of as a final step (Dejman et al., 2010; Matthews et al., 2006). Professional input within from a lower socioeconomic status was considered as a last resort while higher socioeconomic groups integrated it into daily life as a space to discuss feelings (Dejman et al., 2010).

Social treatments through family and friends were the most suggested method of treatment (Knifton, 2012; Lavender et al., 2006; Matthews et al., 2006). They along with support groups were considered an escape from repetitious daily life and increased activity engagement while reducing the stigma associated with MHD and holding more control in information sharing (Alvidrez et al., 2008; Conner et al., 2010; Dejman et al., 2010). Despite this, Black mental health consumers stated that MHD would 'damage' the family's reputation, therefore seeking help was not considered to be a culturally appropriate method to recovery (Alvidrez et al., 2008 p 888).

The role of religion was a key factor in recovery due to the belief it is caused by supernatural experiences (Conner et al., 2010; Lavender et al., 2006; Matthews et al., 2006). Generally, African descended participants from faith groups felt the Church was the first place to seek support (Black et al., 2011) as professional mental health help was tailored to meet the needs of white people within western cultures (Alvidrez et al., 2008). Spiritual practices such as praying, fasting, meditation and exorcisms are considered prior to professional input however they were criticised by African descended participants for their part in limiting access to healthcare (Mantovani et al., 2017; Matthews et al., 2006). It was noted that faith leaders acknowledged their inability to effectively treat and support mental health needs but also struggled to direct individuals to mental health services (Mantovani et al., 2017).

Participants stated acceptance and distraction as another method of coping with MHD. AA elders felt that 'keeping it to themselves' was a mechanism learnt from slavery (Conner et al., 2010 p. 270, 273). The participants thought that 'not worrying about it' would be a natural remedy (Black et al., 2011 p. 654). AA elders, Yoruba and Bangladeshi participants reported how distraction was more effective than medicine (Conner et al., 2010; Lavender et al., 2006). Iranian participants were found to believe that as MHD is a result of personality 'weakness', the most suitable treatment would be to deal with the issue and work to improve oneself through self-reliance, empowerment, and adopting a different attitude (Dejman et al., 2010 p 481; Matthews et al., 2006). Isolation and acceptance of the situation was also mentioned in that South Korean women felt that one should work to process traumatic experiences alone however also acknowledged that this could result in thoughts of ending one's life (Bernstein et al., 2008).

3.2 Factors that Maintain MHD

Relational and identity factors can be influential in the maintenance of MHD. The relationship between the individual and their family with the community held significance in preventing help seeking. Black participants noted a fear of stigmatisation within the community that caused people to conceal their mental health needs (Campbell & Mowbray, 2016). Participants were reluctant to discuss their MHD as they did not want their community to talk about them or label them (Bernstein et al., 2008; Campbell & Mowbray, 2016; Knifton, 2012) as seen above. Additionally AA elders cited loss or a breakdown of relationships as an activator for bouts of MHD (Conner et al., 2010).

> *"I wouldn't accept that my son needed help. I'm ashamed to say that I needed to get past what his label would mean for my reputation before I would go and get his needs taken care of."*
>
> (Matthews et al., 2006 p. 262)

A loss of identity was also named as a factor maintaining MHD. Black participants stated that people can refuse to acknowledge their mental health needs, allowing them to continue unsupported, due to attempts to present themselves as a particular version of themselves whereby mental health needs do not fit with the image (Campbell & Mowbray, 2016). Additionally, African descended participants in the UK felt that employers who discriminate on the basis on mental health can cause individuals to lose hope and aspirations in their role in society causing further loss of identity (Mantovani et al., 2017).

More widely, AA participants felt that systemic factors such as racism and social media portrayals can maintain MHD causing individuals to resort to maladaptive methods to cope such as substance misuse and binge-eating (Matthews et al., 2006).

Discussion

Overview of Findings

This review screened 3029 journal articles and selected 11 papers utilizing qualitative methodology focusing on understanding the experiences of mental health stigma within GM populations. All the papers reported highly relevant information regarding the research area and allowed the thematic synthesis to highlight key themes and future recommendations for research. All the papers contributed to the development of themes about areas that are affected by stigma when experiencing MHD through thematic synthesis. The main areas that arose: Context of Mental Health Stigma, Determinants of Mental Health Stigma, the Effect of Mental Health Stigma. Subthemes included the causes and experiences of mental health, the impact and understanding of MHD, GM views on help seeking and factors that maintain MHD's. All papers also contributed to areas of future research, to be discussed below.

Stigma underpins how GM communities operate despite it negatively impacting almost all areas of their lives. This alongside the importance of family and individual reputation can create invalidating and shameful environments for people struggling with MHD. Over time, it appears that people are beginning to challenge the stigma of mental health creating and identifying safe spaces to support others who need it. This has met some resistance from religious leaders and opinion formers but is still making headway. This change in how GM operate could allow for increased understanding of MHD within the communities, open discussions about MHD, and changes in how mental health services are structured and run to accommodate for cultural diversity. This would directly respond to findings suggesting that mental health services were tailored toward the White population and therefore ineffective when working with GM cultures (Conner et al., 2010) creating distrust toward healthcare professionals in terms of their ability to help, their cultural compassion and their cultural humility (Alvidrez et al., 2008; Campbell & Mowbray, 2016; Knifton, 2012; Lavender et al., 2006). As it was identified that fewer barriers to accessing services may not increase help seeking behaviours (Knifton, 2012), alternative approaches such as support groups and pen dialogue should be taken to address the societal barriers like stigma.

Existing research on barriers to mental health services in various global locations have identified similar difficulties to this review. For example, in a UK setting, it was found that personal and environmental factors such as difficulty recognising and accepting MHD, hesitance to disclose MHD and mental health stigma prevented the utilisation of mental health services (Memon et al., 2016). Similarly, in the US, a lack of knowledge of MHD, the discouragement of seeking help outside of the community. Distrust toward mental health services, and mental health stigma were noted to act as a barrier to mental health help seeking (Leong & Kalibatseva, 2011). At present, research has predominantly focused on individual cultural groups and their experiences of stigma toward MHD. This paper was able to identify patterns and similarities between GM groups in their experiences of stigma. This review does not aim to invalidate the individual cultural contributions to mental health stigma but rather acknowledge that barriers to help seeking is a widespread issue within GM cultures that may improve through similar approaches.

Firstly, this review identified the context mental health stigma sits within enabling further understanding of GM beliefs around causes and treatment of MHD as well as what the current experiences of stigma are. These findings are in line with previous research highlighting the perceptions GM communities can have of someone experiencing MHD. It has been found that members of a GM population can view those with MHD as causing harm and requiring separation as well as more frequently respond with anger (Corrigan et al., 2003; Corrigan et al., 1999, Corrigan & Watson, 2007; Eylem et al., 2020). Understanding how GM culture's view MHD at present is important to recognise where adaptations are needed to be implemented to reduce the mental health stigma experienced within these groups. Further research into identifying these patterns across GM groups and the response to pre-existing anti-stigma work would be needed to further address and understand the barriers currently being upheld.

Secondly, this review identified what may cause the stigma towards MHD. As seen in literature, Snowden (2007) reported on how the collectivist nature of GM groups may exacerbate the stigma towards MHD. MHD are thought to bring blame to an individual experiencing it or their family (Corrigan & Miller, 2004) thus impacting their social status (Matthews et al., 2006) due to a lack of knowledge about MHD so considering it threatening (Birkie & Anbesaw, 2021). As such, families and individuals can resort to hiding their difficulties to avoid shame brought by society, consequently considering MHD a secret maintaining the stigmatising attitudes towards them. Further research into the effectiveness of increasing knowledge around MHD within this group could help to understand whether this is the primary maintaining factor for mental health stigma or if there are underlying, more unknown factors.

This review also identified beliefs around help seeking for MHD, uncovering shared barriers between GM cultures. There has been significant research into barriers for accessing mental health treatment in GM cultures all identifying internal and external factors. Personal barriers such as mental health stigma, lack of knowledge and awareness were reported however there were also systemic barriers such as long waiting lists for mental health assessments, language barriers and poor communication between the service and service users as well as western services' inability to respond to GM mental health needs adequately and discrimination towards GM needs (Leong & Kalibatseva, 2011; Memon et al., 2016). Alongside this, findings of this review support the idea that typical models of healthcare are tailored toward the white population making them culturally insensitive to GM groups. The implication of this is that GM groups can become less inclined to seek help when difficulties first arise, waiting until they reach an episode of crisis with increased social consequences and more chance of being involuntarily detained (Bansal et al., 2022; Grey et al., 2013). Further research should review current models of healthcare to adapt them to allow for cultural diversity and humility, for example creating regular reflexive practice groups with staff members to reflect on trainings they may have done in regard to race, culture and privilege to consider the implications they have on the broader context they work in such as with GM groups accessing healthcare.

Limitations:

Of the seven papers that directed their research toward a particular mental health diagnosis, six looked at stigma towards depression while one focussed on the experiences of schizophrenia. This may limit our understanding of stigma outside of depression as well as only providing the Black British experiences of stigma toward schizophrenia, a diagnosis more heavily stigmatised in GM populations (Matthews et al., 2006)

Of all eleven papers, eight recruited participants of an African descent currently living in a Western country. While this review also considered perspectives of middle eastern and Asian heritage, the findings may be skewed to the African or Black experience. In addition, all but one paper recruited participants who are in the ethnic minority within the country the study was conducted. As such, the results indicate that they experienced external stigmatising beliefs such as a distrust towards services and healthcare professionals and the wider organisational model of healthcare not meeting their needs. This was not the case with Dejman et al.'s (2010) study which was conducted in Iran recruiting Iranian participants. This study found that internal stigma was more prominent in acting as a barrier to healthcare.

This paper has collated the experiences of stigma between cultural groups and identified patterns and similarities in them. Acknowledgement is made toward the differences in region and cultures that may shape the experiences of stigma toward MHD and how these shared beliefs can be addressed in unison to minimise the impact of stigma toward MHD. This however does not negate the fact that collating the experiences of numerous cultural groups under one umbrella may invalidate some experiences or create understandings that are not wholly applicable to smaller GM groups.

Additionally, although the use of the term ‘GM’ has been recently adopted to challenge the idea of a white majority perspective, it does not accurately describe the variations in relationship dynamics between the white and black/brown ethnic populations. The term GB acknowledge the numerical difference between members of each population, but it fails to acknowledge the power imbalance between the groups so therefore does not challenge the oppression and inequality experienced by members of the black/brown population which have been described in this study. The term ‘ethnically minoritised’ may be preferred as it highlights the power imbalance in the relationship between ethnic groups where black/brown populations have been placed in a minority position by white centred privilege.

Conclusion

Stigma of mental health diagnoses and difficulties is a longstanding issue and acts as a barrier to help seeking. Members of GM populations understand this to be caused by a lack of understanding causing fear and unsafety within communities. This unsafety can lead communities to feel threatened by the behaviours caused by MHD inciting further shame and blame towards the individual and the family, negatively impacting how they are viewed within their close-knit community. The stigma towards MHD can therefore cause individuals and families to hide their mental health needs causing them to go untreated and worsen, maintaining the negative beliefs toward MHD continuing and solidifying the cycle. The findings of this review should be interpreted with caution as views were primarily shared by people of one GM culture (African Descended) living in westernized communities (US and UK) so may not be applicable to GM communities in other environments where they are considered the majority as differences were found between these groups. Additionally, the paper collates the experiences from a range of GM cultures which may result in invalidation of experiences and inapplicability of adaptations as a result of the study to individual GM groups.

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Part Two – Empirical Paper

This paper is written in the format ready for submission to the Journal of Advances in Mental Health. Please see Appendix C for the "Guideline for Authors".

Exploring the Experiences of Parental Attachment and Familial Reputation in the Indian Hindu Population.

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Abstract

Objective: To understand the experiences of parental attachment in the context of family reputation in the Indian Hindu population living in the UK.

Method: Nine participants were recruited through volunteer sampling via social media between August 2022 and May 2023. Semi-structured interviews were conducted over video call, transcribed and analysed using constructivist grounded theory.

Results: Experiences of oppression caused a lack of trust towards British people, leading to communities developing, maintaining their Indian Hindu culture. Pressure of perfection within communities led to high expectations, shame and secrecy, control, and punishment. The hybrid generation experienced pressure to choose themselves or family/community, often choosing themselves adding complexity in balancing cultures and challenging the existing rules. Importance of family caused reputation to affect parental relationships acknowledging repair within them.

Discussion: The study enables communities to recognise the negative impact of reputation on attachment to support to those who are affected. Culturally appropriate clinical services considering cultural barriers can be developed within a western model of healthcare through an increased understanding of cultural constructs held by the population. Further research into the male experience within the UK and alternative cultural and religious groups experiences of family reputation and parental attachment should be considered.

Keywords

Family reputation, Parental attachment, Indian, Qualitative

Introduction

Attachment refers to the function of parental relationships in providing emotional security and protection between a child and their caregiver throughout life (Ainsworth, 1982, 1989; Bowlby, 1958, 1977; Gervai, 2009). Through previous experiences of parental responsiveness to distress signals, attachment styles may predict an individual's response to future distress as well as the utilisation and effectiveness of their family support (Kobak & Sceery, 1988). Reputation refers to the judgements a close society makes about the individual characteristics of one of its members (Emler, 1990), while 'family reputation vulnerability' pertains to the extent of which parents acknowledge their family unit's reputation will be negatively impacted by the actions of their children that deviate from ingroup norms (Munniksma et al., 2012).

Attachment theory has evolved to include three styles of attachment classifying the extent to which a child can rely on their caregiver to provide a sense of security (Ainsworth et al., 1978). Securely attached children are easily consoled by their caregiver and seek proximity to them, later in life viewed their parents as available and supportive during distressing event. Children in the anxious-resistant category cannot be soothed by the caregiver and do not seek proximity though in future made attempts to gain parental support but reported feeling loved by parents but not supported. Whilst infants classed as avoidant avoid closeness to their caregiver and do not interact with them upon reunion, noting rejection and absence of love from their parents in future causing feelings of isolation in their relationships (Ainsworth & Bell, 1970; Kobak and Sceery, 1988). These results provide understanding in the connection between attachment styles and responses to distressing events. Those with secure attachments may allow themselves to receive support and acknowledge their feelings of distress, while those with avoidant attachment styles may supress their distressing feelings and avoid seeking support from others (Kobak and Sceery, 1988). Despite the theory's widespread use, it holds limitations through inaccuracies posed by inauthentic testing environments and that attachment styles are not restricted to one per person but rather are adaptable throughout life and relationships (Field, 1996). This knowledge provides deeper understanding into how attachment styles may act as a reaction to environmental and social instability (Davila et al., 1997; Kirkpatrick & Hazan, 1994), strengths and barriers of support networks, family relations and the development of an effective therapeutic alliance in psychological interventions.

Parenting styles have been found to impact relationships with their children. Baumrind (1971) found that ‘authoritative parenting’ described parents who were less restrictive, responded to their child’s needs and encouraged open and honest conversation regardless of whether it undermined parental decisions. This parenting style reflects the development of a secure attachment between child and caregiver while ‘authoritarian parenting’ styles value high control in their children’s activities using physical punishment or threats for ‘incorrect’ behaviour (Jambunathan & Counselman, 2002). According to Baumrind (1971), parents maintain the idea that children should obey all commands without question and are typically emotionally removed from their child’s needs. In a clinical context, it is typically believed that disorganised and insecure attachment styles are perceived as difficult to engage and form a working relationship with (Collins et al., 2002; Hardy & Barkham, 1994).

While attachment theory was developed using a white middle-class sample, it still claims universality due to the differences in socialisation strategies it considers (Keller, 2018) making it relevant to other cultures. Differences between cultures has been found to influence attachment styles. Albert, Trommsdorff and Mishra (2007) found significant differences between acceptance and control with Indian mothers reporting less acceptance and more control than German mothers. It was also reported that Indian mothers and adolescents showed increased avoidance and anxiety in comparison to German mothers and children. Acknowledging the effect of these parenting styles and recognising them can guide understanding into adapting therapeutic styles to better suit individuals or families and strengthen the therapeutic relationship.

Overall, attachment theories are used globally (van IJzendoorn & Kroonenberg, 1988; van IJzendoorn and Sagi, 1999; National Institute for Health and Care Excellence, 2015), whist simultaneously disregarding caregiving practises in cultures outside of a Western perspective

(Keller, 2018). Ainsworth and Bell's (1970) studies were predominantly carried out in the United States overlooking differing cultural methods of raising a child. A meta-analysis highlighted the cross-cultural result of secure attachments being most prominent, supporting the idea of universal characteristics underpinning child/caregiver interactions; however, found variation within insecure attachment styles which may indicate limited overall universality of the theory (Ijzendoorn & Kroonenberg, 1988).

The social construct of reputation can be explained through social identity theory which suggests that an individual makes sense of who they are based on their group membership (Tajfel et al., 1979). Tajfel et al. (1979) proposed that individual members of a group held high levels of pride and a sense of belonging. According to Tajfel et al.'s (1979) theory of social identity, the division of in-groups and out-groups were determined through social categorisation which in turn exaggerates the difference between groups and the similarities within groups.

Emler (1990) highlighted consequences of categorising oneself into a social group. By identifying as a member of a social group, there is an unconscious acceptance of a shared identity within the wider population. This includes the morals and values members of the group hold as well as the behaviour they exhibit in line with these values. Additionally, the definitions of social identities are constructed and agreed upon by the collective as opposed to the individual. This suggests a possibility that not all individuals entirely align themselves with the values of the group, causing blurred lines and definitions as cultural communities develop. Finally, to recognise the values of a group within a wider society, its identity is reliant on the communication of its characteristics from its members to the surrounding community. This communication is therefore negotiable with other people's experiences of the group. As a result, people can build their knowledge and opinion of a social group through third parties.

The term reputation refers to social judgments a community makes about the characteristics of a secondary member (a social group or an individual) including estimates of a person's values and the extent to which they behave in accordance with those values (Emler, 1990). Reputations are a social construct largely created as a group through communication so information about others is regularly shared (Dores Cruz et al., 2021; Emler and Fisher, 1981) making it vital to protect one's own reputation. This may be done by conforming to expectations of good behaviour while concealing behaviour which negatively impacts reputation (Hirschi, 1969; Emler, 1990; Henrich & Muthukrishna, 2021). This can be applied intergenerationally whereby parents perceive the extent their family unit's reputation will be damaged because of their child's actions that deviate from social norms (Munniksma et al., 2012). In regard the first generation born into Western cultures, children of immigrant parents may experience a cultural shift from their traditional ethnic community to the larger western one creating an element of dissonance within themselves (Tirone & Pedlar, 2000). Tirone and Pedlar (2000) found that these children still value their family and culture, but experience an element of conflict when attempting to balance the two cultures they are members of.

In concealing behaviour that may risk reputation, help-seeking is often avoided as involvement from members of the community outside of the family unit may be perceived as undermining a family's ability to effectively collaborate with one another to tackle a problem (Chadda & Deb, 2013). Alongside this, higher levels of internalised racialism of Asian stereotypes co-occur with increased negative opinions towards help-seeking and increased psychological distress (Gupta et al., 2011). Clinicians may find barriers to effectively supporting service users due to the stigma of seeking external help within communities. A lack of healthcare practitioner knowledge about minority populations has been found to result in those seeking help to feel 'othered' (Tarlier et al., 2007 p.140) with their specific needs being unsuccessfully met (Fuchsia-Howard et al., 2014). While, of those who have sought help, those of a minority ethnic background have received poorer outcomes of psychotherapeutic work from mental health services due to early discharge and discriminatory treatment (Sue, 1977). Understanding the implications of seeking help for the individual and their family may prove useful in assisting service users to overcome cultural barriers and systematic racism, as well as recognising sources of support within the community leading to more effective treatment.

Overall, the attachment style and closeness between a child and their primary caregiver is thought to be determined by the extent to which the child's needs and distress is addressed (Bowlby, 1958, 1977; Ainsworth, 1982,1989; Gervai, 2009). Children can carry their experiences of this into later life to ascertain whether their attachment figure is a suitable source of regulation in stressful situations (Kobak and Sceery, 1988). Indian parents often exhibit characteristics of Baumrind's (1971) Authoritarian parenting styles valuing high control in their children's activities opting to use corporal punishment more frequently than parents in the U.S for 'incorrect' behaviour (Jambunathan & Counselman, 2002). This supports the idea that parents of ethnic minority communities favour physical punishments to ensure their children conform to societal norms thus preventing the family from experiencing negative consequences from the community (Silveira et al., 2021). Within cultures that rely on the unity of a community, reputation holds significance so protecting one's reputation by concealing behaviours that differ from the social norm, is a common practice (Hirschi, 1969; Emler, 1990; Munniksma et al., 2012). As time goes on, social norms are everchanging with culture and age (Kuntsche et al., 2021), particularly as generations of children are born in Western countries, therefore suggesting that the values shaping a family units' reputation is also everchanging. There is the possibility that a family's reputation may take precedence over addressing a child's needs or distress. Should a child's distress be considered 'outside of the societal norm' (like adverse mental health conditions) and thus a threat to the family reputation, it may be concealed rather than addressed in a beneficial way for the child (Hirschi, 1969; Emler, 1990; Munniksma et al., 2012). Should this be the case, the child may learn that their distress cannot be soothed by their primary attachment figure altering the attachment style they form (Kobak and Sceery, 1988). This study aims to understand the meaning of reputation within family units and identify areas of overlap between family reputation and parent/child attachment styles while exploring the research question "what is the potential effect reputation may have on a child's relationship with their parents". Through a qualitative methodology, the research will further the current literature around social identity and parental attachment, which predominantly draw upon theories based on Western norms, within the Indian culture. Due to the absence of research in the topic area, a qualitative methodology will allow for a baseline understanding of the issues and experiences in relation to parental attachment in the context of family reputation by those directly impacted by it. Findings may help to form an understanding whereby clinicians can recognise and acknowledge the nature of service user's relationships following non-Western societal norms, and how it may influence their interactions with family's and healthcare workers within a Western country.

Method

Design

A qualitative design exploring familial reputation within parental attachment utilised semi-structured interviews and took a social constructivist approach to grounded theory to analyse the results. The absence of a pre-existing theory of family reputation and parental attachment in addition to the use of a disparate population supports the qualitative methodology chosen. Coding was a line by line descriptive and analytical process whereby particular attention was paid to the language used by participants to construct meaning in a systematic way. Transcript codes were sorted into initial categories and grouped into broader categories to identify emerging theories (Charmaz, 2014). Further interviews asked questions more closely related to the emerging theory and used theoretical sampling to refine the categories developed.

Questions were adapted throughout the data collection process to enable comprehensive exploration of participant experiences prior to ending the recruitment process at the point of data saturation (Charmaz, 2006; Glaser & Strauss, 1967).

Participants

While the researcher hoped to recruit approximately 16 participants from around the UK (Marshall et al., 2013) as recommended to reach data saturation for a grounded theory analysis, this was achieved with nine participants who were recruited via social media between August 2022 and May 2023 (see Table 5) who fit the inclusion criteria below. Participants were aged between 21 and 39 (*M*= 32.67, *SD*= 7.15). All participants considered themselves Indian or British Indian and had lived in the UK for their whole lives. Out of the nine participants, two were male. All participants were assigned pseudonyms to maintain anonymity (See Appendix H and I for the demographic information sheet and consent form).

Inclusion criteria:

- You are a cis-gendered person (identify as the gender assigned at birth).
  - While women are often more exposed to the importance of familial reputation (Chadda & Deb, 2013) a balance of male and female experiences will help to understand the overall link between familial reputation and parental attachment, excluding individuals who do not identify with the gender assigned at birth will create a more homogeneous sample and experiences.
- You are aged 20-40 years.
  - This age range is representative of the children born to parents who are likely to have immigrated to the UK themselves or first generation British citezens.
- You come from an Indian, Hindu heritage.
  - This will allow for an element of homogeneity within the sample population as well as being directly relevant to the target population of the study and their experiences.
- You currently live in the UK.
  - This will allow for an element of homogeneity within the sample population.

- You grew up with a parental relationship (it is okay for this to be a positive or negative experience so long as you are comfortable discussing this).
    - This is directly relevant to the research question.
- You can converse comfortably in English.
    - To allow for optimum understanding and discussion around experiences without the influence of mistranslation.
- You can understand what the research involves and agree to take part.
    - In order to provide informed consent.

Exclusion criteria:

- Under 20 years and over 40 years.
- Lack of sufficient fluency in English to take part in the interview
- Did not grow up with a parental relationship.
- Those not of Indian AND Hindu heritage to ensure homogeneity in cultural upbringing.
- Those currently living outside of the UK.
- Unable to provide informed consent to participate

Procedure

Participants who fit the inclusion criteria volunteered to share their experiences after reading a brief overview of the study and its purpose through advertisements on social media or posters (Appendix J). After expressing their interest, the researcher provided them with an information sheet with further details allowing them five days (before prompting) to read and ask any questions about the study prior to providing informed consent to participate (Appendix K).

When participants agreed to participate, the researcher contacted them to arrange a meeting at a convenient date, time, and location (either in person or video call). Interviews occurred between August 2022 and May 2023. The semi-structured interview lasted approximately one hour *(M= 1:09:14,* Range=1:07:32*)*, was audio taped and anonymised during transcription. At the interview, the lead researcher reviewed the full details of the study including their right to withdraw, what was expected of the participant and responded to any questions. If the participant was willing to partake, the researcher then requested permission to audio record the interview and obtained verbal consent to take part in the study.

Participants were asked predominantly open questions allowing for participants to discuss their overall experiences with family reputation and parental attachment. As the interviews progressed, questions were adapted to further explore emerging topics with variations of the following questions being used:

- Why did you want to take part
- What is your experience of being a member of a family?
- What is your experience of being a member of a community?
- What is the meaning of community to you?
    - Has this meaning changed over time and how?
- What does family reputation mean to you?
    - Has this meaning changed over time and how?
- How has family reputation within a community influenced the behaviour of individual family units, if at all?
- Where do you think caring about other people's opinions came from
- Could you describe what might happen if you were to act outside of community expectation
- Why do you think challenging the structure has pushback from the older generation.
    - What might the pushback look like
- Gender differences
- In your experience, has the family reputation affected the relationship between yourself and your parent(s) and how?
- Impact on how you might parent in the future?

As the interview came to an end, questions became more specific to encourage participants to reflect on the overlap of the two areas. Following the interview, participants had the opportunity to ask any questions about the content and purpose of the study as well as being referred to the participant information sheet containing contact details for support should they require it.

The experiences of participants were reflected through the meanings constructed by the participants as well as the social and cultural environment they are a member of before being interpreted by the researcher (Charmaz, 2006, 2014). Coding considered participants language to construct meaning and were sorted into categories then grouped to identify emerging theories (Charmaz, 2014). Further interviews asked questions more closely related to the emerging theory and use theoretical sampling to refine the categories developed.

It is important to note that the researcher is a member of the research group so have their own beliefs, experiences, and assumptions regarding the topic area. A reflective diary was kept, and two reflexive interviews were held to minimise the influence of their own experiences on the interpretation of data, and to hold focus on the experiences of the participants.

Ethical approval was granted from the university ethics board (Appendix L).

Researcher's position

The researcher takes a social constructivist epistemological position with a post-modernist ontology. They seek to understand reality through social interactions within sociocultural and constructed concepts such as culture and religion (Schwandt, 2000) and follow the idea that reality is co-constructed; reality being constructed by thoughts and beliefs which then construct future realities and societies within them (Flaskas, 1995). Her position is shaped by her experiences of family reputation and the effect it had on parental attachment, as well as her general experiences of being in an Indian Hindu community in Britain. Her slightly pessimistic lens in relation to the negative effects family reputation may have on family relationships, meant that the researcher had to pay particular attention to stories that were not in line with her experiences/beliefs. This was to accurately reflect participants' experiences and to address distressing emotions, similar to the researchers, that arose during discussions rather than avoiding distress to make everyone feel comfortable. Additionally, the researcher's awareness of her own female experiences within the culture meant that she had to place effort in her personal definitions and roles of individuals within family units and wider communities. She has also had to become more flexible in her personal definitions and understandings of families, gender roles and experiences in that the power expectations and reputation holds has lowered as time progressed.

To minimise these biases, the lead researcher sent transcripts and coding to the research supervisors to ensure minimal influence of the researchers beliefs and assumptions, and fair analysis. The lead research also began their reflective statement (Appendix A) and kept a reflective diary to note how their assumptions and beliefs influenced interpretation. The researcher also held two reflexive interviews with their supervisors prior to and at the end of data collection to further recognise her current stance to address these issues within participant interviews and analysis. Taking this into consideration, it is acknowledged that the themes may have been different should another researcher conduct the study with a different socio-cultural background or experience.

Results

Table 6 summarises the four categories and 13 subcategories that emerged from the interviews (See Appendix N for summary including codes to highlight how the categories were created and justified; Urquart, 2013). The model of emerging grounded theory (Figure 2) illustrates how these categories interact with each other. This theory was developed from the diagram shown in Appendix O using the same colour codes which depicts how the themes and subthemes connect to each other and was grounded in existing theories referred to in the discussion. The findings of this study will be presented in accordance with this table.

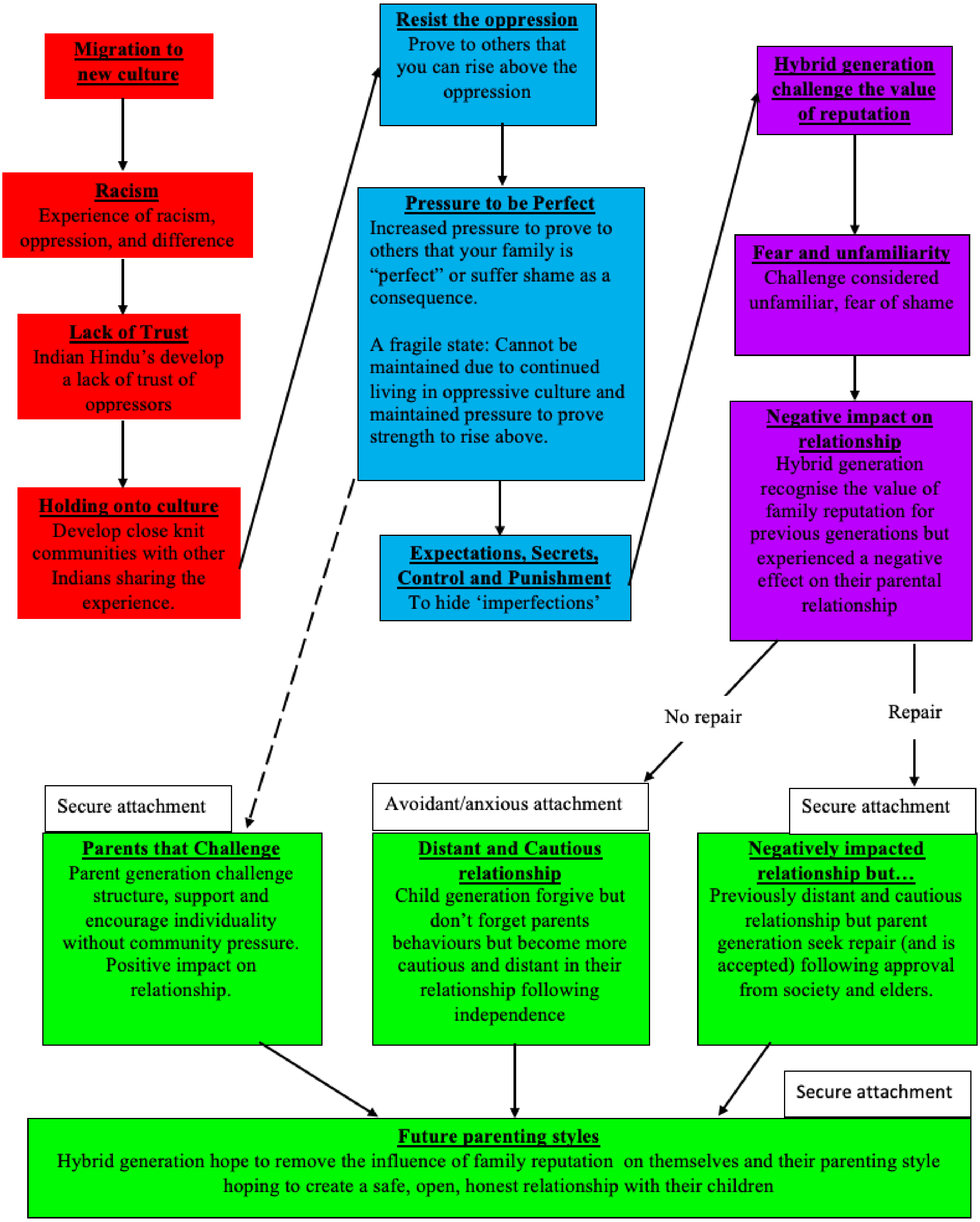
Table 5: Participant demographics

Participant (Pseudonym)	Gender	Age	Length of time lived in the UK	Generation that moved to UK
Krishna	Female	39	39 years	Parents
Arya	Female	37	37 years	Parents with Grandparents
Sohan	Male	29	29 years	Parents
Arjun	Male	31	31 years	Parents with Grandparents
Jaya	Female	37	37 years	Grandparents
Laila	Female	21	21 years	Paternal side: Parent, Maternal side: Grandparents
Divya	Female	21	21 years	One parent
Deepika	Female	40	40 years	Parents and Grandparents
Seeta	Female	39	39 years	Parents and Grandparents

Table 6: Summary of categories and subcategories developed using social constructivist grounded theory.

Category	**Sub-Category**
Oppressive Origins	"A society built to belittle you into oppression"
	Lack of Trust
	Holding onto Culture
Pressure to be Perfect	"Strangled in this box of expectation"
	Secrets and Shame
	Control
	Punishment and betrayal
The Hybrid Generation	Choosing
	Challenging the mould
	Complexity of Balance
Importance of Family	Impact on Relationship
	Repair

Figure 2: Emerging grounded theory model of how family reputation may affect parental attachment.



Definitions

Each interview began with the primary researcher asking participants to define key terms of the research including, family, community, and family reputation. The purpose of this was to understand how, from the participants perspective, they may relate and what may be affected. Participants predominantly constructed a '*modern'* (Laila) definition of family in that it is *"any group of people who care for each other and there's some sort of stability there"* (Divya). Participants stated that that *"family now isn't blood related. Family are people that genuinely love you for who you are, no matter what journey you're going through in life… it's all about the people that love you unconditionally*" (Arya). These definitions demonstrate the common finding that the primary function of a family is to provide a 'support system' (Sohan). The definition of community was constructed to be similar to family in reference to supporting each other (Divya) with a *"more generalized, deeply integrated, intertwined, unspoken bond"* (Laila). Community was considered to hold high importance as it meant to;

> *"Be surrounded by your own, know where you come from. You could draw from very similar life experiences and you can discuss that and people understand where you come from. You're not gonna talk and be wildly different from anyone else. I think it's important to be surrounded by people of similar ilk to you." (Sohan)*

Within this, Laila stated that it also meant that other people were aware of the cultural expectations, leading onto participants definition of family reputation. All participants considered reputation to hold high importance as it was considered prior to the individual/family as a whole (Divya) and defined as how an individual or family is perceived to people i.e., the community. Participants all assigned a negative connotation to the term stating that it refers to behaviour *"being done within a family where other people judge and perceive that as being a bad thing."* (Jaya).

1. Oppressive Origins

This theme refers to the racism and oppression experienced by the generation that migrated to the UK as understood by the participants generation and the perceived impact that had on them. It was perceived to cause a lack of trust for groups outside of their Indian Hindu culture and an emphasis on holding onto their culture within this unfamiliar, unsupportive environment.

1.1 "A society built to belittle you into oppression."

Participants detailed the overt and *"rampant racism"* previous generations had described experiencing in the UK when they first migrated. Alongside the perceived negative social experiences they faced, Laila stated that the only way to cope was to come together and form a community as *"that's how you were going to thrive in a society that was built to belittle you into oppression"*. As such, previous generations were described to 'pass down' lessons as *"this is what we had to do to survive and stay afloat in the economy"* (Laila). Participants felt that these lessons hold relevant as racism still exists in their generation though, as it has become more covert in the form of 'microaggressions', they felt the approach and lessons should be adapted.

1.2 Lack of Trust

Understandably, through the lens of participants, due to the experience of racism during migration, often in the hopes of a better life, migrants grew to feel unsafe and not trust or understand outgroup cultures. Laila explained that she was taught to believe that *"the only people that you could trust, that you could rely on was other people in the community."* There was understanding that participants attending white dominated schools, were inevitably going to make friends with outgroups. If parents allowed participants to socialise with these friends outside of school, they had to come to the participants house, not vice versa.

> *"When I went to school. Me and my brother and my [three cousins] were the only Asians in the entire school. Everybody else who was white. I was allowed to have friends over but was I allowed to get to their house? No, I wasn't. Because they were English. The culture was different than theirs (parents), they didn't understand it. So therefore they kind of limited how often I could go to my*

English friend's house… I think it was lack of understanding and not knowing what would happen.” (Krishna)

1.3 Holding onto Culture

Due to the above experiences, past generations were described to form communities creating a sense of belonging for themselves. The bonds between individuals and families were strengthened through cultural events and holding onto the cultural values they had in their country of origin. Participants described enjoying these events as a child with it serving a function of maintaining the cultural way of living within the home. Families both nuclear and extended remained close, with grandparents often living in the home, eating Indian food daily, teaching participants their native language and teaching respect of elders.

“It was great just to be, like I said, surrounded by one of your own because you learn a lot of life values. I think, particularly within the Hindu culture, where it’s very much like respect dominated and respecting your elders, so I think being part of that Hindu community was huge. And I really think it's important to make sure that we know where we come from and our culture is a big part of our lives. I think it's important. Every British Asian should know where they come from because I know how many good virtues that you get from it.” (Sohan)

2. Pressure to be Perfect.

This theme describes the pressures participants and their families are often put under as a result of communities holding onto culture. Communities have maintained their values and beliefs but due to discrimination have felt pressure to continue resisting oppression. This has led to high expectations for families and their future generations, bringing shame if they cannot meet the expectations. The pressure to be perfect was exhibited through the high expectations for participants and their families to live up *to “always tending to compare to other people… it all comes down to* *the fact of how they're viewed in society"* (Arjun). Parents were described to exert control over participants to ensure they lived in accordance with these expectations, utilising punishments when unsuccessful. Participants described their parents feeling of betrayal in response to their child's active decision to behave outside expectations, alongside shame for being a family who did so. Secrets were kept both from parents to the community and participants to parents. Participants often held negative views around the pressure of perfection and reputation due to its distressing consequences.

> *"I feel completely unable to express myself. There's a lot of anxiety if I express myself incorrectly… I've seen in my family they marry someone who's not necessarily right for them, but is right in the sense of the family and what that reputation comes with of marrying someone who's Hindu, Gujarati, Indian. You know religious, well knowledgeable about cultural practices. You know, that's for some people, they choose to value that over compatibility with that person. I think that's a shame. I think that's so sad that people have to prioritize that and [not disappointing parents] rather than their own emotional, mental well-being" (Laila)*

Divya noted an alternative perspective where reputation and living up to expectations can hold benefit:

> *"If people want to keep up their reputation, it's not always for someone else. It's sometimes for yourself, like if you think ohh, we're known as like a family who do good things. Then they sort of like it. So it's not always necessarily a bad things to be honest like it could be that you're known for doing good things. So like let's keep trying to do good things."*

2.1 "Strangled in this box of expectation".

This theme described participants feelings of *"being forced to fit in a box"* (Laila) and was gendered. Female participants spoke more freely about the consequences they had faced while male participants described more general expectations.

Female participants reported that women had a place in the family and society and were not expected to exhibit behaviour suggestive of stepping out of it. Gender differences were not only identified in how participants were raised but also the values and focusses of parenting approaches. All participants reported that daughters and women hold more responsibility in upholding expectations and maintaining a household from a young age than sons were, with Sohan stating *"the son doesn't have to do as much like they get to sit around and be like the golden boy."* In terms of parenting, fathers focused less on the female expectations than mothers and often taught daughters more independence and how to live as an adult in a white dominated system. While mothers often felt the daughter's primary responsibility was to get married and have a family. As such the expectations placed on women were often in line with perceptions of how successful you would be as a wife and mother. Restrictions and rules were placed on how they dressed, ability to carry out household chores, and previous unsuccessful relationships, while balancing the expectations of a western society working 9-5 or attending school. Arya explained:

> *"Growing up I had chores, [my brother] didn't. So on a Saturday, I would literally have to clean the bathrooms, do the hoovering and the mopping of the hallway and the kitchen, and then iron. I'm sure that he could have taken one of those chores. And also the expectations of you go to school, you come back home, once you've done your homework, come and learn how to cook."*

Participants believed that their generation placed less emphasis on women needing to solely maintain the household to relieve some pressure. Female participants noted the benefit in this approach as it allowed them to function when they moved out of the home for university whereas their brothers often struggled, Jaya stated.

> *"He's been quite sheltered. I feel like I've been independent, after the age of 16, my parents didn't financially support me I had my Saturday job that would cover it. I wanted to do up my room. I would buy the furniture. He wanted to do his room up and mum would do it for him. I've said that to him, mum babies him too much."*

Despite this, female participants felt it easier to look to their fathers for support and advice due to having less focus on reputation and accepting of independence. Male participants reported that they felt supported by both of their parents in pursuing their interests and individuality, untouched by the impact of reputation or community opinions, and were given as many opportunities as possible to make a well-rounded informed decisions on what they enjoyed.

Both male and female participants highlighted the idea of parents moulding their children to be someone they are not, to live up to cultural expectations and pressures placed on them, including respecting elders and providing the community with your skills and knowledge at no cost.

> *"They taught me what was wrong and right…You help everyone. You shouldn't let anyone else do it. Even if you go visit someone else's house, you always offer, like I'll do this, or let me get the drinks. Like it's just it's just respect" (Sohan)*

They explained that by not meeting these expectations they risked damaging their family's reputation and were perceived as 'weak' or 'not good enough' as communities would "gossip". Trying to balance numerous expectations both within the family and the wider community proved to be overwhelming and caused burnout.

> *"You can't always just mould your child into whatever you want it to be, cause I think that's when you see people break into depression and anxiety is when they're being forced to do something that*

> *they didn't ever wanna do. They just do it because they thought that's what they had to do… [Balancing responsibilities] I think it definitely can be a bit overwhelming at some points like there's times where I've got so much schoolwork and then my mum's telling me you have to go to the mandir it wasn't like a choice a lot of the time so I did feel a bit overwhelmed. It's like a sink or swim kind of thing. (Sohan)*

Participants also noted that the elder grandparent generation seemed to be exempt from meeting the cultural expectations set by society. They suggested that this generation may be the primary maintainers of the sociocultural environment and due to the perceived respect given to them, they may not have to behave entirely in line with the expectations. They are less likely to receive criticism or gossip from the community due to their hierarchical standing.

2.2 Secrets and Shame

Participants behaviours were considered a reflection of parenting styles and the family's values. This alongside the reported 'gossiping' and shaming nature of the communities, exaggerations or misinformation can spread quickly.

> *If a community finds out, I've dated a Sikh person, that lessens my chance of finding someone because I'm almost tainted and you know, like I have to be fresh. You know, ready to get married without any blemishes." (Seeta)*

Participants explained that parents often did not want to give the community a reason to "gossip", so to protect their family reputation, and perhaps their own place in society, they resorted to punishment or publicly expressing disappointment and shame towards the child showing the community their disapproval towards their behaviour. Arya stated, *"parents' behaviour and compassion towards you can be heavily influenced by what other people will think"*. Due to this being perceived by the participants as prioritising the views of the community and family reputation over their needs, they often kept secrets from their parents to live more freely, outside of their parent's "claws".

"When I wanted to go travelling, my parents were, yeah, that's fine. But there was that thought saying, look, we won't tell certain members of the family because obviously they'll be questions, you know, eyebrows raised. People probing my parents 'why you letting her do that?'. There was talk of maybe saying that work have sent me away. I'm going for work rather than going for my own leisure" (Deepika)

Participants found that while this had benefits, they were alone in their experiences should they face difficulties. They did not feel able to go to their parents for support, either because it was kept a secret from them, or because they felt they would be ashamed to protect the reputation rather than help. Participants felt that this was not the fault of their parents but rather that their parents' unsupportive behaviours reflected their fear of shame from the community and the long-term impact that can have.

[I told my mum that I had done something out of my expectations] mum was very much like 'Oh my God, what have you done? You have lowered your dad's head. Our reputation in society is going to be disgraced' and, 'I'm not going to be able to go out in public. I'm not going to be able to say 'yes, that's my daughter' very proudly. I'm not going to be able to hold my head up and say, 'I'm proud of her'. You've literally shamed me. I've made you this independent. I've given you everything that you've ever wanted in life and this is the way you repay us.' [She said she'd be] the disappointment [in community]. I remember one bit was 'you're not just ruining your future here. You're also ruining your brothers cause who's going to want to marry him when you've gone and [done that], how would people think of him and our family'" (Krishna)

2.3 Control

In order for families to avoid being shamed within the community due to a child's 'failure' to live in accordance with the sociocultural expectations, participants explained that parents would exert control within almost all areas of their lives including throughout adulthood. Control was experienced through financial, physical, social, and religious methods including dictating who participants were permitted to spend time with, often excluding family members who have previously broken expectation and brought shame to the family's reputation. Feeling as though *"[parents] can dig their claws in and control the child's behaviour."* (Laila)

Participants expressed the frequent need to obtain permission, particularly throughout childhood where it was understood as part of the umbrella of regular parenting techniques. Permission seeking became more indirect and unconscious but still necessary in adulthood but caused frustration towards their parents for not trusting their adult judgement. As participants grew, they felt able to make decisions for themselves but sought parental consent or 'blessings'.

> *"I think it's fine growing up but sometimes you, especially when you're growing up, you want a little bit more freedom. And I think when you're like closed a box and [they're] kind of saying you have to do this and you're being told that your whole life, you do tend to, not rebel, but um. You it's kind of a lot tougher when you then go into, say, higher education where you need to do everything on your own back" (Sohan)*

2.4 Punishment and Betrayal

Participants explained that the language used when describing behaviour outside of the sociocultural expectations were similar to *"crimes"* (Laila) which may emphasise the consequences they would face as a result of committing them. Laila referred to *"facing the wrath"* and *"daring to cross the elders"* highlighting the degree of punishment she may have received. Punishments included physical punishments such as *"getting slapped… hit with slippers and rolling pins", "verbally abused",* or emotional punishments. Physical punishments, while not forgotten, were discussed in a casual, light-hearted way, as though it was normalised within the population, while emotional punishments seemed to hold much longer lasting, painful memories. This included participants describing events where parents removed valued pieces of the participants lives such as not attending or allowing a daughter's wedding ceremony if they were to marry someone the parent didn't approve of. Emotional punishments also induced intense guilt, or *"disgust"* for *"betraying"* them, referring to the idea that children owe their parents for raising them through the commonly used phrase *"this is how you repay us"* (Krishna). Participants described punishments and controlling behaviours as a method to discourage behaviours even into adulthood.

> *"[Acting outside of expectation, there] will be a lot of gossiping, that's for sure. Ohh yeah, a lot of gossiping. I suppose people pick up on something and then, by the time it gets around to everybody else it's been manipulated. It's been changed to suit, whatever that person wants it to come out like. So you know it can be quite destructive. And I think in terms of the person who's it's being targeted at, it can be quite upsetting, quite hurtful, quite degrading even. It's like almost like you're an extreme case. You're sort of ostracised. You're not included in anything. You're like a pariah. (Deepika)*

3. The Hybrid Generation

As generations progress, the importance of collective community values and opinions have faded. Participants referred to the *"hybrid generation"* as the generation born in the UK to at least one immigrant parent, who grew up in a Western culture valuing independence and individuality while balancing their Indian community, who value togetherness and living in accordance with the same rules and expectations. Participants described the difficulty finding this balance between two opposing ways of living often feeling they were living a double life. This generation were raised to meet the societal norms of their Indian community but once they left and attended school or the workplace they were expected and encouraged to be individual in expressing their thoughts. This was reportedly particularly difficult for women as they were expected to be more submissive within their Indian community. This difference led to changing and challenging their current way of living to find balance and blend the two using shared values, like aiming to be a good person and striving to do your best but for yourself rather than other people's approval.

> *My grandparents were a lot more strict like about relationships for example, like a timeline that relationship has to follow, whereas my own parents are less strict with that. And I think growing up as both my parents grew up in the UK. They grew up here means that they've been exposed to different types of relationships, so when it came to like the next generation then getting to relationship, they've just started to become more open. They're not completely in the same mindset as maybe I am but they're definitely trying to not be exactly how their parents were and as strict (Divya)*

3.1 Challenging the Mould.

Participants felt there was a need to 'dismantle' the idea of reputation and the impact it has on individuals. They described this way of living as 'old fashioned' and that they can live in line with their values, unbothered by other people's opinions and assumptions of themselves. Participants felt a key challenge was their own bodily autonomy. They believed that as it is their body and their life, they should make decisions in the best interest of themselves. Despite this differing approach, participants seemed conflicted in their challenges, perhaps demonstrating the complexities of finding a balance between the cultures as mentioned later. While they felt that challenging the mould was necessary, they enjoyed the benefits of community closeness and helping one another when it was needed through the *"unspoken bond"*.

> *We're both learning to accept our parents for who they are but what we want for them is not to change who they are, but to have boundaries for themselves so people don't abuse them in the way that frustrates me... I've heard older women complain about how their mother in laws were horrible to them, but then they'll carry on treating their daughter in laws horribly. And I don't understand that, somebody needs to break it. And it's not about rebelling or anything. It's just tweaking it a little bit and just showing love and compassion for another human being. (Arya)*

3.2 Choosing

Participants spoke of an idea where the hybrid generation had to choose between their family/ community and themselves, each resulting in difficult consequences. Participants choosing family or community over themselves often reported feeling *"miserable", "neglecting"* their needs, and *"experiencing no self-love".* Whereas people choosing themselves over family felt feelings of guilt, selfishness and resentment for their parents' unsupportiveness while feeling liberated and empowered.

> *"I've now come to a place in my life where I'm doing a lot of work on myself to start it doesn't matter what people think. My family have grown up being people pleasers. And I could see from my way, my mum, she's had to like roll over, make big changes in her life changed her personality. Almost have no personality. If I can put it that way. Almost just be there. She's just there to exist. To function for other people, like to be a mom, to be a mother-in-law, or to be a daughter-in-law. She's just existing to fulfil these functions for everybody else. She's not really herself. For myself I have now realised that" (Deepika)*

Participants who accepted the consequence of isolation or distance from their parents to meet their own needs, felt they had made the right decision for themselves and showed compassion for their mental health. While this had benefits, participants explained that the attempts to blend cultures and find a balance became a permanent decision. Participants did not feel able to change their minds should they want to as it risked proving their decision to choose themselves over the community or family was *“wrong”* and would face consequences.

> *Me and my sister, two very different people in that, despite me knowing the consequences of my ‘bad’ actions, I would still choose to do it for myself... when you're pushed and pushed and pushed into a smaller and smaller box, it just makes you want to break out of it, makes me want to break the rules more. I didn't want to break the rules because I just fancied breaking the rules. I did it because I knew that if I was like locked in this forever it would just grow and grow and grow smaller and smaller and smaller and I would be more and more constrained... I thought [my parents] are never gonna come around to the idea and if I die without [doing something]. That'll be so miserable. It would be such a pointless thing to be so caught up on. Because it affects, no one and it makes me happy right now. But with my sister, there was less physical control that my parents could have on me. So I think she’s learned to sort of like fear it and never really step out of line. Ever. Even if it makes her miserable. (Laila)*

3.3 Complexity of Balance

As the hybrid generation tried to integrate their two cultures, they faced difficulty. Perhaps as they did not experience the oppression the past generations had that led to communities developing, they struggled to understand the extent of their fear of shame and need for secrets, but they were able to acknowledge the importance of it knowing how the community currently functions. Participants struggled to understand the methods of punishment but understood the purpose. They felt that reflection and teaching was more effective over *“forcing”* and *“fear”*.

> *“The way I’ve been brought up, is family means everything, treat everyone with respect but some of the things, [parents] come from the culture of traditional views and we live in a world now*

> *where, modern ways of thinking so there can be difference of thinking but it's about compromise really" (Arjun)*

They yearned for freedom in their decisions but felt guilty when choosing themselves over their family, perhaps because of the ingrained underlying belief that it is selfish to choose yourself or the understanding of the societal consequence it may have in addition suggesting a lack of respect. This theme was developed through many contradictions being present in the interviews and exploration on them.

> *At the end of the day, and I have that mum and dad love for them. Like they're my parents. Like if somebody else said anything to my parents, I'm very overly protective about them. Obviously, even I wanted to repair the relationship before the kids and like now, I guess I maintain the relationship more for my children than really for myself. Even though I say I don't trust them, I feel like I want their support. I don't need their blessing. I don't need their approval. I don't need them to care about what I'm doing in life. I just want that support. And like, I care about them. So I care if they're okay. (Jaya)*

4. Importance of Family

This theme highlighted the impact family reputation could have on individual families as well as the effectiveness of repair within those relationships.

4.1 Impact on Relationships

There were three ways reputation impacted the relationship between parent and child, endorsed by all participants. All participants mentioned challenging the existing structure of community and the way it functioned but the impact it had on relationships depended on who challenged and how it was managed by the parent.

Firstly, if the parent challenged the community rules, they may have been met with resistance, but they were able to protect their child from the negative effects of it while still educating them on its presence. Participants (the child in the relationship) were understanding of the challenges faced, but felt their parents' honesty and desire to prioritise their children significantly strengthened the relationship they had with each other. Children felt able to be honest toward their parents, they did not keep secrets, they felt their parents would support them whenever they needed, with their best interest in mind.

Should the child (the participant) challenge the function of society, it often resulted in a negative response from their parents perhaps due to fear of shame and being different. They did not support their child in choosing themselves or questioning things and publicly expressed their disapproval to protect their family reputation. This led to a negative impact on relationships.

"[I had to break up with my boyfriend and because I was a girl] they could stop me. So I had to just do it for their peace. And once I did it, the relief. Oh my God. They were just like so happy. Never mind my anguish and my pain. They didn't recognise it, didn't want to see it as long as they had saved their reputation. That was all that mattered. (Seeta)

Participants described feeling the need to distance themselves from their parents to protect their wellbeing. Parents then had the opportunity to seek repair, usually because of approval from people parents feared would shame them. If they did not, the relationship remained distant though not completely severed as they still valued the relationship. Participants would forgive as they understood the reasoning but remained deeply hurt by the outcome.

"There wasn't a lot of talk about emotion or, checking in with each other. And then I think when I got married. As I sat in the car to drive away to my new home. I saw my dad cry and that was like, the first time I was like, Oh my God. My dad's crying. Why are you crying? Does he love me? Like I

didn't know until that moment that he cared. Because it's just not something you say. It's not something you talk about. So I've made a conscious decision with my children I always say I love you or when I kiss them off goodbye. I show them love and I tell them so that they know they are love. So they don't doubt it and that they feel comfortable coming to me with anything like I didn't feel comfortable going to my parents, about anything really. Unless I actually had to cause I wasn't sure of their reaction. But I think if they showed that they were supportive and that I could go to them, I might have gone to them with a few more things." (Seeta)

Parents maintaining high levels of control throughout adulthood was described, with the impact of a maintained avoidant or anxious attachment styles. Participants explained how they felt distanced from their parents,

Yeah reputation has affected the relationship. As I said, I feel like with my parents being people pleasers. Um, they were more concerned in the community more growing up, but has had an impact on the relationships as we got older as they've been so concerned about what other people think. In every situation they've put a back foot on what their own child was feeling. And you know my opinions and feelings weren't a consideration and that's obviously affected the relationship we have now in terms of trust and communication. And general respect, you know it just. It's it? Yeah, it's just changed it, so 100% affected. (Jaya)

The long-lasting impact of reputation was described should a relationship be negatively affected, despite attempts to seek connection.

"I think it's still affects my relationship with my parents because there's lots of places where I probably should just tell them that I'm doing something that's probably not very good or why, but I've never. It told me to be a secretive child or and even a secretive adult. Rather than like an open

one, which is a shame. I don't think that's what my parents want, and it's not what I want either, but it's just the way that my brain is wired now".

Participants all vowed to adopt the hybrid generation approach to parenting in future as they felt the relationship they have with their child should be open and honest.

"The difficulty that my generation have is how our parents came from a different culture and background they had different views at that time whereas I was born in this country in a different culture but I think going forward, they next generation of kids won't have any challenges that I faced" (Arjun)

4.2 Repair

Within these findings, participants described the primary factor needed to develop and maintain a strong and secure relationship with parents following a rupture due to challenge, was the mutual seeking and acceptance of repair.

"Looking back on it. I think my mum thought their reputation was gonna be tarnished more than it actually has. People don't actually care. Disagreements can strengthen relationships if you recover from it but can damage it long-term if repair isn't made".

Participants reported that repair seeking from parents only occurred if an elder or community did not disagree with the child's challenge, seeming as though they gave the parent permission to support their child alleviating their fear of shame. Jaya stated:

"I told my dad who was the person who had the biggest, kind of, 'what will other people say' when I told other people, like my aunties, my Gran, everyone was so supportive and everybody just said

as long as you're happy, we genuinely don't care. And I think he, I could see in him the relief of everyone's acceptance."

Participants accepted their offer of repair due to their valued relationship which was in turn, strengthened. Repair also included self-healing through introspection as per Hindu practice recommendation, reflection, and therapy from participants whose parents did not seek repair.

"It's taken me over 30 years to learn how to love myself I know I'm not 100% there. [My parents are] still growing, they're still learning as people. So I'm on this journey of accepting my parents for who they are, knowing that they're human beings still growing, and learning to love them from a certain distance where it doesn't affect me too much and accept you for who you are, but I'm still learning who I am, and I need to do what I feel is best for me. I've been doing therapy. I'm being more self-aware now, it's like I don't feel any of the negativity that I did before… my inner child still is a bit like somebody love me, somebody protect me. But I'm also learning that to understand that I'm the person that is only gonna be able to love and protect myself. (Arya)

Discussion

Overview of Findings:

This study primarily aimed to understand the experiences of family reputation and the influence on parental attachments amongst Indian Hindu adults in the UK. The findings suggest that the concept of family reputation arose due to experiences of oppression, but as generations have progressed reputation no longer serves its original purpose of supporting the community but rather encourages shame, punishment, and control. Despite this, family reputation still holds high importance in the population as it is seen as a method to hold onto cultural values, separating the Indian Hindu culture and British culture. As the hybrid generation grew, questions were asked and challenges to the social norm was exhibited. This triggered the fear of shame in the previous generations, so they resisted causing ruptures and distance in the parent-child relationships. If parents did not seek repair, this distance was maintained increasing secret keeping and a lack of trust, whereas if parents sought repair, it was accepted, and the parent-child relationship strengthened. When the child in these relationships became a parent themselves, they were able to incorporate these new hybrid generation ways of thinking while still acknowledging the importance reputation once held. As such, future parent-child relationships demonstrated that of Ainsworth et al.'s (1978) secure attachment style with open, honest communication and decisions made in the child's best interest away from the opinion of others.

The results regarding gender and expectation could be considered through the lens of patriarchy and how the roles of men and women are often predetermined by society. As there was no explicit acknowledgement of the origin of these gender roles, perhaps they could be understood that a patriarchal society has administered women the responsibility of maintaining a community's values and reputation through maintaining a cared for household and teaching children the accepted and most beneficial ways of living. As such, women and mothers hold more importance in maintaining the traditional cultural norms compared to fathers. This may contextualise the finding describing the impact of reputation on a mother-daughter relationship compared to a mother-son or father's relationship with children. This may suggest maintenance of a patriarchal society with a deep and longstanding impact on the women within it as opposed to the men who are supported in progressing ideas. The finding of secrets and shame fell in line with the findings of Hirschi (1969) and Emler, (1990) who state that families can conform to the idea of 'good' behaviour while also concealing behaviour which would negatively impact their reputation as people can build their knowledge and opinion of a social group through third parties and reputation. As a result of this shame and importance of secret keeping, this paper found a theme of control from parents to participants in their parent-child relationships, often extending throughout adulthood. This theme supports the findings of Baumrind (1971) and Albert, Trommsdorff and Mishra (2007) who state that Indian parents often exhibit characteristics of Authoritarian parenting styles, which value high control and less acceptance of their children's activities. This level of control can be maintained once the child has reached adulthood. In line with this parenting style Baumrind (1971) and Jambunathan and Counselman's (2002) found that they can utilise physical punishments or threats for 'incorrect' behaviour, as expressed by participants in the theme of punishment and betrayal.

As the Hybrid generation grew, participants experiences reflected those within the SHARP Framework (Shaia, 2019). This framework highlights how healthcare services often address the consequences of oppression but ignore the oppression or its cause, implying that the difficulties experienced as a result are due to the individual. The framework dissects how oppression can impact individuals while identifying actions to minimise the systemic challenges using five themes: "Structural oppression, Historical context, Analysis of role, Reciprocity and mutuality, and Power". The structural oppression in the UK relate directly to the racism and discrimination experienced within the immigrant generation, the hybrid generation acknowledge the historical context of holding onto the culture to protect themselves from the discrimination, the hybrid generation overall chose to hold the 'disrupter' position to reduce the oppression rather than maintain the segregation between the two cultures within them. With therapy, open and honest discussion and repair, the hybrid generation are finding mutuality between the cultures through differing expertise. The generation continue to discuss challenging topics and promote change in parenting to come, allowing for active change in the future. Perhaps this space for change was possible as participants were less attached to the difficulties faced by the previous generations in racism and oppression so felt less need to hold onto to each other. This generation expressed difficulties in finding a balance in living amongst two opposing cultures as suggested by Tirone and Pedlar (2000) who stated that children born to immigrants into a conflicting culture still value their family and culture, but experience an element of conflict when attempting to balance the two cultures they were members of. In attempting to strike this balance, compromise and challenging aspects of each culture was needed demonstrating Emler's (1990) finding which suggests a possibility that not all individuals of a group entirely align themselves with the values of the group thus causing blurred lines and mixed definitions as cultural communities develop.

As a result of these experiences, participants described how they impacted the relationship they had with their parents. This theme falls in line with the impact of Bowlby (1977) and Ainsworth's (1982,1989) Attachment Theory. Kobak and Sceery (1988) found that those with secure attachments viewed their parents as available and supportive during distressing events, comparable to the parent-child relationships identified when parents challenge the societal norm. Those with an avoidant attachment style noted rejection and absence of love from their parents' causing feelings of isolation in their relationships and lower levels of family support, similar to those participants who challenged the norm and were not supported by their parents. The findings of this research also support Kobak and Sceery's (1988) hypothesis that the high levels of control by authoritarian parents into adulthood could suggest that anxious or avoidant attachment styles will be maintained between child and caregiver throughout life. Despite the negative effect the pressure to be perfect has on parental relationships ruptures are not permanent issues but the way they are managed will affect the attachment between the two parties (Diamond et al., 2016). This paper describes the experiences of repair seeking and self-healing and how they helped participants to repair and strengthen their parental relationship, or cope with a disrupted relationship following a rupture.

Limitations:

The number of interviews allowed for data saturation to be reached using theoretical sampling, and participants were well distributed across the desired age range for the study. However all but two participants were female and therefore, given the gender differences that arose, may not have accurately described the Indian Hindu experiences. In light of this, it allowed the sample to be more homogenous. In addition, the male participants were from similar areas in the UK meaning the development and growth of communities may have been specific to the opportunities of the area. The male participants who were recruited shared their experiences of how for them, family reputation did not negatively impact their relationship with their family as it did for the female participants. Through the exploration of gender differences this may be due to the differing pressures placed on each gender mentioned by all participants particularly due to the patriarchal structure of society, female participants felt it was more important to share their stories because of the greater impact it had on them. Due to this finding being shared amongst all participants of varying backgrounds and experiences, future research may consider collecting data primarily from males within this culture from different areas of the UK.

Participants volunteered for this study if they expressed interest and could spare the time. Their interest could be caused by negative experiences they have faced because of the topic area creating space for noticing difference and difficulty, reflection, and cause for change. As such they may have felt the want or need to contribute their anonymous experiences to the data to bring awareness to the challenges they were facing, often alone, in a community who did not allow the space for these discussions or developments or punished those who did. Future research may consider alternative methods of sampling such as systematic to increase the possibility of an unbiased sample.

Questions were raised during recruitment and interviews about the focus of the research on an Indian Hindu population only. This opened discussions in the comments of the post explaining how other religious communities within India and surrounding South Asian countries share similar experiences of family reputation and its impact on parental attachment. Throughout the interviews religion and Hinduism was not mentioned explicitly, aside from one participant. Ideas originating from religion such as introspection and respect were described but not linked to religion itself. Rather than religion shaping experiences independently, it was described as a contributing factor in creating communities of shared values and experiences. While the focus of this study was on one religious and cultural group to allow for homogeneity in the sample as well as increased accessibility to participants, further research into the experiences of other cultural and religious groups should be conducted to identify whether religion contributes to the impact of family reputation as well as identifying shared experiences between religious groups.

Finally, participants were aware that the researcher was an Indian Hindu female which occasionally proved useful in proving participants comfort in sharing their experiences, may also have limited the richness of results. While the researcher ensured definitions and experiences were the participants own, explaining that 'obvious sounding' questions were asked to allow them opportunity to clarify their understandings without the researchers bias or influence, there may have been times where nuanced experiences of being an Indian Hindu were not further explored due to presumed and unspoken mutual understanding. This meant that topics discussed around the meaning and personal significance of specific events and cultural experiences could have been explored in greater detail, adding to the richness of the data.

Implications:

While literature around reputation, social identity and attachment is well established and growing, the experiences of Indian Hindu's as well as the interconnection between the concepts within this culture has been underrepresented. This study has highlighted the experience and importance of reputation within the Indian Hindu population as well as the impact it can have on the attachment between parent and child to enable clinicians increased understanding of the culture when faced with it in healthcare settings.

This research found that racism, discrimination, and oppression had a direct influence on the construction of family reputation then impacting parental attachment. As identified, the experiences of racism within the UK toward Indian Hindu groups continues through microaggressions as opposed to overt racism. While the research may shed light in the negative impact reputation can have within the target population allowing for further reflection and future change from those within it, the catalyst of racism remains. Participants explained how, due to their negative experiences of family reputation on their parental attachment, they hoped to parent their children using a balance between cultures, allowing for individuality, expression of needs and boundaries, and honesty. However, the role racism played in creating a need for perfection which developed into shame, secrets, control, and punishment remains, perhaps this may pose a barrier to the hybrid generation alleviating these pressures and changing their parenting techniques for future generations.

At present, the mental health model used in the UK is not tailored for people in ethnically minoritised groups. There is an emphasis on individuality and autonomous recovery leading to people from these backgrounds to feel 'othered' (Tarlier et al., 2007 p.140) with their specific needs being inadequately met (Fuchsia-Howard et al., 2014). Increasing clinicians' knowledge and understanding of the importance of valued constructs such as family reputation and the beliefs a clients support network hold can help identify culturally appropriate interventions and support. The use of families and systemic therapies are primarily used as a secondary source of support for individuals in mental health services. This study found a great emphasis on the importance of family and the impact family can have on decision making and shaping individual values therefore it should be equally important for services and healthcare professionals to understand this. As such, it is vital to integrate this importance into Indian Hindu mental health support space for families to understand the experiences of the individual, how they can adapt to better support them and cultural barriers they may face while still holding onto the meaningful cultural values of their community. Findings may also help to form an understanding whereby clinicians can recognise and acknowledge the nature of service users' relationships following non-Western societal norms, and how it may influence their interactions with their family and healthcare workers within a Western country.

Currently there is a distrust and lack of understanding towards mental health services from people within ethnically minoritised communities. While therapy and support from mental health services have been considered by the hybrid generation to overcome the emotional distress caused by challenge and change, they did not always feel that mental health services would understand their experience and therefore be unable to adequately support them. It is important for clinicians wanting to work with this client group to increase their cultural humility and educate themselves on the impact of cultural experiences within the group. This is especially important to ensure understanding without retraumatising individuals by asking them to recall and relive their experience in great detail, perhaps inciting feelings of invalidation due to a lack of cultural understanding by the clinician. Additionally, increased awareness of the services available using social media, charity, and community/religious websites and pages to inform the Indian Hindu population of services and how to access them.

As participants spoke about shame and control from family and community which silenced them into suffering alone, there is a need for support groups led by Indian Hindu clinicians for Indian Hindu people who have experienced isolation because of challenging the social norm and negatively impacting their family reputation. Having a space where people can meet others who have shared social and cultural experiences can act as a source of support that is needed when repair within family's isn't available. Increasing knowledge of shared experiences to reduce feelings of isolation may also be continued within the community through open conversations and continuous conversation of finding and experimenting the balance between Indian Hindu and British cultures along with the difficulties faced as a result. An increase in Indian Hindu clinicians working in the mental health field would also provide greater access and to this client group. This has been supported by Health Education England's (HEE) initiative to improve equity and inclusion for accessing psychological professional training within the NHS Long Term Plan, Mental Health Implementation Plan. HEE has provided funding to every clinical psychology training course in England to allow for development of mentoring schemes for ethnically minoritised trainees and applicants for the course, in addition to commissioning a 60% expansion for places on Clinical Psychology Doctoral courses (HEE, 2021a, 2021b; NHS England, 2019). However, presently clinicians of ethnically minoritised backgrounds face cultural barriers such as racism when working in the NHS. This may include disparities in the number of ethnically minoritised professionals facing disciplinary procedures and reduced access to career opportunities and equal treatment within the workplace (Iacobucci, 2023). To combat this, HEE have implemented a number of initiatives such as increased training in cultural humility, development of an Equality, Diversity and Inclusion committee (Health Education England, 2022), necessary reporting on Workforce Race Equality Standard metrics within a system with protected time to act as agents of change, implementing cultural safeguards, discussion and development of personal objective in addressing race inequalities within personal development reviews, and organizational expression of lived experiences of staff members with protected characteristics to shed light on experiences of discriminations and safety (NHS England, n.d.).

Conclusions

Despite the sociocultural discouragement in discussing family reputation and its impact on parental attachment, each participant was able to share their experiences whether positive, negative, or somewhere in between. They were able to discuss their personal developments as a result of reflection in the area as well as any changes by their family in how they conform to the unspoken rules of community. The study highlighted the current community expectations, how they came about and how they have developed as time progressed. The study identified the impact these expectations have had on individuals and how those born into a hybrid generation are questioning the expectations, adapting their behaviour to balance cultures and the pushback or support they have received as a result. The study also found how the response of the parent regarding the community expectations and challenge of them, reshaped their relationship with their children causing a strengthening of relationship through support and repair, or distancing due to a lack of trust and meeting their child's needs. Further research into the male experience within the UK and alternative cultural and religious groups experiences of family reputation and parental attachment should be considered, perhaps utilising a systematic recruitment methodology.

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Part Three: Appendices

Appendix A: Reflective statement

Deciding the focus of the research:

Being a female from an Indian Hindu background who had experienced the negative impact family reputation can have on parental relationships was a primary motivator for choosing this area of research. I felt I had a passion and drive for creating space for discussion of 'taboo' subjects to shed light on the impacts within the community as well as to provide an element of validation to those who wanted to share their experiences knowing they were not isolated in them. When deciding the research topic, I was overcome by this passion and drive and may not have considered the weight it could hold on my shoulders. At this point in the research, I had not yet come to terms with the impact family reputation and perfectionism had on myself nor had I considered my values within that. I was only aware of the necessary space I was providing for other people, around my age, to discuss this taboo topic openly and without judgement for likely, the first time.

Recruitment process:

I had prepared myself for a difficult start to recruitment to due previous difficulties in undergraduate research with a similar population however I was surprised when so many people expressed interest through volunteering but also starting discussions about the research topic in the comments of my post. I was overjoyed at the thought of exceeding my target sample size and the enthusiasm that was shown to discuss a topic "that affects all Indians" and where discussion around it was "much needed". Being an Indian of Hindu background myself, I found participants to be more open to discussing the difficulties family reputation can bring on mental health and social relationships, with participants often assuming that I was familiar with these difficulties myself expressing feelings of validation and normalisation of taboo subjects, particularly those around gender differences and expectations. I remember participants thanking me following the interviews for providing them the space to share their experiences where they haven't felt able to before, and for choosing this topic to research as in their eyes, it would shed light on a longstanding issue that needs changing within the communities.

As time progressed and more interviews were completed, I reflected more on my experiences of family reputation and the effect it had on me. There were some aspects that I was aware of since childhood in that I was a member of the hybrid generation but my mum, as someone born in the UK herself, had already started challenging some societal expectations. On the other hand, my dad's family were refugees from Uganda. As they involuntarily migrated and were not able to bring their belongings, they placed much more value on community closeness and therefore expectations within the community and rigidity in the societal rules. As I was closer to my dad's side growing up due to family of similar ages to myself, I was more exposed to the importance of fulfilling the expectations. Alongside this, myself and my sister were the only young girls in the family. As such we were able to notice much greater difference in gender expectations and held much more responsibility in fulfilling them or facing negative consequences if not, as expressed by threats of negative consequences and fear. As a result, having reflected throughout the interviews, I realised I no longer had boundaries for myself and lived to please others while bottling up emotions that were frowned upon. Following this realisation, during the recruitment process, I had decided to begin implementing my own boundaries and expressing my needs while attempting to balance respect as a form of self-repair thus placing my experience in line with the hybrid generation that challenged the structure. I found that I felt stuck when discussing experiences that were not in line with my own, though they were uncommon. Discussions felt unnatural and forced. Participant experiences that were in line with my own were easier to explore with additional questions and statements explaining that I wanted to understand their experiences without my own assumptions and biases. However, I felt that the stage of challenge that participants were in, brought up emotions for myself that had previously been bottled up. Due to my own discomfort particularly when hearing participants describe my own story, when they expressed distress, I would often ask if they would like to come back to that topic later. I believe I was able to interpret the emotion and prescribe meaning to them adequately though most participants acknowledged that the research area is a difficult topic with this being the first opportunity they could address their own experiences of it, therefore pushing through the distress was a necessary step in the process.

With this new position I had found, I noticed myself feeling less excitement following interviews and more disheartened, questioning whether I wanted to be in this position. Participants all shared how family reputation had negatively impacted their relationship with their parents following challenge. Participants who described resorting to self-repair felt disconnected to their past experiences and solely focussed on the future, avoiding any negative thoughts they had, while others described acceptance of the new distance and caution between themselves and their parents. I questioned whether this was what I wanted and where I stood in relation to them. Did I want to forget and avoid the experiences that shaped who I am, or was I willing to lose the relationship I had with my parents? Due to the influx of emotions that often arose, I resorted to bottling them up again to maintain professionalism. I do wonder how much emotion I was able to convey because of this. I felt able to use my therapeutic skills to show active listening, validation, and empathy though without addressing my own emotions during the interviews, I wonder how effective participants found it.

Data analysis and the write up:

Once I had got to grips with the grounded theory analysis method, I found this to be much easier than expected. I felt there were so many varying experiences during the data collection that I did not feel developing a theory was possible, however as interviews progressed, more and more fell in line with existing experiences. I felt particularly stuck in incorporating data describing a lack of influence of family reputation in their lives and the positive effect it had on the relationship with their parents. It was almost a lightbulb moment when I realised that their parents had all challenged the norm themselves. It was difficult reading and re-reading experiences similar to my own, along with the recurrent thought that respected elders and community members could read this research and deem it to be a great public challenge and criticism of the community. Despite this, I felt compelled and motivated to share participants stories accurately and inclusive of all experiences due to the interest and enthusiasm I had received through recruitment.

SLR:

Initially choosing my research topic was challenging until my sister received an unexpected diagnosis of ADHD. I noticed the stigma and fear this diagnosis brought in my family and the conflicting conversations between myself, advocating for normalising mental health diagnoses, and my parents' fearing judgement from the community due to a lack of understanding. I chose to focus on mental health diagnoses excluding neurodiversity as I had lost an uncle recently who suffered from bipolar disorder. During his life I observed shame, stigma and ostracisation but following his passing, contradicting ideas about the extent of support they showed towards him and how they shared each other's company regularly. I wondered, due to these overpowering and conflicting ideas alongside a lack of understanding from people without a diagnosis, how stigma really was experienced in minoritised groups by those who have a diagnosis. In this way, I felt closer to the research and the experiences of those with a mental health diagnosis within minoritised communities. I found that the systematic literature review became the comfortable piece of work I could return to when I was struggling with motivation elsewhere. Additionally, I felt that it aligned with my epistemological position in that I was constructing meaning of having a mental health diagnosis as an ethnically minoritised individual based on their subjective experiences. I enjoyed reading the literature and understanding it's recurring themes as not only did it align with my thoughts and experiences, but I was also able to find and understand reasons behind the existing stigma and other ways in which stigma is experienced that I had not previously considered. I found this research extremely interesting and am excited to see the positive changes it may bring in enlightening people without a diagnosis on their impact on those with a mental health diagnosis and creating a safe space for them to live.

Overall, the process of conducting this research has brought personal challenges but has been incredibly rewarding. I hoped to shed light on how social constructs such as family reputation and stigma can change as time and generations progress, but that adapting and evolving these constructs to better suit the people they are applied to is not something that should be feared due to unfamiliarity. I have felt that the stories told by participants reflect the personal story I have begun on my research journey and am hopeful to see change not only in my life but in the community and generations to come. I was initially overwhelmed by the emotions that resurfaced during the data collection and the punishment I may face as a result of it, doubting whether it was the right decision, but over time I became more confident in my work and the positive impact it may have along with the importance it held for my participants in sharing their experience in the hopes for future change. This experience has reshaped my values and self-confidence which I have grown from and will continue in my professional and personal life.

Appendix B: Epistemological statement

Ensuring the researchers epistemological position aligns with the methodology and data analysis of qualitative researchers enables continuous reflection and ability to engage with the research (Bracken, 2010). It is particularly important throughput qualitative research due to its impact on interpretation of data (Willig, 2001, 2013).

Within qualitative research, positivist or constructivist epistemological positions are often chosen. Positivism assumes that the truth is objective and can be observed through correlations. As this research focussed on exploring the experiences of family reputation and parental attachment, a constructivist epistemological position was chosen. This approach gathered information from the participants perspective to co-construct a framework based on truths allowing for the influence of culture, religion, and time. This allowed for greater understanding and descriptions of the topic area on the basis that reality is subjective and socially constructed. Therefore, a social constructivist epistemological position and a relativist ontological position was adopted by the researcher.

The construction of family reputation was considered within immigrant families integrating into westernised cultural norms. General findings discussed how imagery of immigrant families held polarising views of cohesion, the positive stance of close, supportive communities, or threatening, preventing individuality of families and integration (Peltola, 2016) in an attempt to display themselves as respected, accepted in the wider community and functioning within it (Finch, 2007; Peltola, 2016). The socially constructed idea of reputation is maintained through communication about others (Emler and Fisher, 1981) making it vital to protect individual family reputation. The negative impact of this is that help seeking is often avoided to minimise the thought that a family is not well integrated to the community to effectively collaborate with them to tackle the problem (Chadda & Deb, 2013) thus constructing the concept of stigma. The use of language and communication maintains this discourse and creates a concept community considers as ‘truth’. This ‘truth’ holds power in that it prevents individuals and families from acknowledging difficulties and seeking help to remedy them thus creating a vicious cycle of increased negative opinions towards help-seeking and increased psychological distress (Gupta et al., 2011).

The power of language in influencing behaviour caused the researcher to reflect on the power of their interpretations and understanding of the data collected and the impact it may have on readers of the research. A grounded theory analysis was chosen due to its appropriateness in relation to the research question as well as it's alignment with the researchers epistemological and ontological positions. As such, acknowledging language and potential bias in interpretations was crucial in this analysis method as the coding and categorising process became interpretive in itself. Charmaz's methodology of grounded theory was adopted throughout and within that, Charmaz (2012) stated that codes and categories should be constructed based in data that "strikes" the researcher as most important. Taking this into account, further acknowledgment should be given to the fact that interpretive analyses are therefore likely to be impacted by the researchers own lens through their experiences of religion, culture, and society as well as reading and research prior to conducting data collection and exposure to the population's generalised experiences of the topic area, as expected with a constructivist approach.

In conclusion, a social constructivist epistemological position was taken with a relativist ontological stance throughout the process attending particularly to construction of meaning, language used, and impact on interpretations. The results of the research and the theory developed were understood through the co-construction of meaning and experiences across participants through the cultural, religious, and social lens of all involved.

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Appendix C: Submission guidelines for 'Advancements in Mental Health' journal

Preparing Your Paper

Structure

Your paper should be compiled in the following order: title page; abstract; keywords; main text introduction, materials and methods, results, discussion; acknowledgments; declaration of interest statement; references; appendices (as appropriate); table(s) with caption(s) (on individual pages); figures; figure captions (as a list).

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References can be in any style or format, so long as a consistent scholarly citation format is applied. Author name(s), journal or book title, article or chapter title, year of publication, volume and issue (where appropriate) and page numbers are essential. All bibliographic entries must contain a corresponding in-text citation. The addition of DOI (Digital Object Identifier) numbers is recommended but not essential.

The journal reference style will be applied to the paper post-acceptance by Taylor & Francis.

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Should contain a structured abstract of 200 words.

- Objective: a clear statement of the primary purpose of the article, research question or hypothesis of the study.
- Method: a brief overview of the methodology. If a review article, this should describe how the literature was searched and articles identified. For research articles this should include study design, setting, study dates, information on participants (number, how selected) and if applicable the main measures employed in the study.
- Results: the key findings need to be summarised; and
- Discussion: implications of the study for practice, theory and/or research.

Read tips on writing your abstract.

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Between 4 and 6 keywords. Read making your article more discoverable, including information on choosing a title and search engine optimization.

Funding details. Please supply all details required by your funding and grant-awarding bodies as follows:

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This work was supported by the [Funding Agency #1] under Grant [number xxxx]; [Funding Agency #2] under Grant [number xxxx]; and [Funding Agency #3] under Grant [number xxxx].

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Appendix D: Systematic Literature Review: Quality Checklist example

Study identification: Include author, title, reference, year of publication		
Guidance topic:	**Key research question/aim:**	
Checklist completed by:		
Theoretical approach		
1. Is a qualitative approach appropriate? For example: • Does the research question seek to understand processes or structures, or illuminate subjective experiences or meanings? • Could a quantitative approach better have addressed the research question?	Appropriate Inappropriate Not sure	Comments:
2. Is the study clear in what it seeks to do? For example: • Is the purpose of the study discussed – aims/objectives/research question/s? • Is there adequate/appropriate reference to the literature? • Are underpinning values/assumptions/theory discussed?	Clear Unclear Mixed	Comments:
Study design		
3. How defensible/rigorous is the research design/methodology? For example: • Is the design appropriate to the research question? • Is a rationale given for using a qualitative approach? • Are there clear accounts of the rationale/justification for the sampling, data collection and data analysis techniques used? • Is the selection of cases/sampling strategy theoretically justified?	Defensible Indefensible Not sure	Comments:
Data collection		
4. How well was the data collection carried out? For example: • Are the data collection methods clearly described? • Were the appropriate data collected to address the research question? • Was the data collection and record keeping systematic?	Appropriately Inappropriately Not sure/inadequately reported	Comments:
Trustworthiness		

5. Is the role of the researcher clearly described? For example: • Has the relationship between the researcher and the participants been adequately considered? • Does the paper describe how the research was explained and presented to the participants?	Clearly described Unclear Not described	Comments:
6. Is the context clearly described? For example: • Are the characteristics of the participants and settings clearly defined? • Were observations made in a sufficient variety of circumstances • Was context bias considered	Clear Unclear Not sure	Comments:
7. Were the methods reliable? For example: • Was data collected by more than 1 method? no • Is there justification for triangulation, or for not triangulating? • Do the methods investigate what they claim to?	Reliable Unreliable Not sure	Comments:
Analysis		
8. Is the data analysis sufficiently rigorous? For example: • Is the procedure explicit – i.e. is it clear how the data was analysed to arrive at the results? • How systematic is the analysis, is the procedure reliable/dependable? • Is it clear how the themes and concepts were derived from the data?	Rigorous Not rigorous Not sure/not reported	Comments:
9. Is the data 'rich'? For example: • How well are the contexts of the data described? • Has the diversity of perspective and content been explored? • How well has the detail and depth been demonstrated? • Are responses compared and contrasted across groups/sites?	Rich Poor Not sure/not reported	Comments:

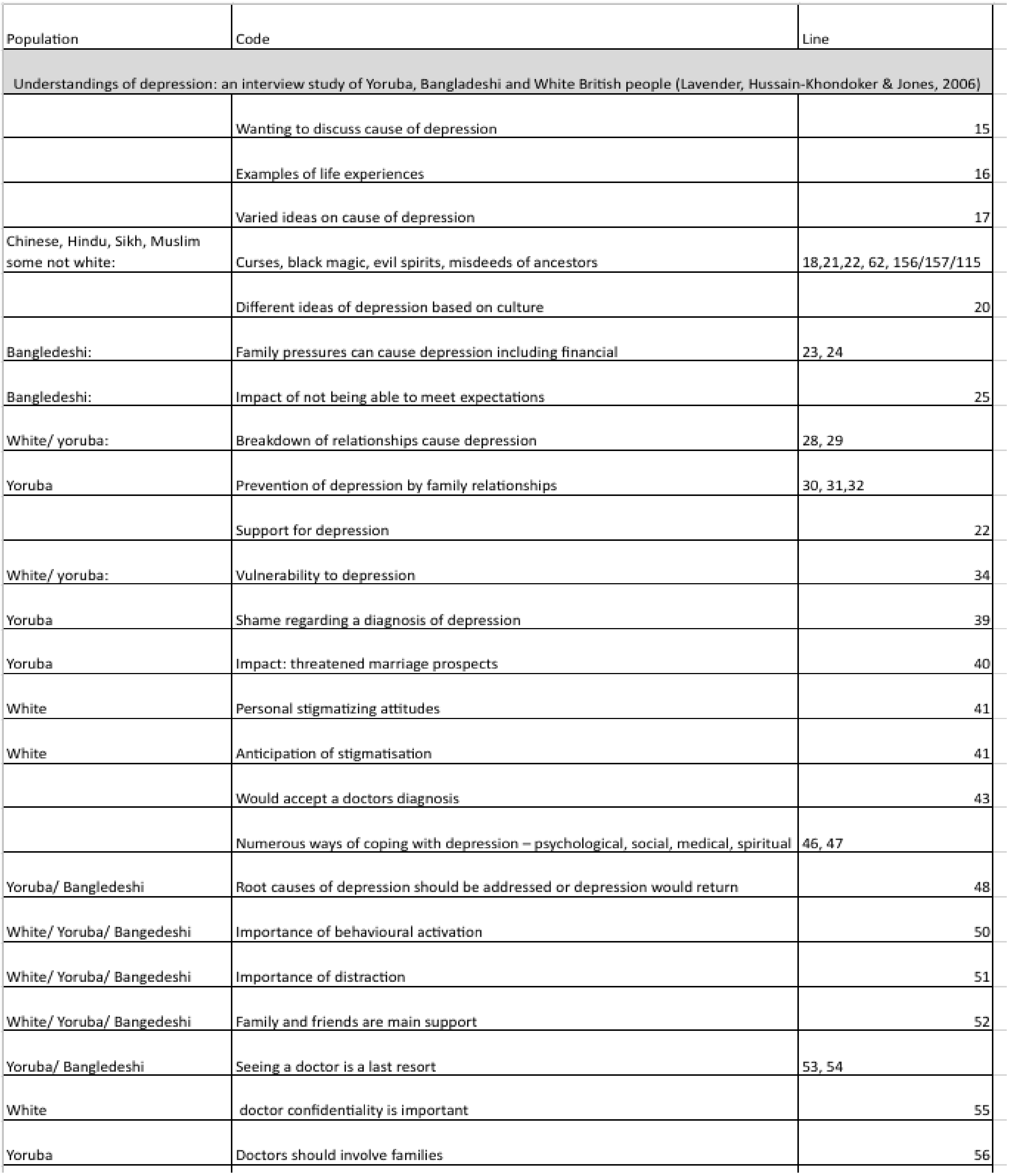
10. Is the analysis reliable? For example: • Did more than 1 researcher theme and code transcripts/data? • If so, how were differences resolved? • Did participants feed back on the transcripts/data if possible and relevant? • Were negative/discrepant results addressed or ignored?	Reliable Unreliable Not sure/not reported	Comments:
11. Are the findings convincing? For example: • Are the findings clearly presented? • Are the findings internally coherent? • Are extracts from the original data included? • Are the data appropriately referenced? • Is the reporting clear and coherent?	Convincing Not convincing Not sure	Comments:
12. Are the findings relevant to the aims of the study?	Relevant Irrelevant Partially relevant	Comments:
13. Conclusions For example: • How clear are the links between data, interpretation and conclusions? • Are the conclusions plausible and coherent? • Have alternative explanations been explored and discounted? • Does this enhance understanding of the research topic? • Are the implications of the research clearly defined? **Is there adequate discussion of any limitations encountered?**	Adequate Inadequate Not sure	Comments:
Ethics		
14. How clear and coherent is the reporting of ethics? For example: • Have ethical issues been taken into consideration? • Are they adequately discussed e.g. do they address consent and anonymity? • Have the consequences of the research been considered i.e. raising expectations, changing behaviour? • Was the study approved by an ethics committee?	Appropriate Inappropriate Not sure/not reported	Comments:
Additional Question (CEBM)		

15. Are the finding transferable to other clinical settings? What should I look for: • What should I look for? Where do I find the information? This may not be applicable to all studies using qualitative methods (e.g. exploratory, pilot studies). However, research using maximum variation sampling and particularly theoretical sampling needs to demonstrate that the findings are transferable to other settings. E.g. A study aims to explore experiences of breathlessness in COPD and a true theoretical/ maximum variation sample has been recruited then the findings are transferrable to other clinical settings with a similar context, E.g. includes a range of illness experiences, age, gender, socio-economic background, illness severity. However if the sample includes only white, middle class men in their 50's, then this is not maximum variation sampling and cannot be transferred to other settings. Where would I find the information: • Check the sampling information in the Methods section. Then compare the sampling strategy mentioned with the actual participant sample recruited in the Findings section. Did the authors recruit the sample they set out to recruit? • In the Discussion/Conclusion section check whether the authors discuss the transferability of the findings. If not check if the authors have outlined whether the findings are limited to a particular context as part of the limitations of the study. • True theoretical sampling as described in Grounded Theory Methodology is guided by emerging themes during constant comparative analysis. This is particular to this methodology so does not apply to all other qualitative methodologies. If this methodology is used, steps to illustrate how theoretical sampling has been followed in the research process should be described throughout the Methods section.	Yes No Unclear	Comments:
Overall assessment		
As far as can be ascertained from the paper, how well was the study conducted? (see guidance notes)	++ + –	Comments:

Appendix E: Systematic Literature Review: Quality Assessment Table

Research paper	Checklist item															Score
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	
Matthews et al. (2006)	Appropriate	Mixed	Defensible	Appropriate	Not described	Not sure	Not sure	Rigorous	Poor	Reliable	Convincing	Relevant	Adequate	Not reported	Transferrable	++
Conner et al. (2010)	Appropriate	Mixed	Defensible	Appropriate	Clearly described	Clear	Unreliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not sure	Transferrable	++
Black et al. (2011)	Appropriate	Clear	Defensible	Appropriate	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not sure	Transferrable	++
Alvidrez et al. (2008)	Appropriate	Clear	Not sure	Appropriate	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	Transferrable	++
Mantovani et al. (2017)	Appropriate	Clear	Defensible	Appropriate	Not described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	Transferrable	++
Dejman et al. (2010)	Appropriate	Clear	Defensible	Appropriate	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	Transferrable	++
Wagstaff et al. (2018)	Appropriate	Clear	Not sure	Appropriate	Clearly described	Clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Appropriate	Transferrable	++
Bernstein et al. (2008)	Not sure	Clear	Not sure	Appropriate	Not described	Clear	Reliable	Rigorous	Not sure	Reliable	Convincing	Relevant	Adequate	Appropriate	Transferrable	++
Campbell & Mowbray (2016)	Appropriate	Clear	Defensible	Appropriate	Not described	clear	Reliable	Rigorous	Rich	Reliable	Convincing	Relevant	Adequate	Not reported	Transferrable	++
Knifton (2012)	appropriate	Clear	Defensible	Inadequately reported	Clearly described	Clear	Reliable	Rigorous	Poor	Reliable	Not sure	Relevant	Inadequate	Not reported	Transferrable	+
(Lavender et al., 2006)	Appropriate	Clear	Defensible	Appropriate	Unclear	Clear	Reliable	Rigorous	Rich	Not sure	Convincing	Relevant	Adequate	Not reported	Transferrable	++

Appendix F: Systematic Literature Review: Example of line-by-line Thematic Synthesis coding for Lavender et al.'s (2006) study.



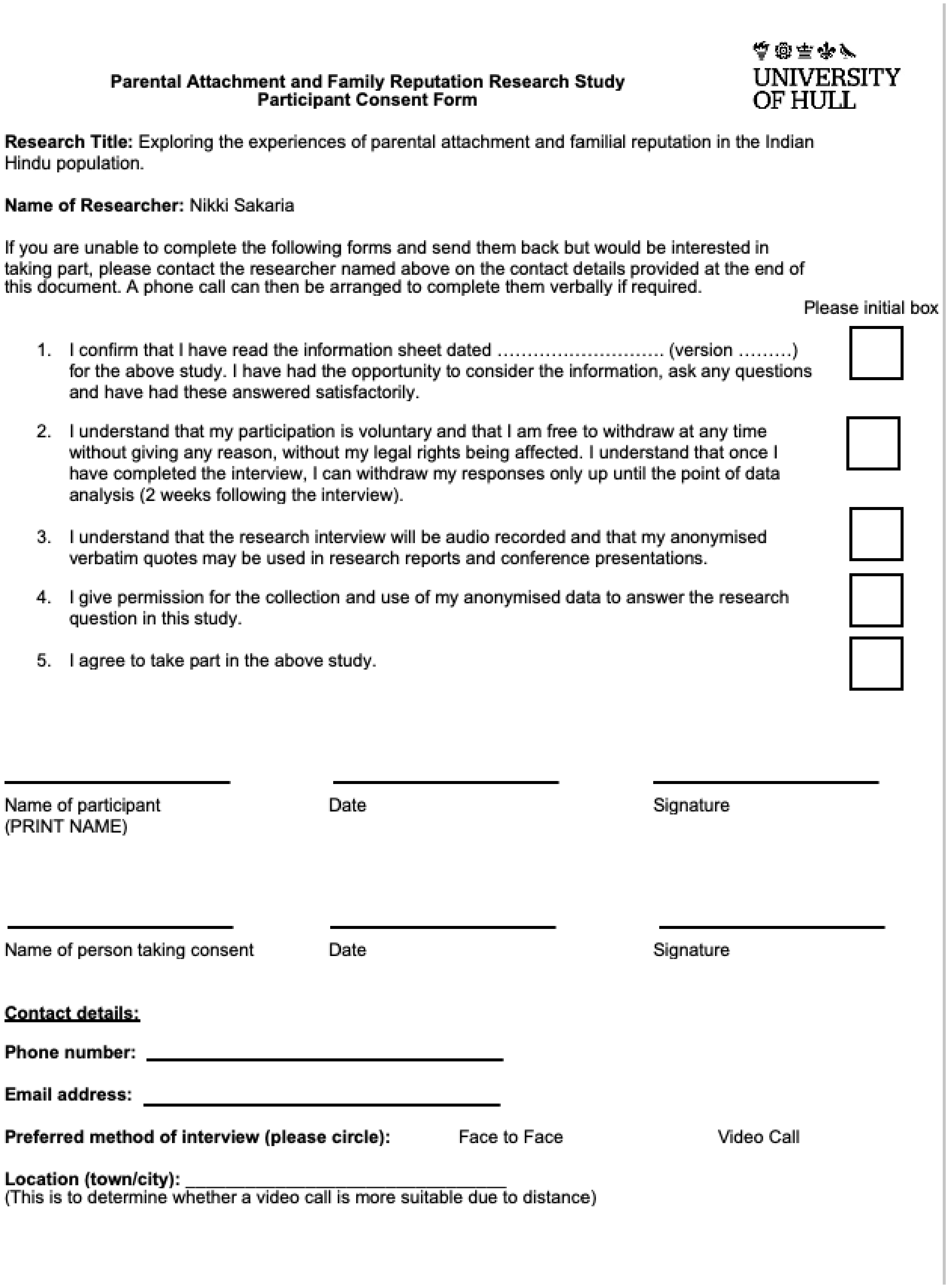
Population	Code	Line
Understandings of depression: an interview study of Yoruba, Bangladeshi and White British people (Lavender, Hussain-Khondoker & Jones, 2006)		
	Wanting to discuss cause of depression	15
	Examples of life experiences	16
	Varied ideas on cause of depression	17
Chinese, Hindu, Sikh, Muslim some not white:	Curses, black magic, evil spirits, misdeeds of ancestors	18,21,22, 62, 156/157/115
	Different ideas of depression based on culture	20
Bangledeshi:	Family pressures can cause depression including financial	23, 24
Bangledeshi:	Impact of not being able to meet expectations	25
White/ yoruba:	Breakdown of relationships cause depression	28, 29
Yoruba	Prevention of depression by family relationships	30, 31,32
	Support for depression	22
White/ yoruba:	Vulnerability to depression	34
Yoruba	Shame regarding a diagnosis of depression	39
Yoruba	Impact: threatened marriage prospects	40
White	Personal stigmatizing attitudes	41
White	Anticipation of stigmatisation	41
	Would accept a doctors diagnosis	43
	Numerous ways of coping with depression – psychological, social, medical, spiritual	46, 47
Yoruba/ Bangledeshi	Root causes of depression should be addressed or depression would return	48
White/ Yoruba/ Bangedeshi	Importance of behavioural activation	50
White/ Yoruba/ Bangedeshi	Importance of distraction	51
White/ Yoruba/ Bangedeshi	Family and friends are main support	52
Yoruba/ Bangledeshi	Seeing a doctor is a last resort	53, 54
White	doctor confidentiality is important	55
Yoruba	Doctors should involve families	56

Appendix G: Systematic Literature Review: Example of derived subthemes from Knifton's (2012) study

🟧		more severe and enduring mental health problems mentioned rather than more common conditions such as anxiety and depression	104	(Knifton)
🟧		Anxiety/ depression more normalised so seen as social over mental health problem	107	(Knifton)
🟧		not differentiate 'severe' conditions such as schizophrenia or bipolar illness and more commonly view them as 'just madness'	109	(Knifton)
🟨		Mental health conditions are a major issue	110	(Knifton)
🟨		Mental health problems are frequently and heavily stigmatised	111	(Knifton)
🟨		Stigma takes many forms e.g. underlying cultural and religious beliefs about causes	112	(Knifton)
🟪		explanations framed mental health problems in the context of blame e.g. punishment from god for a sin	113	(Knifton)
🟨		explanations framed mental health problems in the context of blame e.g. punishment from god for a sin	113	(Knifton)
🟩	Hindu, Sikh, Muslim	Mental illness is inherited through family's	116	(Knifton)
🟦	Hindu, Sikh, Muslim	Mental health taints the person and the family within the community	117	(Knifton)
🟦		Maintaining family reputation could lead to hiding the problem	121	(Knifton)
🟦		Maintaining family reputation could lead to isolation for the people affected	122	(Knifton)
🟦		intelligent, unable to work effectively, and unsuitable as a marriage partner (affect social identity)	124	(Knifton)
🟪		beliefs that severe mental illness is incurable	127	(Knifton)
🟨		Shame emerged as most common response to mental health problems	129	(Knifton)
🟨		findings about beliefs and stigma have been identified in previous international cross-cultural studies	131	(Knifton)
🟧		concepts of mental health may not be culturally constructed as ill-ness	133	(Knifton)
🟨		religious and cultural beliefs still lead to shame and blame	138	(Knifton)
🟨		Shame reduces mental illness help seeking	149	(Knifton)
🟨		Shame expereinced by families reducing help seeking	151	(Knifton)
🟥		Older and first-generation Belief that help from services would not be effectove (recovry pessimism)	153	(Knifton)
🟪		social, religious and medical explanations which, again, supports wider international findings on cultural beliefs and stigma	159	(Knifton)
🟨		social, religious and medical explanations which, again, supports wider international findings on cultural beliefs and stigma	159	(Knifton)
🟢	China, Hong Kong	Traditional treatments over medical help seeking common	163	(Knifton)
🟢		Social treatments e.g. family will help cure	166	(Knifton)
🟥		Interpreters bring issues of confidentiality	171	(Knifton)
🟥		Interpreters may not convey feelings and emotions accurately	172	(Knifton)

🟧	Comparing beliefs about MHD
🟨	Experiences of Mental Health Stigma
🟪	Understanding of MHD
🟩	Causes of MHD
🟦	Impact of MHD
🟥	GM views on help seeking for MHD
🟢	Treatments for MHD

Appendix H: Consent Form for participants



UNIVERSITY OF HULL

Parental Attachment and Family Reputation Research Study
Participant Consent Form

Research Title: Exploring the experiences of parental attachment and familial reputation in the Indian Hindu population.

Name of Researcher: Nikki Sakaria

If you are unable to complete the following forms and send them back but would be interested in taking part, please contact the researcher named above on the contact details provided at the end of this document. A phone call can then be arranged to complete them verbally if required.

Please initial box

1. I confirm that I have read the information sheet dated ………………………. (version ………) for the above study. I have had the opportunity to consider the information, ask any questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights being affected. I understand that once I have completed the interview, I can withdraw my responses only up until the point of data analysis (2 weeks following the interview). ☐
3. I understand that the research interview will be audio recorded and that my anonymised verbatim quotes may be used in research reports and conference presentations. ☐
4. I give permission for the collection and use of my anonymised data to answer the research question in this study. ☐
5. I agree to take part in the above study. ☐

____________________	____________________	____________________
Name of participant (PRINT NAME)	Date	Signature
____________________	____________________	____________________
Name of person taking consent	Date	Signature

Contact details:

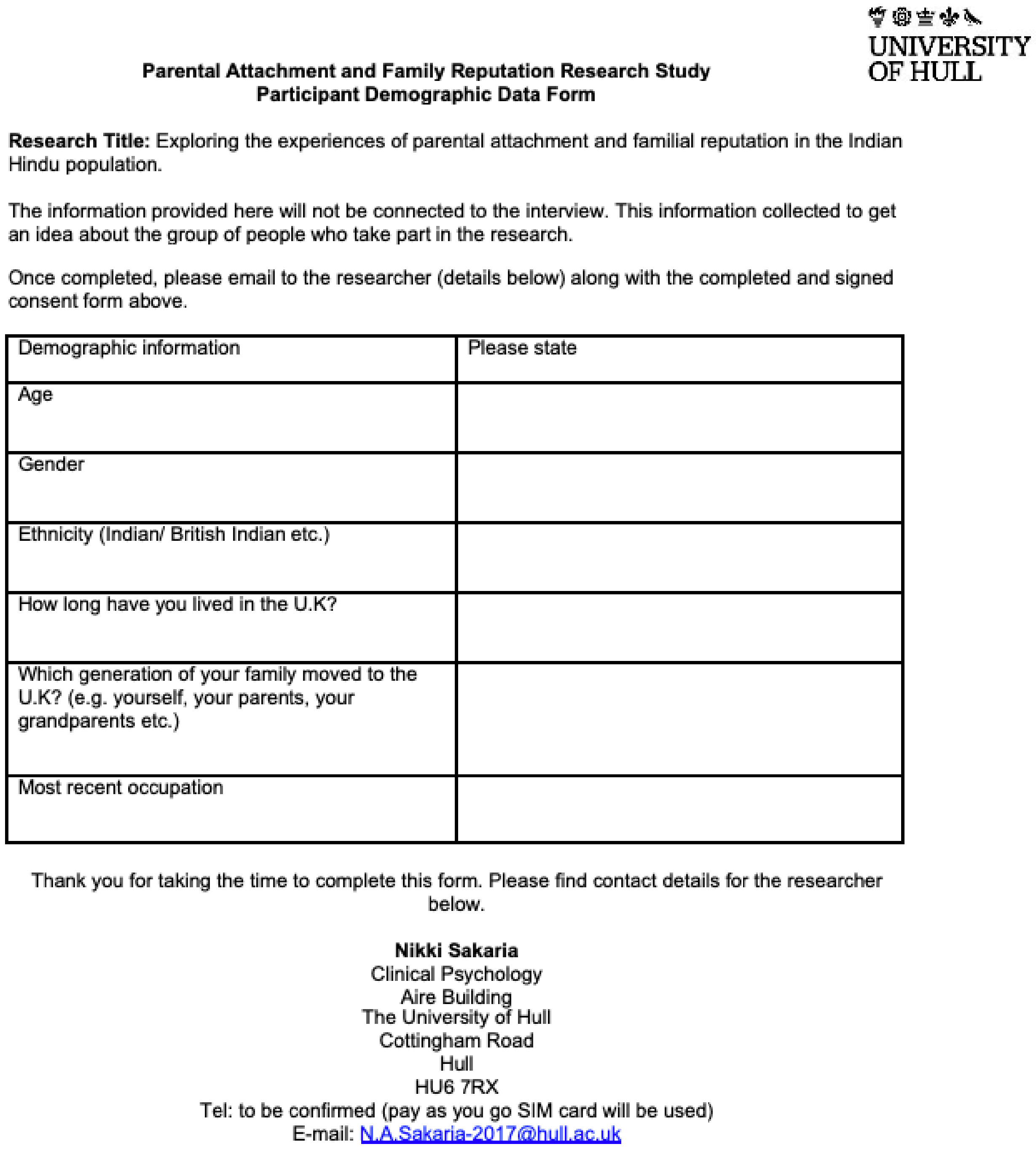
Phone number: ______________________________

Email address: ______________________________

Preferred method of interview (please circle): Face to Face Video Call

Location (town/city): ______________________________
(This is to determine whether a video call is more suitable due to distance)

Appendix I: Demographic information Form for participants



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Parental Attachment and Family Reputation Research Study
Participant Demographic Data Form

Research Title: Exploring the experiences of parental attachment and familial reputation in the Indian Hindu population.

The information provided here will not be connected to the interview. This information collected to get an idea about the group of people who take part in the research.

Once completed, please email to the researcher (details below) along with the completed and signed consent form above.

Demographic information	Please state
Age	
Gender	
Ethnicity (Indian/ British Indian etc.)	
How long have you lived in the U.K?	
Which generation of your family moved to the U.K? (e.g. yourself, your parents, your grandparents etc.)	
Most recent occupation	

Thank you for taking the time to complete this form. Please find contact details for the researcher below.

Nikki Sakaria
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel: to be confirmed (pay as you go SIM card will be used)
E-mail: N.A.Sakaria-2017@hull.ac.uk

Appendix J: Poster used for recruitment on social media.

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PARTICIPANTS NEEDED

◆

STUDY OVERVIEW

My name is Nikki and I am a trainee Clinical Psychologist at the University of Hull. This study will explore the experiences of Indian-Hindu's in the UK regarding family reputation and parental relationships.

In this study, we will converse about your experience growing up regarding family reputation and relationship with parents for up to an hour.

◆

PARTICIPANT REQUIREMENTS

- Aged 20-40 years
- Have an Indian-Hindu background (practising not required)
- Currently live in the UK
- Are cisgendered (identify as the gender assigned at birth)
- Had/has a relationship with parents (positive or negative is accepted)
- Can converse comfortably in English

◆

CONTACT

If you are interested in participating, please email me:
n.a.sakaria-2017@hull.ac.uk

Appendix K: Participant Information sheet

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Parental Attachment and Family Reputation Study
Participant information sheet
Research title: Exploring the experiences of parental attachment and familial reputation in the Indian Hindu population.

My name is Nikki Sakaria, and this is an information sheet about the parental attachment and family reputation research I am undertaking for my thesis. Before deciding whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve. Please take time to read the following information carefully and discuss it with others if you wish.

Please feel free to contact me if there is anything that is not clear or if you would like more information. Additionally, if you would prefer me to talk this information through with you on the phone then please contact me – my number is at the end of this document.

What is the purpose of this research?
Ideas surrounding family reputation and parental relationships predominantly draw upon Western populations. Therefore, there is currently a lack of healthcare practitioner knowledge about minority populations which can lead to those seeking help to feel misunderstood, with their needs not being completely met. This study hopes to increase clinicians' knowledge and understanding of the Indian, Hindu culture and the importance of family reputation and family relationships within it to find the most appropriate support for them.

Who can take part in the research?
You can take part in this research if you fit the following criteria:

- You are a cis-gendered person (identify as the gender assigned at birth).
- You are aged 20-40 years.
- You come from an Indian, Hindu heritage.
- You currently live in the UK.
- You grew up with a parental relationship (it is okay for this to be a positive or negative experience so long as you are comfortable discussing this).
- You can converse comfortably in English.
- You can understand what the research involves and agree to take part.

Do I have to take part in the research?
It is completely up to you whether you take part in the research. If you decide not to take part in the research, this will not affect your current or future use of any services and sources of support in any way.

What will I have to do if I take part in this research?
If you agree to take part, please complete a consent form including your contact details and another form with your demographic information and send these back to the researcher (Nikki Sakaria) via email (a scanned document or clear photograph is permitted). If you are not able to do this, please contact the researcher (Nikki Sakaria) on the details provided at the end of this information sheet. Completion of the consent and demographic forms can be done over the phone if needed. I will then contact you to arrange a meeting at a convenient time and place for you (online or in person). You will have a conversation with me which will last around 60 minutes. I will ask you about your experiences of family reputation and relationships with your parents growing up. I will audio record the discussion. There are no right or wrong answers, and I am only interested in your opinions, your beliefs and your experiences growing up.

Are there any possible risks or disadvantages in taking part in the research?
It may take a while to complete the interview, and we cannot pay you for your time. However, we hope that you will find it helpful to discuss your experiences.

You may want to take part in this research but find that you have never thought about your experience in regards to family reputation or parental relationships before and are not sure whether you would be able to share personal experiences. This can be uncomfortable. If this is the case, please know that you will be able to pause the interview to discuss your discomfort away from the recording with the opportunity to withdraw from the study entirely or come back to the interview later. There are also sources for support provided at the end of this information sheet if you feel like it might help to talk to someone about how you are feeling. If risk to a child is shared, confidentiality is overruled. The researcher will contact the local safeguarding team to discuss the child's safety who may escalate to the police if the instance is severe.

What are the possible benefits of taking part in this research?
We cannot promise that you will have any direct benefits from taking part in the study. However, we hope that you will enjoy taking part in the research. You will have the opportunity to share your experiences and contribute to research, helping to increase awareness and understanding within a healthcare setting of your culture in addition to having the opportunity to reflect on experiences throughout your life that you may not have previously thought about.

Will information about me be kept confidential?
Your data will be processed in accordance with the General Data Protection Regulation 2016 (GDPR).

All the personal information that you provide will be kept strictly confidential and anonymous. Any information that could be used to identify you will not be used in the research. Direct quotes from the discussion may be used in research publications and presentations but you will not be identified in these. To protect your anonymity, you will be assigned a code or pseudonym. This will ensure it will not be possible to identify you from the information you provide. To protect the security of the audio recordings an encrypted recording device will be used. After the research is completed, all the audio recordings will be destroyed. Anonymised transcripts of the recordings will be stored securely in an on-line storage repository at the University of Hull for a period of ten years. The only time that information cannot be kept confidential is if you disclose something that suggests that you or someone else is currently at risk of serious harm. If this happens during the interview, the researcher will need to contact appropriate authorities to ensure that you and other people are safe. The researcher will try to discuss this with you before any action is taken. If you disclose information of historical risk of harm to yourself or others, the researcher will provide you with sources of support should you wish to contact them following the interview.

Your contact details will be held securely for the duration of the research but then destroyed when the research is complete (approximately July 2023).

What if I change my mind about taking part in the research?
Once you submit your data, you have can withdraw your data up to the point of data analysis (which will be two weeks after submission). You can withdrawal without providing a reason, and all your data will be destroyed and not included in the research. After the point of data analysis, your data may be committed to the final report, with demographic data and personal information stored separately to transcribed interviews.

What will happen to the results of the study?
The results of the study will be summarised in a written report as part of a Doctorate in Clinical Psychology. The thesis will be available on the University of Hull's on-line repository https://hydra.hull.ac.uk/. The research may also be published in academic journals or presented at conferences.

Who can I contact if I need to talk to someone?
We hope that the conversation will feel helpful and reflective. However, if you feel upset or would like some support following the interview, the options below may be worth exploring:

- Talking to family and friends
- Talking to your GP (especially if you feel there is immediate risk of harm to yourself or others)
- Visiting a local community centre or temple who may be able to provide support or counselling services

- MIND Infoline on 0300 123 3393. They can provide support and guidance as well as understand what you would like to discuss in particular to signpost you to the most appropriate service in your area. If there is risk of harm to yourself, others, or children, confidentiality will need to be broken by contacting appropriate services such as the local safeguarding team or the police in order to ensure safety.

Who should I contact for further information?
If you have any questions or require more information about this study, please contact me using the following contact details.

Nikki Sakaria
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel: 07419 776 449 (number no longer in use as of June 2023)
E-mail: N.A.Sakaria-2017@hull.ac.uk

What if I have further questions, or if something goes wrong?
If you have any additional questions or concerns that you do not wish to discuss with the primary researcher, or if you wish to make a complaint about the conduct of the study, you can contact the University of Hull on university-secretary@hull.ac.uk or using the research supervisors' details below for further advice and information:

Dr Anjula Gupta
Clinical Psychology
Aire Building
The University of Hull
Cottingham Road
Hull
HU6 7RX
Tel: +44 (0)1482 464170
E-mail: A.Gupta@hull.ac.uk

Dr Chris Sanderson
E-mail: chris.sanderson1@nhs.net

Thank you for reading this information sheet and for considering taking part in this research.

Appendix L: Ethical Approval granted by the University of Hull

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University of Hull
Hull, HU6 7RX
United Kingdom
T: +44 (0)1482 463336 | **E:** e.walker@hull.ac.uk
W: www.hull.ac.uk

PRIVATE AND CONFIDENTIAL
Nikki Sakaria
Faculty of Health Sciences
University of Hull
Via email

20th July 2022

Dear Nikki

REF FHS449 - Exploring the experiences of parental attachment and familial reputation in the Indian Hindu population

Thank you for your responses to the points raised by the Faculty of Health Sciences Research Ethics Committee.

Given the information you have provided I confirm approval by Chair's action.

Please refer to the Research Ethics Committee web page for reporting requirements in the event of any amendments to your study.

Should an Adverse Event need to be reported, please complete the Adverse Event Form and send it to the Research Ethics Committee FHS-ethicssubmissions@hull.ac.uk within 15 days of the Chief Investigator becoming aware of the event.

I wish you every success with your study.

Yours sincerely

Professor Liz Walker
Chair, FHS Research Ethics Committee

UNIVERSITY
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Liz Walker | Professor of Health and Social Work Research |
Faculty of Health Sciences
University of Hull
Hull, HU6 7RX, UK
www.hull.ac.uk
e.walker@hull.ac.uk | 01482 463336
@UniOfHull /UniversityOfHull universityofhull

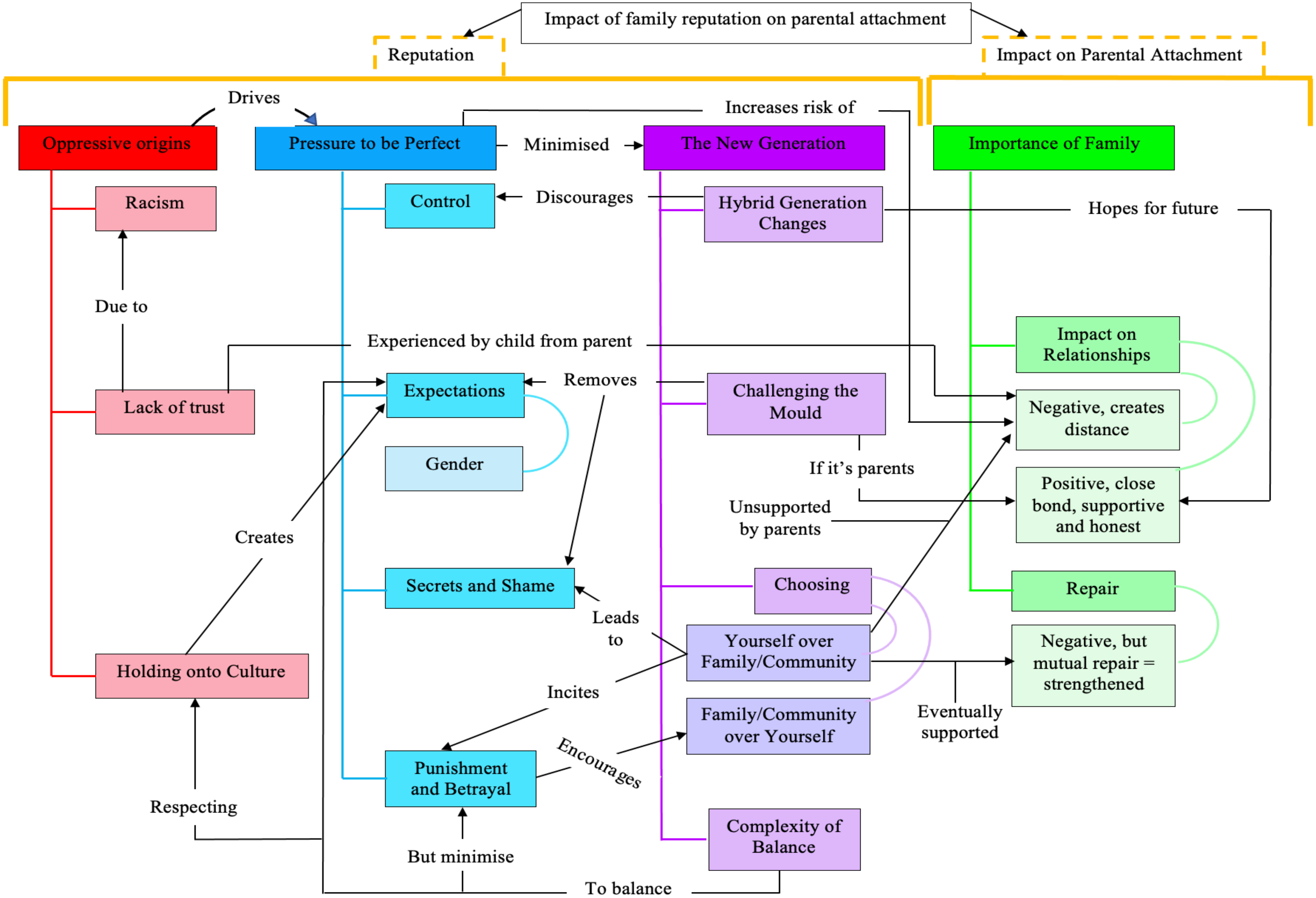
Appendix M: Example of line-by-line coding and development of subthemes

gender	growing up I had chores. He didn't have chores. So on a Saturday, I would literally have to clean the bathrooms, do the hoovering and the mopping of the hallway and the kitchen, and then iron mine my dad's and my brother's shirt. And I'm sure that he could have taken one of those chores. And also the expectations of you go to school, you come back home, once you've done your homework, come and learn how to cook	1602	Arya
complexity of balance	I'm really glad that I was made to learn that because they are basic life skills that any human being should be taught.	1613	Arya
gender	it's pretty much *made* to learn how to do this, whereas he wasn't taught anything, so it's like starting from scratch.	1618	Arya
hybrid (choice made)	I feel like whether you're male or female, it should be passed on. That's something that should be passed. It's a basic human skill on how to look after yourself.	1621	Arya
choosing (family>self)	I'd feel guilty to say no	1630	Arya
challenging	a lot of females. Like on my age in our culture that are kind of like. Breaking through those boundaries and creating healthy boundaries of themselves and justice, talking through them	1631	Arya
choosing family>self	we werent taught how to we werent taught self love.	1634	Arya
choosing (family>self)	We were moulded to become we were taught how to become amazing wife and mother, but not how to look after ourselves and put ourselves first	1640	Arya
choosing (self>family)	taken me over 30 years. To learn how to love myself. Or even learn how to love myself like I know I'm not 100% there	1642	Arya
self repair and forgiveness	taken me over 30 years. To learn how to love myself. Or even learn how to love myself like I know I'm not 100% there	1642	Arya
choosing (self>family)	boundaries are for me to protect me and I'm still working on them	1653	Arya
self repair and forgiveness	They're still growing, they're still learning as people. So I'm on this journey of accepting my parents for who they are, knowing that their human beings still growing and learning to love them from a certain distance where it doesn't affect me too much.	1664	Arya
choosing (family>self)	I was giving all my love to everybody else. Um and. Working from like an empty cup of myself	1673	Arya
complexity of balance	your parents say certain things and when they keep saying it, keeps saying it and it gets frustrating. I mean, you get angry and then you feel guilty for being angry at them. But like, Ohh, I love you, but I'm just frustrated	1676	Arya
self repair and forgiveness	I mean by like I can love you from a distance and accept you for who you are, but I'm still learning who I am, and I need to do what I feel is best for me.	1678	Arya
pressure to be perfect	growing up, I've always been told that I'm too much. Well, I'm too emotional.	1687	Arya
complexity of balance	I can take myself out of it and view it from a third person and have empathy for the person that I'm having challenges with so I can have a bit more understanding. But which is a good thing but also a bad thing to my own detriment, because then I neglect myself again	1692	Arya
choosing (self>family)	actually this is my life and I only get one life and I need to live it for me and I can't. Do things that I feel is just to please them all the time. Like I'm really not a bad person, not a bad daughter, but I need to live my life and do what I feel is right for me,	1695	Arya
pressure to be perfect	my mum's parents disowned her.	1703	Arya
self repair and forgiveness	I've been doing therapy. So I've unlocked a lot of doors and like gone back like way to childhood and figured out what is this in the child part of me	1704	Arya
impact on relationship	I feel like a part of me is always looking for somebody to, like, protect me. Because I felt like I got it for my grandma cause I wasn't able to like form that bond with my mum in on that level.	1714	Arya
impact on relationship	never really, like, wanted loads of my attention and stuff. You kind of keep yourself to yourself. And when my therapist was that well, no children kind of need their mums	1722	Arya
choosing (self>family) where it should be learnt	when I was eight and that security that I had disappeared without explanation, without any understanding on my level or from anybody around me. And then I think I'm just trying to be a good person in order. To feel that love and acceptance from others around me and that is that falls to your parents really,	1728	Arya

Appendix N: Summary of broad themes, subthemes, and codes within them

Category	Sub-Category	Codes
Oppressive Origins	Racism	Overt racism in the past, microaggressions today, survival
	Lack of Trust	Limited socialising with other cultures, only your community could be trusted, out-groups come to you; don't go to them.
	Holding onto Culture	Immigrated to culture outside the norm, keeping culture alive, keep Indian and British sides separate.
Pressure to be Perfect	Expectations	Respect, contribute to the community, uphold reputation, gender, family first, excessive pressure.
	Secrets and Shame	Community shame the family and parents, gossip, isolation, keep secrets from parents and community, better to be unhappy.
	Control	Permission, physical, financial, relationship and religious control, guise of respect, 'mould your child into whatever you want it to be'
	Punishment and betrayal	'This is how you repay us', explosive arguments, 'crimes', physical punishments.
The Hybrid Generation	Choosing	Choosing yourself over family = guilt, Choosing family over yourself = neglect.
	Challenging the mould	Moving away, dismantling reputation, break the cycle of control and punishment, value individuality and being a good person,
	Complexity of Balance	Low understanding of shame origin – acknowledge its importance, Low of understanding of punishment – acknowledge purpose, Frustrated by lack of freedom – guilty for being frustrated, Empathy for family and community – neglect for yourself, Wanting parent support not blessing – needing permission
Importance of Family	Impact on Relationship	Negative impact: Broke trust, fear parents, long-term and irreparable, care more about other people than child, distanced. Parents challenging = positive effect on relationship, children supported by parents, trust parents, believe parents have child's best interest.
	Repair	Mutual seeking of repair, parents seek repair after approval from elders/community, self-repair.

Appendix O: Development of theory from themes and subthemes


Impact of family reputation on parental attachment
Reputation
Impact on Parental Attachment
Drives
Increases risk of
Oppressive origins
Pressure to be Perfect
Minimised
The New Generation
Importance of Family
Racism
Control
Discourages
Hybrid Generation Changes
Hopes for future
Due to
Experienced by child from parent
Impact on Relationships
Lack of trust
Expectations
Removes
Challenging the Mould
Negative, creates distance
Gender
If it's parents
Unsupported by parents
Positive, close bond, supportive and honest
Creates
Secrets and Shame
Choosing
Repair
Leads to
Yourself over Family/Community
Negative, but mutual repair = strengthened
Holding onto Culture
Incites
Eventually supported
Family/Community over Yourself
Encourages
Punishment and Betrayal
Respecting
Complexity of Balance
But minimise
To balance