Moving towards mental wellness by shifting cultural connectedness:

A Grounded Theory Study

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Abstract

New Zealand's population is increasingly ethnically diverse, including a rapid growth in the number of South Asian immigrants. With this changing population, there is mounting evidence that the health outcomes for South Asians in New Zealand need closer examination in the field of mental health. Specifically, there has been little systematic examination of the role of culture in enabling (or impeding) recovery from mental distress for South Asian people living in New Zealand. Using constructivist grounded theory, this research examined the perspectives of 11 South Asian service users and five family participants on the process of recovery from mental distress. The research question for this study was "What is the process of recovery for South Asian people accessing mental health services in New Zealand?"

The theory of shifting cultural connectedness was developed from an iterative process using constant comparative analysis and conceptualisation, theoretical sampling, and theoretical sensitivity. The research study explored the conflict and trauma that the participants experienced in New Zealand after moving from collectivistic culture to highly individualistic culture. Out of this emerged a clearer picture of the stressors faced and the conditions of life stage, social support and family dynamics that led the participants to become mentally distressed. By shifting cultural connectedness, the participants balanced the conflict and moved towards mental wellbeing.

This study highlighted the importance of understanding the different perspectives that people bring to the meaning of mental distress. Clinicians require awareness of their own cultural perspectives and those of the service user in order to provide an effective service. The research has the potential to stimulate critical reflection and ongoing dialogue with mental health clinicians, practice and services regarding the concept of recovery, particularly in terms of how it relates to culture, race, diversity and mental health service delivery in New Zealand. Consequently, there is additional potential for improving mental health service delivery and outcomes for a culturally diverse and growing population.

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Attestation of Authorship

"I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning".

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Chapter 1 Introduction

Namaste.

Aamader jatra holo shuru, tomare kori nomaskar (Tagore, 1925).

[Our voyage is begun, we bow to thee].

The words above reflect South Asian spirituality and acknowledge the participants in this thesis. Jatra means journey or going. The meaning of the song is; let us pray before beginning the new journey (Geetabitan, n.d). Namaste means "*I bow to the God within you or the spirit within me salutes the spirit in you*" (Chatterjee, 2001, pp. 47-48). People in India, Nepal, and Bangladesh widely use Namaste as a symbol of gratitude, respect, and connection.

1.1 Introduction

In chapter one, I introduce this grounded theory study, which investigated the process of mental health recovery for South Asian people living in New Zealand. This chapter begins with the rationale for the study, including my personal and professional perspectives, before presenting the research goals, methods, and significance. The process and structure of the thesis, along with an introduction of several key concepts used in the study are also outlined.

1.1.1 Background and rationale

Recovery in mental health is multi-dimensional concept as the philosophy, process, outcome and vision is pertinent from micro level (individual) to the organisational level (structural) such as recovery-orientated services (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011; Onken, Craig, Ridgway, Ralph, & Cook, 2007). Recovery from mental distress is widely perceived as a journey or process rather than a destination with a definite end point or cure (Slade, 2009). Thus, people with mental distress typically embark on a journey to manage and live with their illness (Deegan, 1988). As recovery is a personal journey, everyone has a personalised experience. However, generally personal growth and development is accomplished for all in subtle and small steps (Onken et al., 2007). Although recovery signifies personal growth and self-actualisation, Dickerson (2006) noted that, for some, recovery involves resolving day-to-day necessities such as finding secured accommodation or suitable employment. Recovery involves a complex interweaving of experiences such as psychosocial,

cultural, and spiritual; the meanings attributed to these experiences, and interactions between the individual, the family and the community and greater society (Onken et al., 2007).

The concept of recovery has attained prominence in mental health services worldwide with the emerging importance of the service user movement (Anthony, 1993; Deegan, 1988). New Zealand was a forerunner in the commitment to adopt the recovery approach as a governing tenet at the national level, recognising the need of service user participation at different levels of mental health services (Gawith & Abrams, 2006). Even though the recovery approach is a significant feature of New Zealand mental health services, there have been some systemic challenges in its holistic application. Leamy et al. (2011) identified key knowledge gaps between an understanding of the underpinning recovery philosophy and the stages and processes of recovery. Some professionals and services have struggled to embrace the many changes in New Zealand's mental health system, such as working in a bicultural partnership, empowering service-users, in a context of increasing cultural diversity, and limited workforce resources (Gawith & Abrams, 2006). Subsequently, Tse and Ng (2114) have stressed the need for research involving diverse ethnic and cultural communities. The present study aims to reduce the knowledge gap in recovery from a cultural perspective.

1.1.2 Aim of the study

This study aimed to explain the recovery process from the perspective of South Asian people accessing mental health care in New Zealand. The methodology used in the study was constructivist grounded theory, as developed by Charmaz (2014a). Grounded theory methodology is an interpretive approach that investigates the undeveloped or hidden social patterns and structures within the phenomenon under study (McCallin, 2003). The application of grounded theory methodology is useful to construct knowledge relating to the behavioural patterns of a specific group and has the potential to describe the process of "What was happening for the participants at the particular time, rather than what should have been going on" (McCallin, 2003, p. 203). The key research question was "What is the process of recovery for South Asian people accessing mental health services in New Zealand?" While recovery can be understood from many viewpoints, Grounded theory methodology provides the opportunity to step beyond what is already known about recovery and enter the perspectives and actions of the research participants; thus contributing to the development of empirical knowledge (Corbin & Strauss, 2014).

My research interest and my academic goal stemmed from my various experiences in New Zealand, both personally and professionally. These experiences motivated me to pursue a doctoral study in the field of mental health focused on recovery from a South Asian perspective. Being a migrant to New Zealand, I approached this study as both "insider and outsider" (Bhui, 2007, p. 245), which provides a unique perspective. As a South Asian migrant, I have an insider understanding of underlying South Asian cultural beliefs, assumptions, and values; and as a social worker working in mental health, I have an outsider awareness from a clinical perspective of mental health in a New Zealand mainstream mental health setting.

1.2   Personal background to the study

Because I was born in a middle-class Bengali family in India, my parents introduced me to Rabindranath Tagore and Bengali literature from a young age. Tagore is a cultural icon and hero in India (Anam, 2011). Born 150 years ago, Tagore rose as a romantic poet, songwriter, novelist, nationalist, painter, idealist, and activist to become a Bengali idol. His 40 collections of poetry are a hallmark of Bengali culture. He is the writer of the national anthems of both India and Bangladesh and the first Asian Nobel Prize winner. His institution, Shantiniketan (abode of peace) even today stands as a lasting and original educational experiment (Anam, 2011). I grew up singing his songs during all family and social gatherings. At a young age I cultivated an interest in the complexities and diversities of life and decided to study social work.

When I was an intern in Mumbai, I had the opportunity of visiting the state mental hospital. Seeing the condition of women locked in a room in inhumane and unsanitary conditions left a lasting impression. Some of the women and girls did not have mental health issues but were dumped and languishing in the hospital for having sexual affairs or were embroiled in property disputes with their families. For me, social work training was like moulding clay. Learning about empowerment, ideologies of human rights and social justice altered my viewpoint on life, my beliefs, and, most important of all, my aspiration in life. I graduated with a strong determination to make a difference in the experiences of vulnerable people in the field of mental health. At this stage, I met my husband in a mental health posting. We were from different states and belonged to different castes. Arranged marriages are the norm in India, where parents decide the marriage of their young children based on criteria such as cultural backgrounds, social status, income, physical appearance, and sometimes the amount of the dowry (Nanda, 1992).

Young people choosing their own life partners attract much social stigma for themselves as well as their families, as it is the ultimate act of defiance that a son or daughter can exhibit (Nanda, 1992). When we married by choice, our families were displeased with our decision, and we lost their support. Marriage, lack of family support, and having a child shifted my priorities. We decided to venture out to a new country, looking for greener pastures. The following poem by Indian poet Gopalakrishna Adiga captures the spirit of my decision to move overseas. It was with mixed emotions of excitement and sadness that I left my family, friends, and country. The Kannada language was the original language of the poem. I am presenting it here as a translation (Byahatti, 2018).

Which flute drew you to a distant shore?
Which paradise tempted your soft eyes?
Outside the seven seas, somewhere,
The lazy sea waits;
The silent whispers of knee-deep waves,
Came nudging along to reach this place.
All of the life's joy is being lost,
In this submission of the soul to desire;
To leave what is and to yearn for what is not,
Is life?

In New Zealand, I started working as a social worker at a community mental health centre. The work was a culture shock for me. I grew up with my grandparents who taught me to be humble and be respectful of elders, and imparted the essential life moral principles of gratitude, prayers, worship, generosity, nobleness, and helpfulness through stories in holy books. Initially, I experienced my New Zealand colleagues' assertive behaviour and sense of humour as rude. Slowly I learned to adjust to the new culture. I met a few amazing people who taught me to adjust and settle. But I was also subjected to racist comments and discrimination. One of my colleagues once laughingly said, "Go and open a dairy". Such generalised comments naturally saddened me. I remembered what Mary Angelou (2017) had said about how people may forget what was said and done, but people never forget how things made them feel. In hindsight, I saw these comments as a reflection of my colleagues' ignorance about my culture and country

(Liamputtong & Rumbold, 2008) and this fuelled an interest in studying cultural and intergenerational diversity.

The New Zealand health system was changing and there was a significant shift in the face of the population with whom I was working. The ethnic make-up of New Zealand's population has transformed dramatically since my immigration, mainly due to changes in immigration policy (Statistics New Zealand, 2013). Almost one-fourth (23.1%) of Auckland residents were classified of Asian ethnicity in the 2013 Census (Statistics New Zealand, 2013). However, the provision of care was still focussed on a Westernised paradigm which does not always meet other cultural needs of other cultures (Bhui & Sashidharan, 2003; Mehta, 2012).

A personal experience highlights how language becomes a barrier between people. I met a young Bangladeshi woman when she had become mentally unwell post-delivery of her first child. She had come to New Zealand after her arranged marriage. She was diagnosed as having bipolar disorder and was treated with lithium. During her second pregnancy, she decided to take control of her mental distress and planned to not breastfeed, so she could continue with her mental health treatment. We made a birth plan. After her delivery, I received frantic phone calls from the maternity unit. The staff at the maternity unit assumed that she had become psychotic and needed admission to a mental health unit. But when I assessed her, she had no symptoms of mental distress. She informed me that she had refused to breastfeed, as planned, but the language barrier led to misinterpretation of her behaviour.

My South Asian cultural background clearly played a significant part in contributing a cultural dimension to my thinking about mental health and culture. My understanding was informed by the collectivist underpinnings influencing South Asian worldviews and identities. I believed that health and wellbeing relied on safe and balanced relationships between the person, his/her family, and the community. Imbalance in these relationships could lead to mental difficulties and distress. I realised that service users from diverse cultural groups each had a different story to tell and often a person with limited cultural understanding did not capture the service users' life experience or indeed the distress. With my personal and professional experience, I became curious to study this potential knowledge gap and support it with research to inform and empower people. Along with my personal intentions, my research aspiration emerged from my social work experience.

1.3   Social work perspective

The social work profession advocates social change through problem solving in relationships between people and works to empower individuals to achieve community wellbeing (Iravani, Azarpoor, Reza, & Nezhad, 2012). In my social work training, I learned to emphasise the influence of a psychosocial interpretation of suffering, empowerment, and facilitating recovery and wellness in mental health care settings (Bergeron-Leclerc, 2007). My social work clinical experience taught me to emphasise the importance of exploring oppression, power and control within social systems, structures, and social relationships (Matsuoka, 2015; Mullaly & Mullaly, 2010).

In the late 1990s, when I started working in New Zealand, mental health services were orienting themselves to concepts of personal recovery including hope, meaning, and purpose in life supported by interaction with peers, family, and mental health professionals (Onken et al., 2007). In the background of acceptance of recovery model, service users who had experience of mental illness used their personal resources to implement changes in the mental health services (O'Hagan, Reynolds, & Smith, 2012). Services users were involved as consultants, educators, and policy makers. Mary O'Hagan, a service user leader, became the Mental Health Commissioner for New Zealand (Leamy et al., 2011; O'Hagan et al., 2012). My social work values aligned with service user perceptions of recovery and I was fascinated hearing the stories of people regaining hope, a positive self-image, and self-management of their health.

However, I was challenged by the lack of presence and inclusion of South Asians in the recovery movement. Even in literature about South Asian perspectives of recovery, I noticed a significant gap, especially in the social work literature, in relation to mental health recovery and South Asian people. Yee (2003) concluded that Asians are a very diverse group, but they share a collectivist rather than an individualistic worldview. Yee proposed that an Asian mental health recovery approach has the potential to be effective when family connectedness and spirituality are highlighted over independence and personal responsibility. Although, I am cognisant that research increases knowledge and confidence in mental health services and, specifically, the social work profession (Taylor & Bentley, 2004); I felt challenged to see beyond the clinical and personal perspective of recovery towards an understanding of a cultural perspective. This research study is grounded in my ambition to make a unique and personal contribution to the field of mental health and social work.

Having explained the personal and professional rationale for conducting the study, I will clarify the key concepts that shape the study. Then I will introduce the unique backdrop and context that comprises the New Zealand mental health system.

1.4 Key concepts

I have used specific concepts in this study. Each concept has multiple meanings and interpretations based on different perspectives; hence, the need to explain the concepts as used specifically in this study. I am presenting the key concepts here. In addition, I presented a brief glossary of salient terms in Appendix A.

Mental health

The World Health Organization (WHO) defined mental wellbeing as:

> … a state of wellbeing in which the individual realizes his or her abilities, can cope with the normal stresses of life, can work productively and fruitfully, and can make a contribution to his or her community. (World Health Organization, 2014, p. 4)

The WHO constitution stated that mental health is an essential and integral component of health. Of significance, mental health is viewed as not just the absence of mental disorders or disabilities; it is a perception of emotional and spiritual wellbeing that recognises the significance of equity, culture, social justice, and personal dignity. Some mental health service users have described living with mental illness as learning to accept the reality of that illness and to include that acceptance within all parts of their life, so that they can feel healthy and whole (Mental Health Foundation, 2017).

Immigration

Immigration means the action of coming to live permanently in a foreign country (Oxford dictionary, n.d.-a). Migration means the movement of people from one place to somewhere else with the objective of settling permanently in the new location (United Nations, 2018). The terms immigrant, migrant, and refugee are often used interchangeably, but each has a distinct meaning that carries different international obligations and consequences (United Nations, 2018). The main difference is that an immigrant or migrant has entered the foreign country by free choice, for work or education; whereas a refugee is forced to flee their home country. All participants in the present study and their families had immigrated to New Zealand by choice, so in this study the term 'immigrants' will be used for the participants.

Recovery

The Mental Health Commission (1998) has defined recovery as:

> The ability to live well in the presence or absence of one's mental illness or experiences (or whatever people choose to name their experience) and the many losses that may come in its wake, such as isolation, poverty, unemployment, and discrimination. Recovery does not always mean that people will return to full health or retrieve all their losses, but it does mean that people can live well in spite of them. (p. 1)

This foundational definition of recovery promoted New Zealand's view of recovery and the fundamental concept lives on (O'Hagan et al., 2012).

Social work

The International Assiociation of Schools of Social Work General Assembly and the International Federation of Social Workers General Meeting (Hare, 2004), accepted the following definition of social work:

> Social work is a practice-based profession and an academic discipline that promotes social change and development, social cohesion, and the empowerment and liberation of people. Principles of social justice, human rights, collective responsibility and respect for diversities are central to social work. Underpinned by theories of social work, social sciences, humanities and indigenous knowledge, social work engages people and structures to address life challenges and enhance wellbeing. (p. 409)

South Asia

South Asia, or Southern Asia, represents the southern region of the Asian continent, including Afghanistan, Bangladesh, Bhutan, India, Maldives, Nepal, Pakistan, Sri Lanka and (sometimes) Myanmar (Burma) (Oxford Dictionary, n.d.-b) (see Figure 1).

Figure 1. Map of South Asia (South Asian Concern, 2017)

Before leaving India in August 1947, the British divided the subcontinent of India into two independent nations of Hindu-majority India and Muslim-majority Pakistan. Although there were tensions between Hindus and Muslims before the partition, which were often fuelled by regional and local political leaders, the partition resulted in one of the largest migrations in human history when millions of Muslims shifted to West and East Pakistan while millions of Hindus and Sikhs went in the opposite direction. Unfortunately, across the Indian subcontinent, communities that had lived together previously assaulted each other in a ghastly uprising of secular violence among Hindus, Sikhs, and Muslims, leading to unexpected mutual genocide. The partition forced people from India and Pakistan to move and live in a non-sectarian community (Dalrymple, 2015; Jain, Murthy, & Sarin, 2016).

After the partition, Pakistan was united by its religion, but language and geography divided East and West Pakistan. In the East, the Bengalis were ethnically and linguistically diverse from the Punjabis, the Sindhis, and the Pathans in the West, leading to some level of alienation. In 1971, Bangladesh became an independent nation after achieving independence in the Bangladesh Liberation War from Pakistan (Chowdhury, 2017).

Though South Asian people have linguistic and religious differences, common traditions, languages, and cultures still connect people. In general, South Asian people do not identify themselves by their language or religious faith. For example, in Bengal, a Sunni Muslim weaver would have more commonality in terms of his language, views on life, and food habits with one of his Hindu colleagues than he would with a Karachi Shia from Pakistan, even though Sunni Muslims and Kashmir Shias share the same fundamental Islamic beliefs (Dalrymple, 2015).

South Asian language

There are numerous languages spoken in South Asia, mostly determined by geography and the distribution of religious boundaries. The languages might have many common characteristics, such as grammatical structure and vocabulary, yet they also have distinct differences (D'souza, 1988).

South Asian religion

Like language, religion also divides the people of South Asia. Hinduism is the most common religious practice, followed by Islam, while the Buddhists, Christians, Jains and Sikhs constitute most of the rest (Smith, 2015).

Clothing and South Asia

South Asian people have an intimate connection with their clothing. During India's struggle for independence, Gandhi adopted the loincloth to illustrate the rejection of European power and symbolise the contrast between Indian poverty and British wealth. South Asian people continue to manage and express their identities through their clothing (Tarlo, 1996).

Wrapped and draped garments are the most usual style of clothing for men as well as women in South Asia. The sari (also spelt as saree), in multiple and various sizes and wrapping techniques and worn with a choli (blouse), is the most conventional form of South Asian women's dress. While saris play an essential role in Indian identities, salwar kameez are also worn both in casual and ceremonial settings. Salwar is a type of loose pants and kameez is the shirt (Kalman, 2009).

Jewellery and South Asia

Along with clothes, gold jewellery is significant in South Asian culture. Gold is an essential component of religious ceremonies in South Asia, regardless of religion. It is recognised as a family heirloom and has sentimental value. During marriages traditional gold jewellery is given to the bride to enhance her appearance and as part of her inheritance from her parents. Gold represents power and status, so South Asian people love to wear their gold jewellery (Pahl & Pollard, 2008).

South Asian food

Cuisine is an essential part of the culture and history of the South Asian countries. The range of South Asian cuisines are enormous and diverse. There are variations not only between countries but also within regions, households and even between generations. However, there are specific distinctive characteristics; for example, meat or vegetarian dishes are not served as the main part of a meal but come along with rice or roti (bread) and are served with chutneys and dhals. Milk products like yoghurt, paneer or ghee are also part of every meal. A meal consists of assorted vegetarian or meat dishes, chutneys, yoghurt, rice and bread served together with deep-fried snacks and a dessert (Kalman, 2009).

Traditional beliefs

Along with maintaining cultural practices, South Asians are influenced by their cultural health beliefs that directly shape their perception, experience, and expression of illness (Bhui & Dinos, 2008) and these are important for outcome measures to assess recovery (Bhui & Dinos, 2008). There are many traditional health beliefs, including the 'evil eye'.

South Asian people of all religious faiths firmly believe in the evil eye, which they connect to misfortune, illness, or even death. A malevolent gaze or complimenting someone out of envy or jealousy can cause evil eye, which will then often be warded off by a senior person waving a lemon, an egg, or some chillies around the head of the targeted person (Claus, Diamond, & Mills, 2003).

Having considered the key concepts of the study, the New Zealand mental health system will be reviewed starting with demographic information outlining the importance of the Treaty of Waitangi and the structure of the health system, with

specific reference to the health reforms of the 1980s and 1990s. The significance of the recovery model in the delivery and history of New Zealand mental health services will be highlighted. As the study included only adult participants, I have focused on the adult mental health service and have not included child and youth mental health services or mental health services for the elderly.

1.5   New Zealand mental health system

"Mental health is a state of well-being in which an individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and is able to make a contribution to his or her community" (World Health Organization, 2014). Mental distress or disorder involves medically diagnosed conditions such as anxiety disorders, bipolar disorder, depressive, cognitive (reasoning) disorders, personality disorders, eating disorders, schizophrenia and other psychotic disorders, as well as substance-related disorders (Ministry of Health, 2010). Symptoms of mental distress are mostly described by a composition of abnormal thoughts, behaviour, emotions, perceptions, and relationships with others. The symptoms may include anxiety, sadness, depression, delusions (firm but false beliefs), hallucinations (a perception of something that does not exist), highly inappropriate or violent behaviour, addiction, or suicide attempts.

In New Zealand, mental distress is the third-leading cause of health loss (11.1% of all health loss), after cancer and vascular and blood disorders (Ministry of Health, 2012). Based on the 2012/13 New Zealand Health Survey, 16% of New Zealand adults, or an estimated 582,000 people, had been diagnosed with a mental distress sometime in their lives (Ministry of Health, 2012). Within this group, anxiety and depressive disorders (accounting for 5.3% of health loss), alcohol use disorders (2.1%) and schizophrenia (1.3%) were the most prevalent (Ministry of Health, 2012). Most data provided in this section have been outlined from the national database of hospital admissions, though that does not indicate a reliable estimate of prevalence. There is considerable stigmatisation associated with mental distress, so there is likely to be major under-reporting and under-utilisation of services for these conditions (Durie, 1999; Mehta, 2012).

In New Zealand, government policy suggests that approaches to mental distress need to go beyond addressing the conditions and related symptoms to protecting and promoting

mental wellbeing, including physical, environmental, and spiritual health (Health & Disability Commissioner, 2018a). In New Zealand, culturally specific mental health services such as Māori mental health services are delivered alongside mainstream mental health services (Bhui, 2007). Bhui and Sashidharan (2003) identified that culturally specific mental health services develop innovative ways of securing engagement and functional improvement besides symptom alleviation that focuses on personal contact and fostering relationship in the context of culturally congruent thinking.

A significant factor in the creation of these culturally responsive services is the Treaty of Waitangi, which laid the foundation for an ongoing partnership between European settlers and the indigenous Māori population.

1.6   The Treaty of Waitangi

Te Tiriti O Waitangi (The Treaty of Waitangi, in English), signed in 1840, was an historic accord between the British Crown and Māori to explain and cement the connection between Māori and Pākehā (non-Māori). New Zealand acknowledges the Treaty as its founding document that set the foundation for biculturalism and cultural safety in New Zealand (Bhui, 2017; Durie, 1994).

The Treaty integrates the principles of partnership, participation, and protection in relation to all aspects of healthcare services and social policies for all New Zealanders, and especially for Māori (tangata whenua), the indigenous peoples of New Zealand (Orange, 2015). Partnership involves achieving Māori wellbeing and applicable health and disability services for Māori communities by working alongside iwi (tribes), hapū (clans or sub tribes) and w*hānau* (family). Participation means complete engagement with Māori at all levels of the health and disability sector, involving planning, decision-making, delivery, and development of health and disability services. Protection implies that the New Zealand Government ensure Māori people have culturally appropriate healthcare as well as sustaining Māori cultural concepts, practices, and values (New Zealand Government, 2017).

While the Treaty is primarily about the relationship between Māori and the Crown (now represented in the New Zealand Government), it also embraces the essence of health promotion that is reflected in all New Zealand health services. The Treaty principles have specific meaning for mental health promotion for Māori and all other peoples of

New Zealand (Health & Disability Commissioner, 2018a). The New Zealand Public Health and Disability Act (2000) amalgamates several substantial references in relation to Māori health that collectively identify and honour the Treaty principles, to improve the health status of Māori (New Zealand Legislation, n.d.).

Although government policy and systems acknowledge the implications of the Treaty for improvement of Māori health status, there is evidence that mental health problems are the dominant health problems facing Māori (Durie, 1999). In contrast to non-Māori, the prevalence of poor Māori mental health has increased continuously, especially for young Māori adults (Durie, 1999). Māori are highly depicted in crisis, acute inpatient, and forensic services and have noticeably greater rates of re-admission than non-Māori (Ministry of Health, 2016b). Durie (1999) suggested that mental health services ought to be closely incorporated with primary health care, Māori youth, Māori-centred frameworks, and evidence-based practices.

There is still a long way to go for mental health services in New Zealand to achieve a complete cultural and paradigm shift towards recognising each service user, his or her family, culture and partnership in the journey to recovery. Although mental health services and policies in New Zealand have seen significant changes in philosophy and direction, fundamentally there has been little cultural shift (Gawith & Abrams, 2006).

The next section explores some fundamental developments in the history of mental health services in New Zealand, with a specific direction on the acceptance of the recovery approach as the steering principle for the national mental health strategy.

1.7 Journey of recovery-oriented service delivery in New Zealand

Along with mental health services worldwide, New Zealand's mental health services made significant ideological and management changes with the emerging leadership of the service user movement (Gawith & Abrams, 2006). A major step in de-stigmatising mental distress occurred with the shift of the historic psychiatric hospitals into general hospitals and the general health system (Gawith & Abrams, 2006). In 1996, the landmark Mason report led directly to the formation of the Mental Health Commission and the adoption of the recovery approach (Gawith & Abrams, 2006). The Mental Health Commission's Blueprint for Mental Health Services 'the Blueprint' (1998) encouraged active participation and inclusion of service users and carers as a collective

at all levels of treatment from service planning to evaluation of services (Mental Health Commission, 2012).

Recovery

The Blueprint acknowledged that recovery is both a personal and social process and identified recovery as the new post-institutional foundation for effective mental health services (Mental Health Commission, 2007). A recovery approach perceives and enhances service users' participation in living well with presence or absence of their mental illness. Participation also means reconstructing a sense of self and regaining one's voice in every aspect of life, embracing the experience of mental health services. The aim of mental health services with a recovery approach is to encourage hope for people with mental illness while engaging them with their families and communities. Although the recovery-oriented service delivery in policy was an international phenomenon, New Zealand pioneered the application of recovery principles in the national mental health policy. With the recovery approach in the national mental health policy, the service user movement in New Zealand emerged as a voice of freedom and liberation (Mental Health Commission, 2007, 2012).

Service user involvement

Personal narratives and experiences of people with a mental illness confirmed that beyond their diagnosis, or use of services, they have something valid to say and contribute towards service delivery (Mental Health Commission, 2012; New Zealand Government, n.d). In New Zealand, service users, by adopting the recovery principles, advanced the delivery of mental health services and integrated a focus on human rights, the reduction of compulsory treatment, and anti-discrimination into the recovery perspective (Mental Health Commission, 2001). The development of the peer support workforce has also been a significant manifestation of recovery principles, such as empowerment and hope, as people have used their lived experience of recovery in supporting others (Gawith & Abrams, 2006).

Primary mental health care

The establishment of Primary Health Organisations (PHOs) in the early 2000s was also crucial for shaping mental health service delivery. This brought a greater acknowledgement of the importance of working at a population level, intervening early, and helping the significant population who have mild to moderate mental health needs

through primary care services (Mental Health Commission, 2007; Ministry of Health, n.d.-b).

Mental health workforce

The Blueprint (1988) identified the need to establish a culturally responsive workforce. Several workforce centres were established as Ministry of Health delegated agents to provide workforce-related resources and support. This included national organisations to support the adult mental health and disability workforce (Te Pou) and child and adolescent mental health workforce (Werry Centre), as well as organisations for supporting those working with Māori (Te Rau Matatini) and Pacific peoples (LeVa). Across these centres the focus has been on Māori and Pacific responsiveness because of the over-representation of these populations in mental health statistics and obligations to Māori under the Treaty. However, with the changing demographics, the Blueprint also highlighted the additional need to address the mental health needs of Asian people. However, the full paradigm shift of incorporating broader cultural diversity in workforce development remains a challenge.

1.8   New Zealand mental health services

In the New Zealand Health Survey (2015), about one in five people had experienced a mental distress at some time in their lifetime; and about one in 30 people had experienced severe mental illness and accessed specialist services during their life (Ministry of Health, 2015). The proportion of people with a diagnosed mental health issue seen by primary care increased from 16% in 2013 to 22% in 2015 (Ministry of Health, 2015).

New Zealand has a public and private mental healthcare system. The Ministry of Health funds the national health services, so the essential mental healthcare services are administered free for all New Zealanders and is available for people in New Zealand on a work permit valid for more than two years (Ministry of Health, n.d.-a). Private mental healthcare services offer treatment in clinics at the service user's cost for non-urgent conditions.

In 2000, the present system of District Health Boards (DHBs) was constituted by the endorsement of the New Zealand Public Health and Disability Act 2000. The 20 DHBs throughout the nation provide or fund health services in their region and are accountable for the development, advancement, and protection of the health of people and

communities (Bhui, 2007). A board of up to 11 members governs each DHB, establishing the overall strategic direction for health and supervising the DHB performance (Ministry of Health, n.d.-a).

Referral process

When an adult person (aged 18-65) experiences any significant problems and emotional distress, the person or their family/whānau can seek the service of an adult mental health team. Adult mental health teams deliver specialist inpatient and community based mental health services for adults who are New Zealand residents and are living in the team's local region. These services can accept referrals from anyone concerned about a person's behaviour or mental health within these ages. It could be the service user or whānau, the general practitioner (GP), police, or community services (Healthpoint New Zealand, 2017).

After receiving a referral, the Intake and Acute Assessment team assess the service user's support needs and transfer care to the appropriate mental health team. In the adult mental health team, a medical doctor and clinical staff member are allocated to coordinate the care of the service user. The coordinator might be a nurse, a social worker, or an occupational therapist. The coordinator works with the service user to provide the best support for the person and his or her family/whānau. Mental health services offer services at home or at clinics around the region (Healthpoint New Zealand, 2017).

Mental health teams

Adult mental health services are comprised of different teams that offer a range of support and treatment services for the need of service users and their whānau. Some teams provide support for people with acute concerns who need immediate help in hospital or residential facilities, while others support individuals with less severe concerns that nonetheless impact on their life. The service users and their whānau are provided with a combination of different support services including medication, talking therapies, emotional support, practical assistance, cultural support, and peer support to relieve mental distress and improve mental wellbeing (Te Pou, 2018).

1.9 Mental health system challenges

Since the first Mason Inquiry (1988), New Zealand has made substantial progress in mental health and addiction services, shifting from an institutional foundation to a strong community base. A variety of community based services and innovative approaches have further developed specialist acute and rehabilitation services. However, there exist key challenges within the mental health system that have weakened a full paradigm shift towards recovery-oriented service delivery.

Increasing demand for services

With New Zealand's growing and changing population, demand for services has also increased. Kevin Allan, Health and Disability Commissioner of New Zealand (2018), reported that, since more people are accepting health services for mental health and addiction issues in New Zealand, mental health services are under duress and many service users' needs are not being appropriately met (Mental health Foundation, 2018). Allan voiced concern about the lack of early intervention options, the limited shared planning with service users and their family and whānau, reduced coordination within and between services, the rise of compulsory treatment, increased seclusion, poor physical health consequences for people with serious mental health and/or addiction issues, and contrast in outcomes for Māori and other population groups (Health & Disability Commissioner, 2018b).

Lack of investment and funding

Greg Schollum, Auditor-General of New Zealand, also revealed limitations in the current mental health system, namely inadequate preparation and communication among DHBs and community services, limited bed numbers in inpatient units, and speedy discharges into the community. He contended that these limitations were due to cumulative underfunding of the health system (Public Service Association (PSA), 2017).

The Mental Health Foundation has welcomed the recommendations made by the Mental Health Commissioner who emphasised the need for mental health services to broaden their endeavour from mental illness and addiction to mental wellbeing and recovery, including holistic, social, and clinical services (Health & Disability Commissioner, 2018b). The Mental Health Foundation (2017) has endorsed the focus of resources

being on the advancement of New Zealand's mental wellbeing and prevention of mental illness.

Creating inclusive mental health services

The Mental Health and Addiction Workforce Action Plan (2017) concluded that managing the current challenges needs a strong and capable primary health workforce, an enhanced community workforce, and staff training (Ministry of Health, 2016 a). The mental health system requires inclusive practices for Māori, Pacific, Asian, the deaf and LGBTQI (lesbian, gay, bisexual, transgender, queer, and intersex) communities (Ministry of Health, 2012). A person's relationship with his or her family, identity, and culture can either strengthen or hinder recovery; thus, mental health services must be committed to a better understanding of these different elements. This includes respecting and incorporating people's relationships with culture, family, and identities in the recovery process (Onken et al., 2007). As mental health services, campaigns, and systems improve, new approaches need to be appraised and successes shared across the country (Mental Health Foundation, 2017).

Increasing cultural responsiveness in mental health

Culture plays a significant role in peoples' lives, influencing their perceptions about health and wellbeing. Bhui and Sashidharan (2003) recognised that cultural diversity is crucial for conception and development of mental health services in a multicultural setting. However, they noted that cultural, spiritual, and religious beliefs were often not acknowledged by professionals or incorporated into mental health care plans. Sometimes perceived differences between racial and ethnic groups are misjudged and lead to neglect of unfamiliar expressions of distress. Bhui, Ascoli, and Nuamh (2012) acknowledged that recovery is more than symptom alleviation and concluded that the health sector is still confined to handling risk, as distinct from imparting an optional engagement by way of building relationships, which aids recovery and instils hope.

The philosophical development of the concept of recovery has seldom included an ethno-cultural or diversity lens (Lal, 2010), despite populations in most Western countries becoming increasingly diverse (Jacobson & Farah, 2012). The dominant cultural perspective often limits research examining the meaning and process of recovery for individuals with mental distress (Lal, 2010). Some major research reports have acknowledged a lack of cultural representativeness on the topic of recovery (Lam et al., 2011; Onken et al., 2007). Limitations in understanding the impact of culture on

the meaning and process of recovery is a fragment of broader issues related to scope of the mental health system to provide appropriate, engaging, and accessible services to culturally diverse groups (Bhui & Sashidharan, 2003; Tse & Ng, 2014).

The first New Zealand mental health survey, entitled Te Rau Hinengaro [literally meaning 'many minds'] (Oakley-Browne, Wells, & Scott, 2006) examined the prevalence of mental disorders and its relationship with sociodemographic factors. The survey highlighted the importance of improvement in health outcomes for Māori and Pacific people by developing a Māori and Pacific mental health service in a cultural context to reflect cultural priorities and realities (Ministry of health, 2008; Oakley-Browne, Wells, & Scott, 2006). Though, *Te Rau Hinengaro* gave insight into the prevalence of mental illness in New Zealand, the language barrier excluded other ethnic groups from non-English speaking backgrounds (Oakley-Browne et al., 2006). Furthermore, the study did not incorporate health beliefs nor capture the unique experience of each participant (Oakley-Browne et al., 2006). Twelve years on, in an increasing multicultural New Zealand society, it is crucial to understand the mental health beliefs and unique mental health recovery process of the culturally diverse population so that mental health policy and interventions can be engaging and inclusive.

Acknowledging the cultural and intergenerational differences, disrupted family and social relationships, language barriers, and social isolation as major challenges to mental health access, Waitemata DHB developed an integrated Asian mental health service in 2007 (Abbott & Young, 2006; Ho, 2003; Minister of Health, 2005). Te Tāhuhu (2005) [meaning the ridgepole that provides essential support], the second New Zealand mental health plan, recognised that improvement in responsiveness to New Zealand's growing ethnic diversity requires a focus on different perspectives on recovery (Minister of Health, 2005).

1.10 Significance and Focus of the study

Ongoing mental health research helps us to understand mental health issues and practice better. Research can demonstrate effective mental health treatment and service outcomes and ensures dissemination of findings that promote mental wellbeing. This study aimed to make a significant contribution to South Asian mental health in New Zealand by increasing understanding of the social and cultural context that shapes the beliefs, perspectives, and actions of South Asian people accessing mental health services in New Zealand. The study presented in this thesis focused on understanding

the process of mental health recovery from the perspective of the cultural collectivism of South Asian peoples. The study examined the strategies that influenced the process of recovery from mental illness for South Asian people.

This study explains the challenges to mental health recovery that South Asian people face as a result of immigration. Knowledge of the psycho-social aspects of the South Asian community will help mental health providers understand the varied behaviours and practices in this population and could potentially influence clinical work in achieving the best possible outcome for mental health clinicians. The knowledge collected from this study has the potential to further enhance the cultural sensitivity of mental health practice. Additionally, the findings will present implications for social work research and promote advancement in the development of knowledge and inform social work practice.

1.11 Overview of thesis

This thesis contains eight chapters. This first chapter has presented an introduction to the research topic. The chapter began with setting the background for the study, highlighting the history of mental health system in New Zealand, and explaining the context of the study.

In chapter Two, I review national and international literature pertinent to the research question. This chapter highlights the links between the research question and the present knowledge base related to mental health, recovery, and the South Asian community in New Zealand. Significant gaps in the literature are identified.

Chapter Three presents the methodology used in the study, elucidating the key philosophical notions that underpin aspects of the research process. Chapter Four explains the research methods including ethical concerns, data collection, and analysis.

Then the study findings are presented in Chapters Five to Seven. An overview of the process of shifting cultural connectedness is provided in chapter five. In Chapters Six and Seven, the theoretical categories underlying the theory of shifting cultural connectedness are explained. In Chapter Six, findings related to encountering cultural difference are detailed, and in Chapter Seven, findings related to experiencing trauma are presented.

Finally, in Chapter Eight, the research findings are critiqued and located within the professional literature. I discuss the implications of the research findings for mental health practice and policy in New Zealand, suggesting further research areas, and I consider the significance, limitations, and strengths of the study. Where relevant, I have written in the first person to reflect the processes of discovery and add my personal and professional experience to the thesis.

1.12 Summary

This chapter has set the background to this study, beginning with my personal and professional perspectives for doing this research. I presented the aim and purpose, as well as the research question. I explained the key concepts of the study and reviewed the history of mental health in New Zealand. The cultural perspectives of Māori, Pacific and Asian people were discussed, and I described the mental health service of the local DHBs and the significance of the study. I concluded the chapter with an overview of the thesis.

The next chapter reviews the literature to justify the need for this research. Although a variety of literature on recovery exists, little research focuses on the process of recovery for South Asian people.

Chapter 2 Review of literature

2.1 Introduction

A literature review is an analysis, evaluation, and summary of derivable research and literature on the issue being studied (Cronin, Ryan, & Coughlan, 2008; Wakefield, 2014). The purpose of this literature review is to provide a review of relevant contextual literature that informed and supported the focus of the study. The present thematic review of literature examined international and New Zealand studies and discussion documents related to the research question. This chapter outlines the position of a literature review in constructivist grounded theory and describes the thematic literature search process. The literature review presented in this chapter illustrates existing knowledge on shifting cultural connectedness, together with a range of topics including the conceptualisation of recovery, different models of recovery, and diversity of South Asian culture and concepts.

2.2 Position of a literature review in grounded theory

A literature review is where the researcher clarifies, evaluates, and defends the decision to accept or reject earlier ideas and evidences (Charmaz , 2014a). It provides a framework, enunciating what has been done before, the need for the study and how it will expand on previous works. The standing of a literature review in grounded theory research has, for some time, been argued and challenged.

Classic grounded theorists (Glaser, 1978; Glaser, Strauss, & Beer, 1968) advocated holding back the literature review until the completion of data analysis to stay "open to what is actually happening" (Glaser, 1978, p. 3). However, critics have argued that researchers enter the study with experiences within the field of study as well as some familiarity of relevant literature (Charmaz, 2014a; Clarke, 2003; Thornberg, 2012). Thus, rather than avoiding pre-existing literature altogether, Charmaz (2014a) recommended tailoring the literature review to the purpose and argument of the research. She suggested undertaking a preliminary literature review before entering the field, to initiate inquiry and minimise preconceptions, but to keep the review of literature aside during data collection and data analysis. Subsequently, when the substantive theory has been developed, Charmaz recommended revisiting the literature to uncover, assess and defend the emergent theory (Charmaz , 2014a).

The literature review at the conception of a study could be related to 'baseline theoretical sensitivity', in grounded theory terminology (Thornberg, 2012); where the researcher brings in exclusive, professional, and experiential history (Birks & Mills, 2015) but stays with what the participants want to talk about (Strauss & Corbin, 1998). Thornberg (2012) approved Henwood and Pidgeon's (2003) proposal of adopting a stance of theoretical agnosticism that recognises being enlightened by existing research literature and theoretical frameworks; yet engaging the data critically and comparatively to rigorous scrutiny (Charmaz, 2014a). The constructivist grounded theory method perceives the extant theoretical and research literature as an additional creative source of historical, ideological and socio-cultural context that could be weaved into discussion as the data are " social constructions and not exact pictures of the reality" (Thornberg, 2012, p. 249).

The present research adopts Charmaz's (2014a) constructivist grounded theory. Accordingly, contrary to the general literature review template, the present study followed Charmaz's approach to the literature review. The pre-data collection literature review focused on building a baseline understanding of recovery in mental health and the cultural dimension of recovery, to provide a justification for the study and confirm my candidature as a doctoral student (McCallin, 2003). Following data collection and analysis, I returned to the literature to further investigate topics that I had explored prior to data collection, as well as new areas that had emerged as significant during the study. Therefore, the review of the literature is presented in two main sections. In the first section, following Charmaz's approach, the literature review was situated to the current discourse and the pre-data- collection reflected the literature over a 25-year period (1989 to 2018). Most of these publications fall within the past 10 years (2004 to 2014) but seminal papers prior to 1989 were included for historical context. The second section, post data collection, explores pertinent literature published from 2014 to 2018. The post data collection section informed the emerging concepts by focusing on the significant areas of recovery, acculturation, and theoretical development within the current literature.

2.3 Locating the literature

National and international literature was gathered from diverse database searches of government and non-government documents, books, theses, and journal articles post 2000. Databases accessed from the AUT library included CINAHL, Google Scholar, SCOPUS, PsycINFO and Trove. Initially, different combinations of key terms related to

the research question were selected, e.g. 'South Asian', 'mental health recovery', 'immigration', 'cultural difference', and 'grounded theory'. Gradually, I compiled a list of alternative terms related to emerging categories including, 'models of recovery', 'acculturation', 'South Asian immigrants', 'cultural conflict', 'cultural dissonance', 'citizenship', 'family support', 'life stages' and 'strategies'. Table 1 summarises the search terms, databases, and results.

Table 1. Literature search

Data base	Search terms	Limits	Total number of results	Retained
CINAHL	Mental health recovery, mental wellbeing, cultural conflict, South Asian, immigration cultural difference, strategies	English language	170	24
Scopus		Excludes news items	16	6
Psych info		Peer-reviewed academic articles	74	8
Trove		2014-2018	24	2
Govt./District Health Board websites	Recovery, South Asian Immigration act		12	5
Total			296	45

A total of 35 studies were identified for inclusion in the review. The search of databases provided a total of 296 citations. After eliminating 35 duplicates, 261 remained. Of these, 211 studies were discarded because review of the abstracts showed that these papers clearly did not meet the inclusion criteria such as models of recovery, cultural influences on the process of recovery, studies from 2014, and research on South Asian people. Six abstracts retained from SCOPUS were obtained through the AUT database. An additional 12 studies that met the criteria for inclusion were identified by manual searches of recent articles on recovery and web-based resources on recovery. Figure 2, p.26, depicts the process for selection of articles.
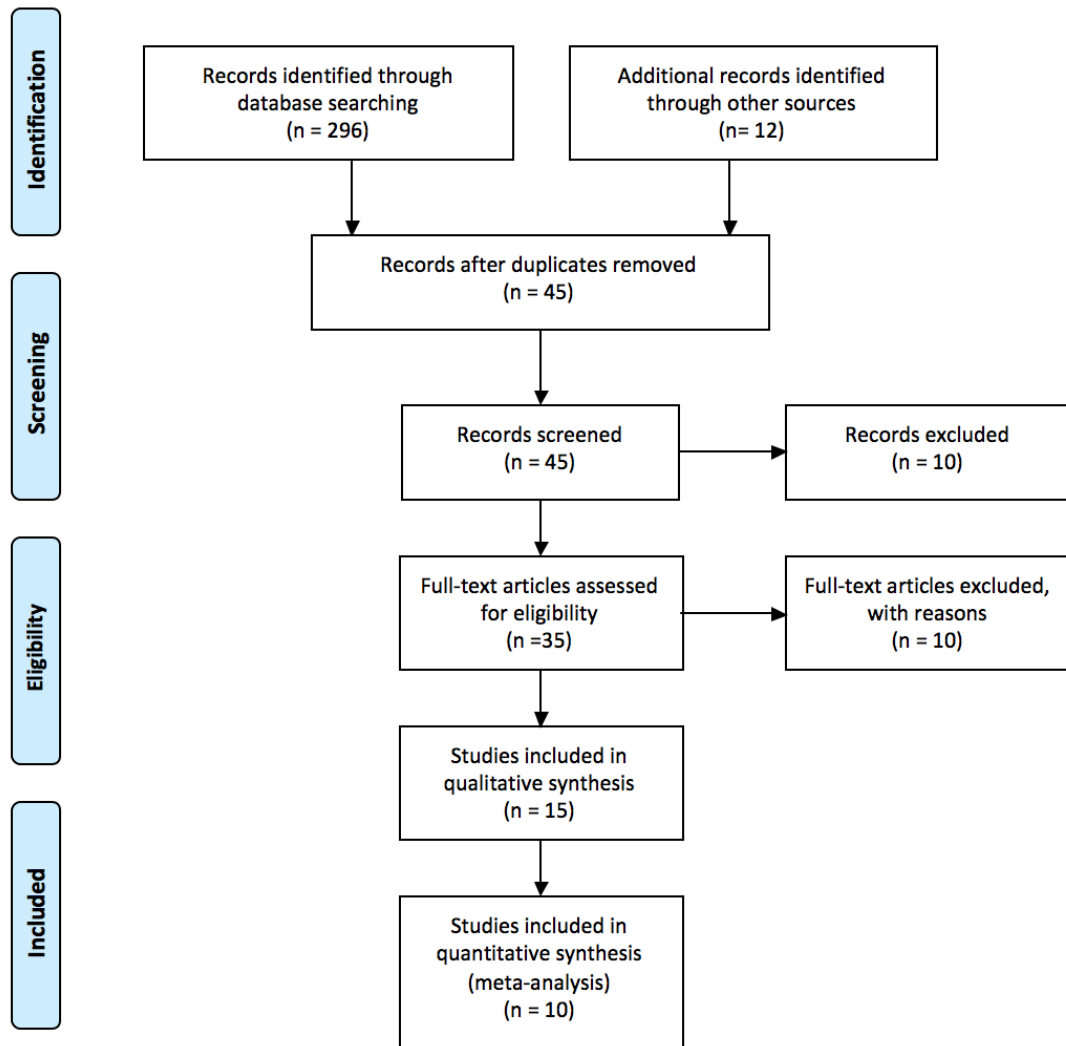
Figure 2. Flow diagram of review selection (Moher, Liberati, Tetzlaff, & Altman, 2010)

Once I had my final selection of articles, I then returned to the articles and commenced a critical review of the articles. I used a data extraction sheet (Appendix B) to organise, synthesise and critique the articles. The process of summarising the articles assisted me with record keeping and helped to group the articles into categories that shaped a base for writing the literature review.

2.4 Pre-data collection literature review

This section includes an introduction of the key concepts of recovery. It examines the connection of the recovery concept with cross-cultural perspectives, specifically with South Asian populations.

2.4.1 The meaning of recovery in mental health

Recovery is the principle tenet of mental health policies and philosophies in New Zealand (Mental Health Commission, 1998). As noted in chapter one, several

definitions of recovery have shaped mental health services and practices (Lal, 2010; Mental Health Commission, 2011). This section examines the recovery concept in the context of definitions and critiques the clinical and personal dimensions and different frameworks.

William Anthony (1993), front-runner and former Director of the Boston Centre for Psychiatric Rehabilitation, developed the following seminal definition of mental health recovery:

> A deeply personal, unique process of changing one's attitudes, values, feelings and goals, skills, and/ or roles. It is a way of living a satisfying, hopeful and contributing life even with the limitations caused by distress. Recovery involves the development of new meaning and purpose in one's life. (p. 15).

It is beyond belief that this article is 25 years old! Yet, the challenges to operationalising recovery processes remain, so the significance of the definition still holds key importance in the world of mental health recovery. The salient attribute of the above definition is it does not define recovery as simply a deduction or cure of symptoms, but recognises that recovery involves personal growth. From another point of view, Hatfield and Lefley (1993) conceptualised recovery in terms of adaptation. They stated, "It is thought to be a process of adaptation at increasingly higher levels of personal satisfaction and interpersonal functioning" (Hatfield & Lefley, p. 130). The literature suggests that recovery is an exclusive and unique process; people with mental distress create their own meaning in the recovery process. Thus, research highlights the diversity in the course of recovery due to the subjective meaning making and interpretation rooted in the recovery process. Despite the diversity, there are common themes within the literature, which will be discussed in the following section.

Clinical recovery

Early conceptualisations of recovery were focussed on improvements in the level of functioning and the control or absence of symptoms (Slade, Amering, & Oades, 2008). Little thought was given to the subjective experiences of those who were recovering or their quality of life (Watkins, 2007). Typically, service providers measured symptom profiles, health care applicability, health outcomes and universal assessments of functioning, rather than indicators of personal recovery. Thus, the service providers leaned toward what could be better described as clinical recovery (Lloyd, Waghorn, & Williams, 2008).

The essence of clinical recovery is significant. For instance, in a South London study, Turton et al. (2011) using qualitative methodology analysed the meaning of recovering from mental distress with service users (n=18) and reported strong desires of freedom from symptoms and yearning to lead a normal life. The study outcome recognized recovery as management of symptoms along with facets of care that reflected hope, kindness and active involvement in treatment, better lifestyle choices and peer support. Although reducing distressing symptoms is no doubt important for most people in their recovery, stories of recovery emerged that reported being in recovery, even when they experienced ongoing symptoms. Thus, personal narratives signified recovery in mental health does not merely imply just clinical recovery (Anthony, 1993) but involves psychosocial functioning such as school or work and family life (Liberman & Kopelowicz, 2005).

A number of longitudinal studies published in the 1980s and 1990s debunked the prevailing view that conditions such as schizophrenia are degenerative disorders, with little or hope of recovery (Harding, Brooks, Ashikaga, Strauss, & Breier, 1987; Harding & Zahniser, 1994). The authors collectively cited that half to two thirds of patients significantly improved or recovered. Research and personal narratives signified that a person with severe mental illness wants and needs more than just symptom relief. People with severe mental illnesses had multiple residential, vocational, educational, and social needs and wants. Accordingly, based on research work and first person narratives, the understanding of recovery shifted towards personal recovery (Anthony, 1993).

Personal recovery

Literature related to personal recovery emphasises that people with mental distress might need to recover from more than the symtpoms of mental illness. People are also recovering from the iatrogenic effects of deep-seated experiences of stigma, the impact of treatment side effects and the treatment environment, a lack of favourable opportunities for self-determination, the negative consequences of unemployment, and from crushed dreams (Anthony, 1993). Several definitions of personal recovery highlighted that recovery can occur with or without remission of symptoms (Anthony, 1993; Slade et al., 2008). Some people have been known to live fulfilling lives while hearing voices (Slade et al., 2008). In contrast to clinical recovery, personal recovery highlights the essence of hope, identity, meaning and personal responsibility (Slade, 2009). Thus, recovery from mental illness is perceived as a process of adapting and

managing one's mental illness, rather than symptom minimisation alone (Anthony, 1993). Acceptance of living with mental distress and its limitations was reported to be challenging, but however was recognised as a central part of and a critical stage in the recovery process (Deegan, 1996; Mizock & Russinova, 2016). In mental health, the foundational concepts of personal recovery dawned from the writings of people with the lived experience of mental distress.

Roads to recovery (voices of experience)

Emerging from several autobiographical analyses were three hopeful themes of recovery. Firstly, the notion of recovery was viewed as a process or a journey rather than an outcome to arrive at a destination. It was perceived as a profound exclusive experience connected to an individual's life aspirations (Deegan, 1988; Ridgway, 2001; Saks, 2007). Patricia Deegan, a psychologist diagnosed with schizophrenia, is a globally esteemed scholar and mental health advocate. She was one of the first people to poignantly describe her experience with psychosis and how she moved on from a '*patient*' role and lived in recovery. Deegan (1988) stated, "Recovery is a process, a way of life, an attitude… a series of small beginnings with small steps… each person's journey of recovery is unique" (p. 16).

A second theme originating from these autobiographical reflections was the influence of daily work, routines, and normal life cycles in fostering recovery. Saks (2007), a university professor with lived experience of schizophrenia, noted that her "very survival hinged on structure and predictability… work is my solace… when I am away from it, I lose all my bearings…I need to be in my office seven days a week" (p. 332). The personal stories of recovery highlighted that though mental distress could be challenging, it could co-exist with high achievement and could even contribute to life changing experiences.

Hope is another important theme. Deegan (1988) concluded that recovery was the outcome of progressing through various stages to emerge from the catastrophic impact of a serious mental distress. She described recovery as a way of life, a process of transition from despair, anguish and pessimism to hope, with support and care that served as motivation for change. Deegan (1988) proposed that the pillars of recovery were hope, willingness, and responsible action. Hope marked the beginning of recovery. She suggested that acceptance was the paradox of recovery. She explained that, when a person accepted the limitations of the distress, they learned to discover new hopes that

motivated them to move forward. In sum, these themes beyond defining personal recovery sketched the map of the journey of recovery and shaped the direction for development of different frameworks of recovery.

2.4.2 Different frameworks of recovery

Since the 1990s, the concept of mental health recovery has developed and connections have been made between the process and influencing factors in the economic, social, political, and cultural context of the person recovering. Hence, depending on the context, recovery has different meanings from varying perspectives. In a clinical sense, recovery from mental illness is described as an outcome involving the abatement of symptoms (Slade, 2009). Whereas, being '*in recovery*' focuses on the personal process of adjustment to disability, empowerment, increasing self-esteem, and self-determination and is usually described in relation to autonomy and a life in the community, despite on-going symptoms (Davidson & Roe, 2007). Altogether, these different perspectives provided a panoramic view of recovery across the globe and enhanced understanding and identification of factors that facilitates recovery.

Lapsley, Nikora, and Black (2002) applied a narrative methodology to explore the recovery journey from a cultural perspective in the first New Zealand based qualitative study of recovery. Stories of illness and wellness of 40 Māori and non-Māori men and women of different age groups, occupations, and with a range of mental illnesses were compared to describe pathways to mental wellness. The study specifically examined the formation of self and identity in mental health narratives and presented stories of recovery grouped as the acronym: H E A R T. The key themes included Hope, Esteem, Agency, Relationship, and Transition in identity. The study findings emphasized the significance of events or circumstances specifically abuse, loss and feelings of difference as stressors, which steered the participants towards mental distress.

Based on empirical research, from a constructivist perspective, Slade (2009) viewed the recovery process as placed within a social and symbolic context where personal identity evolved within relationships. He presented the personal recovery framework based on four recovery tasks: building a positive identity, containing the mental distress, self-managing the mental distress, and developing valued social roles (Slade, 2009). He highlighted the importance of having hope for a positive future, finding meaning in the distress and purpose in life as well as taking personal responsibility in the recovery process and explained how hope emerged when the potentiality of positive identity is

sensed. However, the way people understand and achieve these elements vary greatly. Meaning making involves making sense of the mental distress. Personal responsibility implicated the progression of the ability to self-manage the mental distress and other life challenges.

Leamy, Bird, Le Boutillier, Williams, and Slade (2011) completed a meta-analysis of recovery research and narratives to consolidate the many existing conceptualisations of personal recovery. The themes from this review were similar to the frameworks outlined previously and can be summarised using the acronym CHIME (Connectedness, Hope and optimism for the future, Identity, Meaning in life and Empowerment). The CHIME framework described connectedness as societal relationships and connections. Hope referred to the belief in becoming well and having a life beyond distress. Identity was about rebuilding a positive sense of self, while meaning referred to finding meaning in life through avenues such as work or spirituality. Finally, empowerment referred to reclaiming a sense of personal responsibility and autonomy (Leamy et al., 2011). Price-Robertson, Obradovic, and Morgan (2017) critiqued the CHIME framework and concluded that it captured the process of recovery. However, except for connectedness, the framework emphasized an individualized perspective in which social life and relationships were given less emphasis.

Recognizing mono-cultural representation, Leamy et al. (2011) encouraged future research with culturally diverse ethnic groups and at different stages of recovery. Brijnath (2015) explored cross-cultural application of the CHIME framework with 28 South Asian Indian people and 30 Australians in Melbourne who were recovering from depression. She found that while connectedness was significant, Indian participants struggled with stigma within their families. Furthermore, the author reported that spirituality provided Indian participants with meaning in life while Australian participants derived meaning from the experiences of distress. However, this cross-cultural study was unable to describe the process of recovery or the influence of relationships in the recovery process. Thus, while personal narratives (eg. Deegan, 1988, Saks, 2007) and recovery frameworks have emphasized the importance of elements such as hope and social connection the application of these ideas in practice is limited if we do not understand the process of developing hope or *how* relationships influence recovery (Price-Robertson et al., 2017). Other authors have highlighted this need for further exploration of the actual processes and tasks involved in the process of recovery (Price-Robertson et al., 2017; Slade, 2009).

Stages of recovery

Several studies have interpreted the stages of the recovery journey of people recovering from mental distress (Andresen, Oades, and Caputi (2003); Davidson, Drake, Schmutte, Dinzeo, & Andres-Hyman, 2009). In their review of published experiential accounts of recovery, Andresen, Oades, and Caputi (2003) conceptualised a five staged model of recovery comprising: moratorium, characterised by denial and hopelessness; awareness, determined by the first glimmer of hope; preparation, characterised by a decision to initiate working towards recovery; and rebuilding, described as the hard work involved to reach recovery and lastly, growth, which is the consequence of the recovery process. An issue with this staged model, like any staged model, is that it might not fit everyone's experience. Moreover, Slade (2009) critiqued that the staged model could easily be perceived as a model for what should happen, with consequent feelings of failure for people who do not seem to be 'recovering' in this way. In addition, the stages do not consider relapses and appear to be linear and progressive rather than recursive (Andreasen et al., 2005; Andresen et al., 2003).

Considering the shifts in the process of recovery, Leamy et al. (2011), who developed the CHIME framework, explained the stages of recovery using a transtheoretical model of change that is illustrated in Figure 3, p. 32. This model posits that recovery is a non-linear process that begins with feeling of being struck and demoralization (pre-contemplation), followed by glimpse of hope, acceptance of illness and help (contemplation) then developing connections and establishing independence (preparation), active engagement and rebuilding life (action) and finally, taking control and improving quality of life (maintenance).
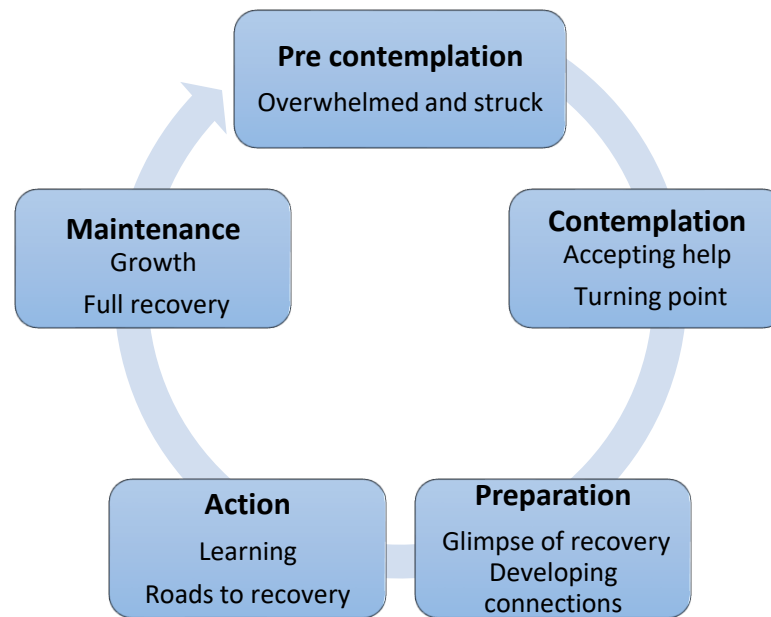
Figure 3. Stages of recovery (Leamy et al., 2011)

Based on the different perspectives, recovery could be summarized as a unique and individual process; a journey that could be difficult but, with proper meaningful support and connections, full recovery is possible. As Deegan (1996) explained, "Just like water-lily, recovery has its seasons, its phases of darkness and light. Recovery is certainly a slow, delicate and sometimes difficult process. But the end result is frequently beautiful and amazing" (p. 11).

Recovery happens in stages, emerging from the interaction and engagement between person and their environment, and that relationship is crucial. Actually, although much of recovery is achieved away from clinical settings, there are clearly essential obligations for clinicians in encouraging people with mental distress in their endeavour towards making complete usefulness of their health, endurance and achieving their goals (Amering & Schmolke, 2009). Onken, Craig, Ridgway, Ralph, and Cook (2007) developed an ecological framework of recovery. Similar to Lapsley, Nikora, & Black's (2002) study, the ecological framework identified elements of recovery that were primarily associated with individual motivations. These elements included hope, sense of agency, self-determination, meaning and purpose, awareness, and potentiality. Furthermore, these elements also involved interaction with others, including family, friends, and/or mental health professionals. These interactions could support or block the ability of the individual to access hope and to take self-determined action, develop agency, and discover meaning and purpose in life pursuits. Slade (2009) suggested four

ways of practice that mental health clinicians could use to enhance recovery: fostering relationships, facilitating wellbeing, providing treatments and advancing social inclusion. Simply put, recovery is an active process that should be enriched through promotion of hope and meaningful relationships (Slade, 2009).

Pettie and Triolo (1999) studied identity and meaning through the life experiences of people with mental distress. They concluded that successful recovery involved the completion of several important developmental tasks, including the conflict for meaning and the restoration of a positive identity. Both milestones were fundamental for self-care and personal responsibility for wellness (Pettie & Triolo, 1999). In contrast, Jacobson and Greenley (2001) described recovery as a process consisting of both internal and external conditions. The internal conditions were the positions, experiences, and ways of change in individuals who are recovering and the external conditions involved the contexts, situations, policies, and practices that facilitated recovery. Some of the key external conditions that defined recovery were human rights, a positive culture of healing, and recovery-oriented services (Jacobson & Greenley, 2001). Thus, recovery encompasses a shift away from traditional clinical preoccupations such as medication adherence and avoiding relapse, towards new perspectives of supporting the person in working towards their own goals and taking responsibility for their own life.

Lloyd et al. (2008) proposed that recovery could be conceptualised in four domains – clinical, personal, social and functional. Clinical recovery referred to identifying and achieving treatment goals to reduce symptoms, while personal recovery attended to the subjective meaning and needs of service users. Social recovery indicated social skills and social inclusion in the society, whereas functional recovery specified recovery in the area of interest to the person that was valued by the wider community. For service providers, the domains could be translated to convey positive messages about the person's capabilities and readiness to make changes to reach his or her goals. Lloyd et al's. (2008) framework is useful for guiding service providers to conceptualise and understand recovery. However, the framework lacked detailed analysis and distinction between social and functional recovery.

Lal (2010) advanced the work of Lloyd et al. (2008), adding two domains to the recovery concept – occupational and environmental. She argued that the meaning and application of the recovery concept needs advancement and further development in terms of dimensions. She concluded that meaningful participation in employment,

education, leisure or other related activities, having secure accommodation, and supports for the individual's physical, political, social, and economic environment were all significant for recovery. Similarly, in New Zealand, a phenomenological study of 13 people highlighted the importance of occupational engagement in recovery from mental distress. The study highlighted that all kinds of occupational engagement, even disengagement, could be meaningful in the recovery process (Sutton, Hocking, & Smythe, 2012). In disengagement, the participants sensed refuge and protection from the demands of daily life, while in everyday engagement participants reconnected with the shared social norms and goals of doing with and for others. In full engagement, participants transcended the everyday and entered into states of flow, where they were in touch with their 'own most' self. Thus, by understanding the experience and meaning associated with different forms of occupational engagement, mental health clinicians could better support the process of recovery (Sutton et al., 2012).

Several researchers have described the dimensions and stages involved in the journey of personal recovery. Recovery involves discovering, retrieving, or restoring oneself, and it is a much greater process than treating the symptoms of mental distress (Slade, 2009). Anthony (1993) identified recovery as a complex and powerful vision involving a complicated and gradual process with multiple dimensions. Therefore, the starting point for recovery oriented mental health service is to consider an approach that promotes personal recovery and perhaps an approach that emerges from the rehabilitation component of the mental health system. Rehabilitation, according to Deegan (1988), involved services and technologies, whereas recovery guided the lived experience of person as they accepted and overcame the challenge of the distress. Deegan (1988) concluded that effective rehabilitation services best operated within a recovery framework.

2.4.3 Recovery-oriented service delivery

"Recovery has become the new mantra for reforming the mental health system" (Lal, 2010, p. 82). In recent years, countries such as Australia, Canada, Ireland, New Zealand, the United Kingdom, and the United States have accepted recovery-orientation as a guiding principle of their mental health policy. At a national level, New Zealand adopted the recovery approach early in mental health services. The New Zealand Mental Health Commission's Blueprint for Mental Health Services (1998) acknowledged the recovery approach (Mental Health Commission, 1998; O'Hagan, Reynolds, & Smith, 2012). The Blueprint echoed New Zealand's early reasoning about

recovery and addressed some of the gaps in the recovery literature at the time. The Blueprint defined recovery as "living well in the presence or absence of one's mental distress" (Mental Health Commission, 1998, p. 1). As stated in Chapter one, the Blueprint suggested the significance of hope and social connections, together with personal responsibility for recovery. The Blueprint emphasised the importance of people with mental health problems, their families, and the community's active involvement in the recovery process. As mentioned previously, recovery must engage the whole person and be inclusive of the mental, emotional, physical and spiritual needs of each person to overcome the double stigma of mental distress and diminished social standing. The Blueprint also affirmed that discrimination is the biggest barrier to recovery.

In New Zealand, recovery based services has been a collaboration of mental health professional and service users. The service users through their expertise knowledge of lived experience of struggles and triumphs over mental distress are providing the mental health service with evidence-based experiences to inform policy and development (Amering & Schmolke, 2009). The directives, training modules, and system transformation initiatives have rapidly replaced traditional core beliefs and attitudes about mental distress (Gawith & Abrams, 2006; Lapsley et al., 2002). In New Zealand, the Mental Health Foundation, as noted in the last chapter, a major national NGO, has developed various recovery resources such as a mindfulness and mental wellbeing kit (Le Boutillier et al., 2011; Slade, 2009).

By the mid-2000s, the national leadership for recovery had weakened in New Zealand; however, integral concepts still prevailed within recently adopted terms such as whānau ora (Māori families assisted to accomplish their maximum health and well-being) and wellbeing (O'Hagan et al., 2012). Whānau ora services are a change from working with individuals to working with whānau or extended family and mending relationships within generations. The Māori concept of wellbeing recognised the significance of cultural understanding and meaning within the concept of wellbeing that included principles of whakapapa (genealogy), māuri (life force) and hauora (well-being) (O'Hagan et al., 2012; Slade, 2009). Recovery for Māori reconnects the strength of a person's identity with intergenerational families and Māori health providers leading towards mental wellbeing (O'Hagan et al., 2012).

In New Zealand, wellbeing is another concept that has emerged along recovery and has developed within the advancement of Māori models of recovery (Gawith & Abrams, 2006; O'Hagan et al., 2012). Thus, recovery is viewed as the process of mental health or well-being that was promoted by the World Health Organization (2005) acknowledging the interconnection between health and mental health including wider social key determinants such as improved relationships within families, greater productivity of workers, better educational performance, and safer communities.

The focus on positive functioning has attracted increased attention into research on wellbeing. Keyes (2002) surveyed 3032 people in America to measure people's affect and described a two continua model of mental health and illness. The model viewed wellbeing as a continuum from loss of wellbeing i.e. languishing (mental distress such as major depressive episode, generalized anxiety, panic disorder, and alcohol dependence) to optimal emotional, psychological, and social wellbeing or flourishing as shown in Figure 4 (Keyes, 2005).
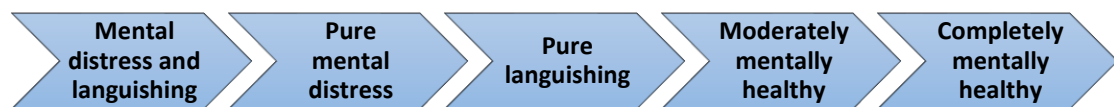
Figure 4. Complete state model of mental health (Keyes, 2005).

From the continuum perspective, mental wellbeing was not accepted as the opposite of mental distress; that is, absence of mental distress did not implied mental wellbeing. As discussed before, personal recovery was possible even in the presence of active symptoms. Furthermore, according to Keyes, flourishing was related with functional disorder such as decline in work, health, and psychosocial functioning. In the same way, languishing related to a low state of subjective wellbeing together with low levels of psychological and social wellbeing. Accordingly, the functioning axiom considered that within mental health, a completely mentally healthy person would function better than moderately mentally healthy individuals, who consequently should function better than a languishing individual. Thus, those who were not languishing or flourishing were considered to be in moderate mental health. In essence, when the person is flourishing, the person is rebuilding their life with qualities better than before their difficulties began. In relation to the continuum model, O'Hagan et al. (2012) added that by

including people's responses to trauma and other life stressors and events, the concept of wellbeing normalised mental distress and reduced stigma and discrimination.

Existing literature has demonstrated that the concept of recovery has shaped the areas of mental health at all levels comprising policy, systems, research, and practice (Lal, 2010). However, fully embedding recovery-oriented services introduced a number of challenges for mental health service providers (Gawith & Abrams, 2006; O'Hagan et al., 2012). The paradigm shift towards supporting recovery involved reorganisation of power arrangements that challenged some mental health clinicians to work in partnership with service users, restricting the scope of the recovery approach (Slade, Adams, & O'Hagan, 2012). Added to this, stigma and discrimination associated with mental distress leads to further isolation (Mental Health Foundation, 2008). Finally, full system transformation needs more resources and funding (Gawith & Abrams, 2006; O'Hagan et al., 2012). As Deegan (2003) suggested "Yet much work still remains. We must remain critical, but not cynical" (p. 374), as being cynical we lose hope and for achieving recovery, hope is important.

Overall, recovery oriented mental health services are designed to support service users to acquire hope, meaning, and purpose in their lives as they are experiencing mental distress. In the vision of supporting service users with hope and empowerment, recovery is a concept at the heart of social models of distress and disability (Slade, 2009) that shares its values and approaches with social work practice.

Recovery and social work

A recovery-focussed clinician has an important position towards facilitating the process of recovery in the service user. Working in a recovery-oriented mental health service therefore emerges from a consideration of core values. The central principles of the recovery movement are assisted by social work values, particularly consumer empowerment, self-determination, meaningfulness of the individual, and consideration for the role of environment in personal experience (Carpenter, 2002). The operational framework used in social work – that of the person-in-environment – endorses the philosophy of the recovery movement (National Association of Social Workers, 1994).

Social workers in the field of mental health aim to empower people to identify their personal strengths and the resources available within their social environment. The strengths approach has been shown to contribute to social recovery and has been

reported as leading to a major relief in symptomatology when compared with the conventional assertive outreach approach (Barry, Zeber, Blow, & Valenstein, 2003).

The strengths model is based on the idea that support and services should be focused on the individual's positive internal qualities and abilities, the strengths that assist the patient to function in the community (Rapp & Goscha, 2011). In an assertive outreach approach, treatment plans are centred on providing a range of services for reducing the symptoms. Assertive outreach treatment approaches can be effective in shortening hospital bed use, enhancing engagement with services and social functioning as was established in a rural study at the United Kingdom. Earlier findings from Wane, Owen, Sood, Bradley, & Jones (2007) demonstrated that a strengths treatment approach provided significantly greater clinical gains with regards to reduction in symptomatology. Thus, over time in social work practice, the strengths perspective emerged as an alternative to the more common traditional approach to helping people.

The strengths model was developed because of concerns that traditional case management and other assertive community treatment emphasized impairment and did not, at least from a theoretical perspective, take into account patients' personal assets that could be mobilized to meet individual goals. The strength treatment plan, however, focuses on the individual making and finding membership in their community (Barry, Zeber, Blow, & Valenstein, 2003; Rapp & Goscha, 2011). Tse, Davis, and Li (2010) conducted a qualitative study and investigated the suitability of the strengths model as a model of community mental health service for 35 Chinese people in a New Zealand setting. The participants regarded the pragmatic approach of the strengths model as a practical and helpful feature in assisting with the recovery process and with settlement and integration into the host society. Most participants reported that focussing on their personal and collective abilities supported them to replace shame and blame often associated with mental illness among Chinese people.

The recovery concept resonates with social workers because of its similarities with strength-based practice. Accordingly, social workers recognize that the recovery concept may be used as a base for direct practice and agency administration, and a paradigm for policymaking, as well as providing an opportunity for mental health research. Ramon, Shera, Healy, Lachman, and Renouf (2009) compared the implementation policies and practices of recovery in the provision of mental health care in four countries: Australia, Canada, England, and Israel. They concluded that despite

an alignment in philosophy and values, the social work profession had not fully accepted the opportunities offered by the emerging recovery paradigm. However, Tew et al.'s (2012) conceptual review of the emerging international literature and recovery practices in the United Kingdom noticed a shift in focus of social work practice in the mental health settings from the individualising focus towards developmental work with families and communities. The review concluded that key social factors in terms of empowerment, positive social identities, personal relationships and social inclusion might promote (or inhibit) recovery. Through this, emerges the importance of working with not only individuals but also on engaging with families and communities. The shift in direction of social work practice would enable mental health practitioners to support the relevance of the social and cultural factors within multidisciplinary recovery practice (Tew et al., 2012).

In addition, there has been increasing demand on service providers to confirm that the services provided to people with mental distress are recovery oriented. Ryan, Merighi, Healy, and Renouf (2004) conducted a cross-national Australian and American qualitative study of 35 mental health social work practitioners. Central to their mental health social work expertise were features such as belief, optimism, and caring. The analysis revealed that though social work practice is shaped by recovery principles, expert social workers alter and change their knowledge and skills to fit in with distinct needs in particular circumstances (Merighi, Ryan, Renouf, & Healy, 2005). The authors reported that practitioners first and foremost had a strong belief in their own capacity to understand client circumstances and their capacity to effect change and exhibited similar beliefs and optimism in the clients' capacity to improve and recover that maximised the possibility of positive client outcomes.

Thus far, service users have primarily been the main promoters of recovery with a specific emphasis on personal recovery (Deegan, 1996; Slade, 2009). Yet it remains unclear whether the concept of recovery is applied in a consistent manner or whether its significance for service delivery has been considered in a systematic way (Meehan, King, Beavis, & Robinson, 2008). There have been growing concerns with regard to the application of recovery concepts for various groups such as youth and families and minority populations (Lal, 2010). However, such knowledge could promote better planning of education, research, and administrative practices and facilitate the transformation towards recovery-oriented care. This is particularly important in New Zealand, where recovery is a key concept for the national mental health strategy.

To further understand the role of recovery in the multicultural context of New Zealand, the next section illustrates the current demographic changes in New Zealand.

2.4.4   Changing face of New Zealand's population

New Zealand has always been an attractive destination for immigrants, and it continues to appeal to increasing numbers of people ready or obliged to leave their native countries. Immigrants and refugees comprise an increasingly significant proportion of New Zealand's population. Changes heralded in the Immigration Act 1987 have led to a diverse population in New Zealand. The Immigration Act 1987 relaxed access into New Zealand by replacing entry criteria based on nationality and culture with criteria based on skills (New Zealand Government, 1987). Later, the Immigration Amendment Act (1991) replaced the occupational priority list with a point-based system in which immigrants were selected based on skills, qualifications, experience, and money for business investment in New Zealand (Bhui, 2007).

Today, South Asians comprise the fastest growing migrant population in New Zealand. Statistics New Zealand (2013) estimated that 9.5% of New Zealand's current population is Asian compared to 3% in 1991. This population is anticipated to increase to almost 15% of the national population by 2020 (Rasanathan, Ameratunga, & Tse, 2006). Although the South Asian ethnic group in New Zealand has grown significantly, their coping skills, health, and outcomes within the New Zealand community have received inadequate research focus and resources (Duncan, Schofield, Duncan, Kolt, & Rush, 2004; Rasanathan et al., 2006). Research on family and mental distress issues within the South Asian community in New Zealand is limited, and there is increasing evidence that these issues require closer examination (Rasanathan et al., 2006).

Acknowledging New Zealand's growing ethnic diversity and calls for increased responsiveness to the needs of these communities, the Mental Health Commission developed the first Asian-focused document to address the rapid changing shape of the New Zealand population (Ho, 2003). It should be noted that Asian people are from China, Japan, Korea and Taiwan, which is significantly wider continent than South Asia. Based on a research review, two major themes influenced mental health-related research on Asians in New Zealand: adaptational dilemmas and barriers to adopting mental health services such as language issues, lack of job opportunities, separation from family, and stigma (Ho, 2003). The first Asian literature review of mental health research suggested promotion of mental health in Asian communities, increased cultural

responsiveness in mental health services, and highlighted the need for further Asian mental health research (Ho, 2003).

Abbott and Young (2006) underlined the need for greater engagement and development of ethnic-specific health promotion initiatives, further research, and workforce development. Yet despite increasing ethnic diversity and awareness of ethnic disparities in access to mental health services, the current New Zealand mental health system has failed to incorporate, respect or acknowledge the histories, traditions, beliefs, languages and value systems of culturally diverse groups (Durie, 1999; Tse & Ng, 2014). It is well documented that knowledge of cultural beliefs, values and practices could enhance mental health services (Bhui, 2007; Tse & Ng, 2014). As the New Zealand population becomes more divergent, the demand for the delivery of culturally competent and appropriate mental health care services is becoming important.

Cultural competence is described as "the ability of individuals and systems to respond respectfully and effectively to members of all cultures, races, classes, ethnic backgrounds and religions in a manner that recognises, affirms and values the cultural similarities and differences and their worth" (Tse, Nayar, Thapliyal, & Bhui, 2006, p. 23). Knowledge of service users' cultural beliefs, practices, their interpretations of mental distress and help-seeking patterns, enhance cultural awareness, improving cultural sensitivity and finally, yet importantly, cultural safety that empowers safe mental health service delivered to a culturally diverse service user population. Cultural competency depends on the local context of distinct records of immigration, national perspectives towards immigrants and citizenship. Understanding the cultural influence of the service user is significant for working with increasingly diverse populations.

2.4.5 Cultural influences on recovery

Culture is described as customary beliefs, ideas, traditions, and social behaviour of particular people or society that is passed on to successive generations (Bhui, 2007). Culture refers to the shared language, behaviour, customs, symbols, knowledge, and way of comprehending reality (Lamont & Small, 2008). Reviewing the barriers to effective mental health services among Asian Americans, Leong and Lau (2001) proposed that people's conception of the nature, causes and cures of mental distress were culturally shaped. Thereby, culture influenced mental health service seeking and utilisation. Leong and Lau (2001) noted that the roads to recovery for ethnic and racial minority groups were often blocked by the dominant cultural views of mental distress

and therapy and needed rigorous but applicable research to recognize and lower these cultural barriers.

The mental health of immigrants is a significant area within psychiatry, offering opportunities to identify risk factors for mental disorders and cultural differences in the expression of psychopathology (Abbott, Wong, Williams, Au, & Young, 1999). For an immigrant community such as South Asian peoples, the cultures of the countries of origin, as well as the societies in which they live, play a crucial role in their reaction to mental health and distress. Culture also has a meaningful role in such immigrants' beliefs and practices regarding mental distress and their ways of seeking help. However, a study of the mental health recovery literature uncovers very little attention to culture, race and ethnicity (Lal, 2010).

To improve awareness of the psychiatric needs of increasingly diverse populations in the United States, Lin and Cheung (1999) in their literature review paper discussed issues influencing Asians' mental and physical health-seeking pathways such as modes of immigration, the effect of racism and discrimination, the history of trauma and refugee experiences, the impact of language on psychiatric assessment and treatment, the cultural appropriateness of assessment instruments, and access to health insurance. In a similar way, Versola-Russo (2006) reviewed how cultural and demographic factors influenced the diagnosis, treatment, and re-integration of a person with schizophrenia. She concluded that culture shaped symptoms, coping style, support system, and willingness to seek treatment. Appropriately, traditional healers played a crucial role in the management of distress, especially among new immigrants' cultures, or where Western medicine was unavailable, perceived with scepticism, or adopted in parallel with traditional treatment methods (Versola-Russo, 2006).

A London quantitative study compared 27 Asian women who accessed hospital care after attempted suicide with a group of similar age Asian women attending GP clinics for other reasons and with 46 Caucasian suicide attempters (Bhugra, Baldwin, Desai, & Jacob, 1999). On comparing Asian attempters with the Asian GP attenders group, the former were more likely to have a history of previous suicidal behaviour, a psychiatric diagnosis, and be unemployed. Their parents were more likely to have arrived in the United Kingdom at an older age. In addition, those who attempted suicide were more likely to be in an inter-racial relationship and had changed religions.

The inter-group comparison revealed that Asians were more likely to make suicidal attempts due to social stress and cultural reasons such as arranged marriage and inter-racial relationship; whereas Caucasians were more likely to have a history of mental illness. Caucasians reported more auditory hallucination and suggested others were responsible for their conditions whereas Asian took personal responsibility and expressed greater remorse for an uncompleted attempt (Bhugra, Baldwin, Desai, & Jacob, 1999). Although, previous studies have suggested that cultural and social factors influenced mental distress, this study provided insight into how the cultural and social factors influenced suicidal behaviour. However, the sample size was small so perhaps a larger sample size and effective recruitment process could have provided stronger and more generalizable results.

Based on a literature review, Furnham & Wong (2007) explained that traditionally, Asians regard the body and mind as one entity. Traditional Chinese medical theory perceived mental illness as nature orientated and resulted from an imbalance of two basic life forces, based on the concept of Yin and Yang (male and female) so accordingly, alternative medicine and acupuncture has been used to correct the imbalance. Founded on a literature review, Furnham & Wong (2007) conducted a quantitative cross-cultural comparison of 100 British residents in central London and 100 Chinese people living in China and Hong Kong about their beliefs regarding the causes, behaviour manifestations and treatment of schizophrenia. The comparison study validated that despite Western influences, Chinese participants adhered more to superstitious and religious explanations while the British looked for internal (biological and psychological) and external (societal) factors (Furnham & Wong, 2007). However, the Chinese participants were from only from two provinces: Tianjin and Hong Kong. In future, perhaps more China provinces could be included for robust comparison.

Li and Seidman's (2010) literature review of cross-cultural research studies found that Asian American youth had higher levels of unmet mental health needs and poor mental health service engagement than US-born youth. The authors cited the major reasons for the lack of engagement in mental health services in the US as stigma, different distress explanatory models, logistics like financial burden or inconvenient clinic location, and perceived barriers including perception of the need for treatment by parents. Li & Seidman (2010) reported that these reasons could be applied to other minority population in another country in general.

Disparities between Western and Eastern value systems have been reported as creating mental trauma among South Asian youth. Topics concerning acculturation and intergenerational issues have been connected with high stress that negatively influences mental health (Farver, Narang, & Bhadha, 2002). Given the continuous and dynamic changes due to worldwide migration and globalization, the need to understand acculturation and the relation with mental distress is imperative. Accordingly, I now review and examine literature and research that sheds light on the relationships between acculturation and mental distress.

Acculturation

Acculturation is described as the double process of change - cultural and psychological- that happens following contact between two or more cultural groups and people (Berry, 2005). So at the group level, it involves changes in social structures and institutions and in cultural practices, and at the individual level, it entails changes in a person's behaviour. When people of diverse cultural backgrounds come to live together as a result of immigration, then the society becomes culturally plural. In many circumstances, immigrants form cultural groups because of economic, political, or religious reasons. These groups formed due to power differences are called minority or ethnic groups (Berry, 1997).

Professor John Berry, an eminent cross-cultural psychologist with extensive international research experience mainly in the areas of intercultural relations including acculturation made a significant impact in the field of psychology through the introduction of a model of acculturation. Based on a series of quantitative studies of acculturative stress of 1197 people comprising native people, immigrants, refugees, sojourners (temporary immigrants) and ethnic groups in Canada, Berry and Kim (1988) noted four modes of acculturation, namely: integration, assimilation, separation and marginalisation, which, they suggested, were different immigrant attitudes towards acculturation. Integration implied that the immigrant identified and involved with both cultures. Assimilation signified that the immigrant identified wholly with the new culture. Separation indicated that the immigrant remained involved with the traditional culture, and marginalisation was referred to lack of involvement and rejection of both cultures. Berry and Kim (1988) added that the different modes of acculturation were significant predictors of mental distress. Integration was associated with optimal mental well-being due to low levels of acculturative stress, followed by assimilation, separation, and finally marginalisation (Berry & Kim, 1988).

In another conceptual perspective on cross cultural adjustment, based on the sample of series of empirical studies in Canada, Berry and Kim (1988) noted that an immigrant faced five types of early difficulties, including physical (different weather and new environment etc.), biological (dietary and new distresses), social (disconnection from friends and developing new relationships), cultural (radical changes in political, economic, and religious conditions), and psychological issues (changed attitudes and values, and mental health conditions). Krishnan and Berry (1992) extended the study of acculturation attitudes and stress with 76 Indian immigrants in the Midwest of the United States, and surmised that the nature of the host society, modes of acculturation, social and psychological traits of the individual, and the acculturation experience variously determined the adjustment stress.

Mehta (1998) used a multidimensional approach to study 200 first generation Indian immigrants residing in the Southeast states of America. The researcher applied a multidimensional framework to study three variables that were pertinent in the process of acculturation namely, contact experience with the host country, cultural orientation, and cross-cultural skills to gain a better understanding of the complexities underlying multiple constructs of acculturation. The author reported that better mental health was connected with greater perceptions of acceptance, familiarisation with the American culture and more English usage. However, the participants represented only skilled and professional backgrounds so it would be important to determine how non-professional and second-generation immigrants coped with the acculturation process (Mehta, 1998).

A quantitative study of influence of family acculturation, ethnic identity, and psychological functioning of 180 American-born Asian Indian adolescents and their immigrant parents in the Los Angeles metropolitan area validated that conflict was higher in families with mismatched acculturation styles between parents and adolescents (Farver et al., 2002). In families where parents had a marginalized or separated acculturation style, parents reported more frequent family conflict than did parents with an integrated or assimilated acculturation style. Additionally, where there was no acculturation gap, adolescents reported less anxiety and higher self-esteem.

Although, much research has been carried out to comprehend acculturation and adaptation in the new country (Berry & Kim, 1988; Krishnan & Berry, 1992; Mehta, 1998), notably, the models of acculturation are two-dimensional and compartmentalised and fail to explain the process of shifting between the four acculturative styles. How,

when, and why people move and the associated distress was not addressed by the literature review and studies on acculturation. Birman and Trickett (2001) addressed the gap by studying the acculturation process of refugees and immigrant adolescents (n=144) and their parents (n=60) from the former Soviet Union, residing in the United States. The acculturative process was described as three different combinations of processes: language competences (an immigrant's ability to communicate in the languages of the two different cultures), identification (the extent an immigrant adopted membership in either of the two cultures) and behavioural participation (engaging in behaviour specifics of one culture or another) (Birman & Trickett, 2001).

In addition, Birman, Trickett, and Buchanan (2005) replicated the earlier study in contrasting community context with 269 students and examined how the specific features of the local community impacted on adaptation processes and found that the reflexive process between the culture and context were interconnected. As the sample size was small, the study is limited in terms of making clear inferences about causality. However, the study made an interesting point about the causal relationship between differences in school adaptation with the receptivity of the communities and schools. For instance, when the immigrant student adapted well to the school, the school's acceptance of cultural diversity improved (Birman et al., 2005). Perhaps future research work could focus on examining these reciprocal relationships in contrasting community contexts to benefit new immigrants and refugee adolescents.

Nayar (2015) contended the claim that during the process of acculturation (Berry, 1997), people seek different acculturative strategies prior to accepting one that is more helpful and agreeable than the others. Applying an occupational perspective, Nayar (2015), presented three vignettes to point out the tensions that emerge when immigrants work according to different modes of acculturation. The New Zealand study of the process of occupational engagement of 25 Indian immigrants concluded that in increasingly cross-cultural countries, for instance New Zealand, that already have accepted bicultural foundations, the acculturation process is significantly more transactional than the current model of acculturation (Berry, 2005). Nayar (2015) noted that immigrants constantly reconstructed their traditions, practices and occupational routines in response to the meaning of the situation. Recognising acculturation as a transactional process accepts immigration and the subsequent process of acculturation as a dynamic process that occurs within multiple contexts such as physical, societal and cultural and minimises the risk of immigrants feeling pressured to conform to one

particular acculturative mode. Nayar's, (2015) suggested that the current models of acculturation failed to acknowledge the transactional process of acculturation and needs resituating and revisiting, specially in the multicultural context of New Zealand society.

In contrast to earlier models of acculturation, Allan's (2003) ethnographic study in The Netherlands examined the cultural interpretation of 171 international students. Findings identified that ethnocentrism, cultural adaptation, and assimilation were not merely transitory phases, but were outcomes of cultural dissonance. Moving to a new country, the students initially noticed differences in their language, norms, and cultural values. Experiencing cultural dissonance, the students gained new perspectives and insights into their own values and assumptions that helped the students negotiate cross-cultural personal interactions. Thus, cultural dissonance was perceived as both a means and the medium of intercultural learning. The study concluded that schools must acknowledge and facilitate cultural dissonance for the encouragement of intercultural learning and also adopt plurality of learning styles in helping immigrant students to achieve their academic potential and develop self-esteem (Allan, 2003).

Immigration is a complicated experience where the individual immigrant might go through many stages of adjustment and respond to several stressors connected to migration preparation, processes, and post-migration adjustment (Bhugra, 2004). These intervals and external stressors influence the immigrant's outcomes, which are also dependent upon whether the migration was forced (refugee status) or voluntary (chosen). When immigrants "cross borders they also cross emotional and behavioural boundaries. Becoming a member of a new society stretches the boundaries of what is possible because one's life and role changes, and with them, identities changes as well" (Espín, 1999, p. 445). In addition, several resilience factors such as educational background, occupational experience and social support also influence outcomes. Recognizing the paramount role of social and cultural factors in the aetiology and management of mental distress, these factors need to be studied further.

The pace and commitment needed to map mental health needs varies from country to country based on its allocated priority in relation to local health and social priorities that face each nation (Bhui, 2007). Definitions of health and successful management of distress depends on cultural perceptions of health and disease (Bhugra, 2004). Somatisation is very common in Asian countries due to strong cultural disapproval of strong expression of emotions, especially negative emotions (Ho, 2003). Mental

wellbeing is necessary for productiveness, healthy relationships, and the ability to cope with change, and lends to the wellbeing of the individual, family and society. However, it is often neglected until problems arise (Jacob, Gray, & Johnson, 2013). Mental health crises could shift people's perception of who they are and how others view them. Thus rebuilding positive personal and social identities could be a core component of recovery (Pettie & Triolo, 1999).

The notion of recovery has brought about relevant changes in the way researchers, practitioners, and service users think about the aetiology, nature, and outcomes of mental distress (Jones, Hardiman, & Carpenter, 2007). Recovery involves overpowering the effects of being in a patient role, together with resolving hardships, poor housing, isolation, unemployment, reducing impairment of esteemed social roles and identity, increasing self-regard and purpose in life, and decreasing the potential induced effects of involuntary treatment and hospitalisation (Davidson, Rowe, Tondora, O'Connell, & Lawless, 2008). An analysis of the social factors that contributed to mental distress revealed fundamental issues of powerlessness, injustice, abuse or social defeat (Tew et al., 2012). To move onward from such disabling social situations, service users need assistance in changing their social context from perceived feeling of being struck in limiting or oppressive circumstances to finding an empowering environment (Tew et al., 2012). Hutchinson and Haasen (2004) reviewed the psychiatry literature and discovered that the rates of psychotic distress among immigrants had increased in a range of European countries due to social inequalities, family fragmentations, and living in urban settings.

Ida (2007) reviewed recovery studies within diverse communities in America and highlighted the importance of culture. Failure to understand the significance of culture could lead to misdiagnosis and poor services. The review emphasised that although culture is a critical factor, each individual's experience is unique and needs to be respected (Ida, 2007). An individual, whose ethnicity or sexual orientation is different, must not only recover from his/her mental distress, but also heal from the wounds suffered by virtue of his/her minority status. Ida (2007) explained that understanding, respecting, and incorporating the histories, beliefs, traditions, languages, and value systems of culturally diverse groups improved recovery-oriented services and helped individuals to reclaim their culture and community as part of feeling whole again.

Based on an analysis of recovery literature, Onken et al. (2007) noted that mental health recovery emphasised concepts of competence, autonomy, self-management, purposeful connection to others and assurance on natural community supports, Similarly, Jones et al. (2007), by exploring literature on service utilization and treatment needs for African Americans, highlighted the paucity of empirical studies in the area of recovery. The authors suggested culturally competent services to support recovery within minority communities. Each of the recovery notions fits with South Asian cultures and worldviews, suggesting that recovery is an important paradigm that is worth examining in South Asian populations with mental health issues.

However, there is very little research directly exploring recovery from varying cultural perspectives and none from a South Asian perspective in New Zealand. Jacobson and Farah (2012) developed a culturally responsive model of recovery to enhance the cultural sensitivity of mental health organisations in Toronto, Canada. They conducted six focus groups with service users and family members from Caribbean, Somali, and Tamil communities in Toronto. Their model recognised that individuals live in a fluid web of relations constituted by family, community, and large socio-political units that promote a sense of belonging and reduce isolation and loneliness that immigrant groups often experience in a new country (Jacobson & Farah, 2012). Although, the culturally responsive model of recovery represents a beginning, it needs further theoretical work.

Penny, Newton, and Larkin (2009) used a phenomenological approach to explore the treatment experiences of families of Pakistani origin in one of the United Kingdom's Early Intervention Service (EIS) for psychosis. Three themes were identified: story of loss - social illness and divergent points on the path to change that reflected the impact of the mental distress on the service user and their families, the families' experiences, and value of cultural resources. The study demonstrated the importance of engaging with families for successful collective working relationships with mental health services to improve communication and care.

Most of the international literature, acknowledging the experiences of South Asian people, comes from the United States, Canada and Britain. Not surprisingly, these countries have been a traditional destination for South Asian people. However, the American recovery concept is monocultural and individualistic. Though New Zealand recognises some aspects of cultural diversity, it mostly maintains an individualistic approach. New Zealand mental health research needs to acknowledge cultural diversity

and the importance of cultural connections as key to recovery (O'Hagan et al., 2012). The use of recovery theories, models, and frameworks needs to be carried out carefully in the background of populations that have usually been under resourced by the mental health system, including youth, recent immigrants, and minority migrant populations. It is important to probe the meaning and process of recovery cross-culturally, beyond the lifespan, and at different levels of service delivery. The exploration should consider the viewpoints of potential and existing mental service users, caregivers, service providers, and other stakeholders (O'Hagan, 2004). The Mental Health Commission's Blueprint (1998) has addressed some of the gaps in the recovery literature and has guided the development of recovery process with a New Zealand flavour (Mental Health Commission, 1998; O'Hagan et al., 2012). Tse (2004) highlighted the need for further research regarding recovery in New Zealand to help identify intervention methods that could contribute to successful recovery among Chinese immigrants with mental distress. Bhui (2007) noted that where clinical care is not guided by research it could result in inferences about the role of culture and stereotypical perspectives of cultural groups. This highlights the need for research that explores the process of recovery for diverse ethnic and cultural groups including South Asians living in New Zealand.

In summary, recovery is complex and elusive concept with various definitions, perspectives and approaches. In this section, I reviewed the key national and international literature on recovery. First, I discussed and critiqued the concept of mental health recovery, the shift of perceptions of recovery from clinical recovery to personal recovery. Then, the recovery-oriented service was discussed and explored through a cultural lens. Finally, the review identified gaps in knowledge related to recovery.

A lack of New Zealand research about recovery among South Asians and the need for empirical knowledge to improve mental health practice and service development motivated me to explore this area of research. The focus of the present research also stemmed from my experiences of working as a social worker with immigrants in the field of mental health, together with my self-identification as an immigrant who has witnessed and experienced the challenges of settling in a new environment. Lastly, the process of recovery for different ethnic and cultural groups had not been explored. There was a great need for a study to explain and explore the process of recovery for South Asian people.

From this review of the literature, I had concluded that recovery has personal, professional, and societal meanings. The autobiographical studies prompted me with inspirational reflections about the journey of recovery and stories of resilience. Another theme that became visible was the importance of culture in relation to the recovery process.

2.5 Advances in mental health recovery: Post data collection

The final section followed the teachings of grounded theory of fitting or situating the emerging theory with the significant literature to compare the new substantive theory with conventional work (Charmaz , 2014a). This section sought to provide an understanding of how views of the literature were used throughout the study to provide support conceptualisations during the data analysis phase. This section examined the literature thematically, as described in section 2.3, after completing the data collection and analysis and focussed on the significant frameworks of recovery followed by exploration of the theoretical developments within acculturation and links within mental health recovery in New Zealand. The literature applicable to the findings has been examined in Chapter Eight.

2.5.1 Recovery and social (re) connections

Recovery, is a journey of personal transformation together with social (re) connection that signifies the importance of developing, accepting, and facilitating social environments within which recovery could be fostered (Tew et al., 2012). Theoretically, recovery transcends distress and disability, as everyone experiences the calamities of life and challenges of recovery (Anthony, 1993). Theories have been developed to explain recovery and have contributed to understanding the complex dynamic of recovery, especially that of personal recovery (Deegan, 1988; Leamy et al., 2011; Ridgway, 2001; Saks, 2007) which is conceptually unconnected to the biological theories that have accepted recovery as remission of symptoms (Slade, 2009; Tew et al., 2012). In contrast, the biopsychosocial model facilitates appreciation of the person along with the physical, psychological or psychosocial structures in people's lives (Davidson & Strauss, 1995).

Sociologically, many theories have described the connections between mental health recovery and social factors. The literature has emphasised agreement among researchers that mental health recovery could be improved by integrated biomedical, psychological, and social processes. Definitely, positive relationships are central to recovery as it

shapes positive identity, connects people with their social world, and provides a subjective sense of belonging (Tew et al., 2012).

Prince and Gerber (2005) studied the connection between subjective wellbeing and physical, social, and psychological integration in a sample of 92 people, who received services from assertive community treatment for psychiatric distress in Eastern Ontario. The study findings established relationships between subjective well-being and psychiatric symptoms and self-esteem. Regarding psychological integration, the study emphasised issues such as accepting attitudes from neighbourhoods and good living standards that from mental health service perspective signified the importance of facilitating opportunities that would enhance feelings of self-worth (Prince & Gerber, 2005).

Citizenship was recognised as a foundation for mental health recovery and community integration. A person achieved full citizenship through a combination of social connections and the support from those connections (Harper, Kriegel, Morris, Hamer, & Gambino, 2017). Three themes were identified as contributing to achievement of citizenship: micro (relationship with family and friends), macro (positive social recognition) and intermediate interaction with general public. The study suggested community-based interventions to support engagement at the different levels are significant for promoting positive support.

Social inclusion thus involves an active form of citizenship. As discussed before, barriers to social inclusion are not merely social stigma and discrimination (Harper et al., 2017) but involve practical issues that might develop as a consequence of mental health difficulties such as lack of opportunities and poor housing (Prince & Gerber, 2005) and sometimes internalised stigma (Kondrat & Teater, 2009). Social relationships and expectations may induce feelings of guilt, shame, and anger. Kondrat and Teater (2009) illustrated a social work case study involving the narrative approach and principles of social constructivism that supported service users to shed their socially constructed stigmatic self-perception. By applying narrative therapy, the service users were empowered to reconstruct their sense of self and rebuild connection with family and community.

Social factors might promote (or inhibit) recovery through empowerment, supportive personal relationships, negotiating positive social identities, and social inclusion. So,

what are the specific interventions that might influence the social factors and enhance the process of recovery?

2.5.2 Recovery focussed interventions

A radical model of mental health nursing, the Tidal model (Barker, 2001), was developed from a series of studies at the University of Newcastle, UK. The study probed the distinct roles of psychiatric nursing within a multidisciplinary team and challenged traditional assumptions about the focus of interpersonal connections within nursing practice. By translating the theory of the need for nursing into practice, the Tidal model incorporated the importance of interpersonal relationships and the process of empowerment to acknowledge the change and unpredictability of human experience and re-empower people disempowered by mental distress (Barker, 2001; Barker & Buchanan-Barker, 2004). The water-related metaphors in this model enhanced participation and collaboration within the service user-nurse relationship that supported the service user to articulate the complexity of their experiences.

The Tidal model employed a caring and cross-cultural construct to perceive the present situation of the person that included his/her relationship with distress and health (Barker & Buchanan-Barker, 2010). The model acknowledged the connection between wider social factors such as poverty, discrimination and inequality, together with trauma such as abuse, violence and the consequent emotional distress, like confusion, fear or despair, or troubled behaviour. Emphasis was given to the kind of support and services the person would need to live an 'ordinary' life (Cook, Phillips, & Sadler, 2005). Although context-specific, the model failed to explain how service users developed strategies to reflect, change, shift and/or cope with distress. In New Zealand, the study was conducted in acute forensic settings so the processual nature of recovery that happens in the community was not addressed by the study. As the model is limited to a descriptive interpretation of the interactive relationship between the nurse and the service user, it does not account for other relationships that could support recovery.

Williams, Almeida, and Knyahnytska (2015) suggested that recovery oriented interventions should advance social citizenship for people with mental distress, thereby helping service users to withstand stigma and assist them to develop the psychological and social environments for discovering meaning and hope. Their Canadian study, a mixed-methods design, starting with quantitative methods (65 participants) followed by life history research method (20 participants), was designed to enhance the

understanding of recovery from mental distress by examining the perspectives of people diagnosed with schizophrenia. The participants reported that being in recovery implied living in dynamic processes embracing biomedical (grappling with diagnosis and medication), psychological (finding purpose, meaning and hope), social (finding a meaningful social role), and socio-political components (rejecting marginalisation and stigma, and asserting entitlement to respect, dignity and support for full participation in society). The study findings promote recovery as multidimensional connected with the biopsychosocial models.

Paradigm shift

Shifting from a diagnostic model of mental distress, a relatively newer model '*Power Threat Meaning*' framework, called for a paradigm shift towards conceptual system of the biopsychosocial model of mental distress (Johnstone, Boyle, & Cromby, 2017). The framework has attracted international interest due to the move from the current medical or disease model towards working in conjunction with service users in developing a multi-factorial and contextual approach.

Developed by a group of psychologists, service users, and researchers in 2013, the Power Threat Meaning addressed an international demand for global mental health for alternatives to psychiatric diagnosis. The framework is grounded on the understanding that recovery begins with the resolution to abandon the diagnostic labels and acceptance of the understanding of the emotional distress, unusual experiences and troubling behaviour that lead to the mental distress. The framework was founded on the assumption that regardless of geographical or cultural place or time, all forms of distress are understandable in the contexts of inequality and other negative agencies of power, such as deprivation, discrimination, marginalisation, and social injustice (Johnstone et al., 2018).

At a mental health service level, the framework enables service users to make coherent sense of their experiences and engage positively with their future (Johnstone et al., 2018). The Power Threat Meaning framework acknowledged the significance of dealing with adversities through the identification and development of strategies such as building social, cultural, and educational assets, the development of available support networks, and using possibilities for social and environmental rescue (Johnstone et al., 2018).

Contained within the framework is an acknowledgement of how mental health services become an authority reflecting power and threat. The authors of the framework perceived that the mental health services induced, traumatised and re-traumatised the service user by denying the relevance and credibility of their life stories (Johnstone et al., 2018). Changing the diagnostic question from 'What is wrong with you?' to 'What has happened to you?' at policymaking, education and research levels, the framework offered an evidence-based alternative to deal with mental distress, experiences, and behaviour. The authors argued that the framework accepted existence of diverse cultural incidences and expressions of distress without positioning them in any diagnostic paradigm. Further, the framework is not connected to any biological, social, or psychological explanation or to a particular theoretical position such as cognitive, behavioural, or systemic. It has the potential to progress beyond diagnostic assumptions and medication, offering different ways to conceive various issues and could be applied widely across cultures (Johnstone et al., 2018). The framework however supports the application of sociocultural and psychosocial factors to psychological distress.

Understanding sociocultural influences is important. In New Zealand, applying the concepts of recovery, Randal et al. (2009) developed the *Re-covery model*. The Re-covery model is an innovative approach depicted in a three-dimensional spiral model, to represent biological, social, psychological, cultural, and spiritual development within the conditions of resilience as well as vulnerabilities that shape the person. The spiral movement begins before birth and carries on throughout life as the person experiences different stressors and trauma. The person responds to stressors based on temperament and physiological and social/cultural/spiritual factors (Randal et al., 2009).

Like the Power Threat Meaning framework, the Re-covery model normalises and validates the bio-social-psycho-cultural-spiritual journey of recovery. Both models could be in principle applied to everybody, whether or not a person had mental health issues (Johnstone et al., 2018; Randal et al., 2009).

Similar to the Power Threat Meaning framework, Randal et al's (2009) Re-covery model reframes a crisis or an intense behaviour such as a self-harm attempt as a possibility to improve self-understanding and learning, enhance existing coping skills, and develop new skills. Thus the model provides a supportive, empowering, nurturing framework for renewing a sense of hope, purpose and meaning for anyone who applies the model (Johnstone et al., 2018; Randal et al., 2009). Another key concept of the Re-

covery model (Randal et al., 2009) is building trust that, like the Power Threat Meaning framework (Johnstone et al., 2018), emphasises that clinicians need to be cognisant of their construction of the meaning of their attitudes, beliefs, experiences, feelings, memories, thoughts and values, which they bring into building a trusting relationship with service users.

Although the new paradigm shift has contributed to a unified concept of recovery, balancing the interconnection between the symptomatic and psychological aspects of recovery, the challenge is how to incorporate the power threat-meaning framework into existing mental health and education. The Tidal model and the Re-covery model have both been implemented in New Zealand but only in residential centres (Cook et al., 2005). The models have not been extended to community care or explicitly to people from diverse cultures (Randal et al., 2009). To implement the Power Threat Meaning framework, mental health clinicians must be helped to develop narrative-ethical competence to be sensitive and work with the constructions and reconstructions of the concepts of power, threat, and meaning. Successful application of the Power Threat Meaning framework would also need acknowledgement and acceptance of existing contradictions between the Power Threat Meaning framework and current broader political issues like discrimination, bullying, and abuse (Grant & Gadsby, 2018). The Re-covery model and the Power Threat Meaning framework also highlighted the need for further research to elucidate the relationship among these complex recovery processes.

The literature recognises the significance of understanding the construction of meaning of the distress for better resolution of conflict and mental wellbeing. The review of literature also identified that cross-cultural studies are necessary for better understanding culturally different perceptions of distress. There have been some studies about cultural conflict during acculturation to a new country (Alamilla, Kim, Walker, & Sisson, 2017; Greenwood, 2000; Gupta, Johnstone, & Gleeson, 2007). However, those studies lacked depth in relation to South Asian people and how they managed cultural dissonance in becoming mentally well. As Berry (2005) stated, "Diversity is a fact of contemporary life; whether it is the "spice of life" or the main "irritant", is probably the central question that confronts us all, citizens and social scientists alike" (p. 711). The present study aimed to develop a theory related to the process South Asian people applied to become mentally well in New Zealand.

2.6 Summary

This chapter presented an overview and exploration of mental health recovery. The literature review was set out in two sections. The first section began with an introduction and elucidation of the position of a literature review in grounded theory studies and then discussed the literature that was reviewed before data collection. Several researchers have conducted valuable work in the area across many decades, but due to the complex process of mental health recovery, there is need for greater clarity between and within the concepts of culture and recovery. The present study planned to address the gap.

Following data collection and analysis, the second section reviewed current developments in the area of mental health recovery. The focus was on the current models of recovery and how they could improve the process of recovery for South Asian people in New Zealand. The next chapter will describe the methodology and methods applied in the present study.

Chapter 3 Research methodology

Methodology is a set of ideas and principles that underpin the design of a research study (Mills, Bonner, & Francis, 2006). This chapter reviews the essential features of grounded theory methodology used to analyse and explain the process of recovery for South Asian people accessing mental health services in New Zealand. Figure 5 below, illustrates the methodological components of the study. The chapter begins with an introduction to grounded theory methodology. Then I present an overview of the development of grounded theory, followed by its philosophical perspectives - pragmatism and its sociological perspectives - constructivism. Next, I describe constructivist grounded theory and the reasons for choosing that approach. I end the section with a global perspective of grounded theory.

Ontology
(Pragmatism)

Epistemology
(Constructivism)

Axiology
(Values and history)

Grounded theory
methodology
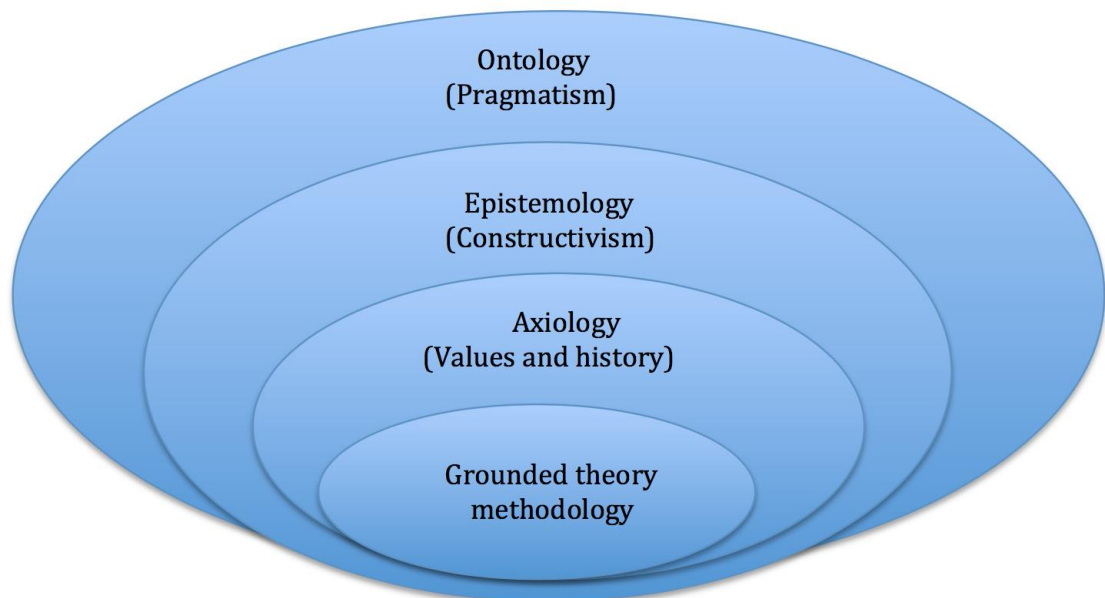
Figure 5. Methodological foundation of the study

3.1 Introduction

Grounded theory is a systematic, inductive, and comparative methodology for conducting qualitative research directed toward theory development (Birks & Mills, 2015). Grounded theory is intended to unearth patterns of behaviour in a particular group of people in a specific context (McCallin, 2003). It is a valuable methodology for exploring and understanding social processes that occur within a society and helps to develop theory when current theories are inadequate for the phenomenon being studied (Bryant & Charmaz, 2007; Lewis-Beck, Bryman, & Liao, 2003). As a consequence, the

grounded theory approach of generating theory from data, rather than testing existing theory, has become increasingly popular among social scientists; and various disciplines such as nursing, social work, and psychology are using the grounded theory approach extensively for research studies (Grant & Giddings, 2002).

Grounded theory has the potential to analyse people's experiences to explain what is happening in little-known areas of work (McCallin, 2003). Hence, a grounded theory methodology enabled me to study the social processes of mental health recovery from a cultural (South Asian) perspective that has, to date, been an underexplored area of study. As noted in the literature review, cultural perspectives on recovery have not been extensively researched in New Zealand. The *Mental Health Blueprint II* (Mental health Commission, 2012) highlighted a greater need for shared learning, evaluation, and research processes to develop a better understanding of diverse cultural paradigms and how that could be translated into effective mainstream recovery services or specific cultural services (Birks & Mills, 2015; Mental Health Commission, 2012). This study aims to contribute to meeting this need.

Denzin and Lincoln (2011) noted that all research is informed by the researchers' fundamental ontology, epistemology, and methodological principles or beliefs. The weaving of these principles and beliefs creates a framework or paradigm that guides the research study and the interpretation of the findings (Denzin & Lincoln, 2011). Accordingly, the methodological process is shaped by philosophical beliefs about the nature of reality, knowledge, and values and by the theoretical framework that informs perception, comprehension, and selection of literature and research. In brief, every researcher brings his or her unique ways of knowing and seeing the world into the research study. In developing a research design it is vital to explore one's own beliefs and premises at the beginning.

Grounded theory has various philosophical and methodological influences of sociology, positivism, interpretivism, and constructivism; therefore, before embarking upon the philosophical worldviews, I will first begin with the historical development of grounded theory from a post-positivist inquiry paradigm to an interpretive constructivist paradigm. Then I will describe the philosophical positions of grounded theory.

3.2   History of grounded theory development

Grounded theory originated from Glaser and Strauss's 1960 sociological research on dying in hospitals (Denzin & Lincoln, 2000; Glaser, 2012). Their investigation led to a methodology that enabled the researcher to develop a systematic and substantive theory from empirical data. The grounded theory approach, as a research design, became increasingly popular as social scientists adopted the methodology of constructing theory from data (Glaser, Strauss, & Beer, 1968). It is a systematic generation of theory from a set of rigorous research procedures leading to the emergence of conceptual categories, which provide theoretical explanation of the action(s) that answers the main concern of the participants in a substantive area. Though, most grounded theories are substantive theories that address delimited problems in specific substantive areas, there is an ongoing debate regarding the combination of quantitative methodology with qualitative approaches (Birks & Mills, 2015).

In the history of grounded theory development, the initial designers or the first generation (between the years 1950-1970) of grounded theorists were Glaser and Strauss. Though Juliet Corbin co-wrote some seminal texts with Strauss and other first-generation grounded theorists, she perceived weaknesses in the original grounded theory. Strauss and Corbin (1998) concluded that grounded theory described only the various strategies and techniques (methods), but lacked a methodological basis (Birks & Mills, 2015). Erikson (1968) endeavoured to rectify the methodological gap in seminal texts by elucidating pragmatism and symbolic interactionism. However, Glaser (2008) argued that adopting such a perspective diminished the broad aspect of grounded theory. Subsequently, grounded theory became diversified and somewhat fractured as Glaser, Strauss, and Corbin maintained their diverging positions (Birks & Mills, 2015).

In the second edition of *Basics of qualitative research: Grounded theory procedures and techniques*, Corbin affirmed that although Strauss had passed away before publication, the writing was indeed their combined work (Corbin & Strauss, 2014; Kenny & Fourie, 2014). The further development of grounded theory did not cease with Strauss's death. Charmaz, an alumni doctoral student from the Sociology Department of the University of California San Francisco (UCSF), continued the academic debate and boldly shaped a third variation of grounded theory (Charmaz, 2014a).

Learning grounded theory in person from both Glaser and Strauss, Charmaz acknowledged their influence on her progress. But she disagreed with Glaser's essential

viewpoint of discovering an implied theory (Charmaz, 2006; Kenny & Fourie, 2014). She accepted that researchers' past and present interactions, perspectives, and research practices were involved in constructing a grounded theory. Charmaz also considered Strauss' systematic coding system, consisting of detailed rules, recipes, and requirements, as excessively rigid.

Accordingly, the second-generation grounded theorists developed their grounded theory methodological framework underpinned by their philosophical understanding (Bowers & Schatzman, 2009; Charmaz, 2014a; Clarke, 2003). I discuss the significance of the philosophical and sociological perspectives, in section 3.3, after the history of grounded theory development. Briefly, though, pragmatism is a philosophical perspective, while symbolic interaction and constructivism are sociological perspectives (Charmaz, 2014a).

In 2003, Adele Clarke brought Strauss' legacy of pragmatist philosophy and grounded theory methods to the 21st century (Charmaz, Clarke, Friese, & Washburn, 2015). Clarke also regarded Strauss's work on social worlds, arenas, and negotiations as an essential feature of situational analysis and used the concept of a conditional matrix as a stepping-off point to push grounded theory in a postmodern direction. Clarke argued for a reframing of the data analysis approach. In a situational analysis, the condition of the situation is an essential factor in the analysis. A situational analysis research design uses grounded theory methods and combines them with three distinct varieties of situational maps and analyses: situational maps, social world maps, and positional maps (Clarke, 2003).

Meanwhile, before Charmaz and Clarke, Schatzman, a student and later colleague of Strauss, developed 'dimensional analysis' (Bowers & Schatzman, 2009; Clarke, 2003) as another variation of grounded theory methodology. Like Clarke's situational analysis, it had the same conceptual foundations of grounded theory. However, Schatzman adopted an essential aspect of natural analysis. He adapted dimensional analysis to analyse coded data and group them according to the general problem solving processes of interpreting, defining, comparing, evaluating, and deciding to form a conceptual story and build a theory.

The diagram on p.63 adapted from Morse et al. (2016) summarises how grounded theory has evolved and is still changing. Nonetheless, the variations in grounded theory all retain the core of grounded theory origins (Hunter, Murphy, Grealish, Casey, &

Keady, 2011). Although there is distinct variation, and despite some intense 'family altercations', they remain within the grounded theory family (Kenny & Fourie, 2015).
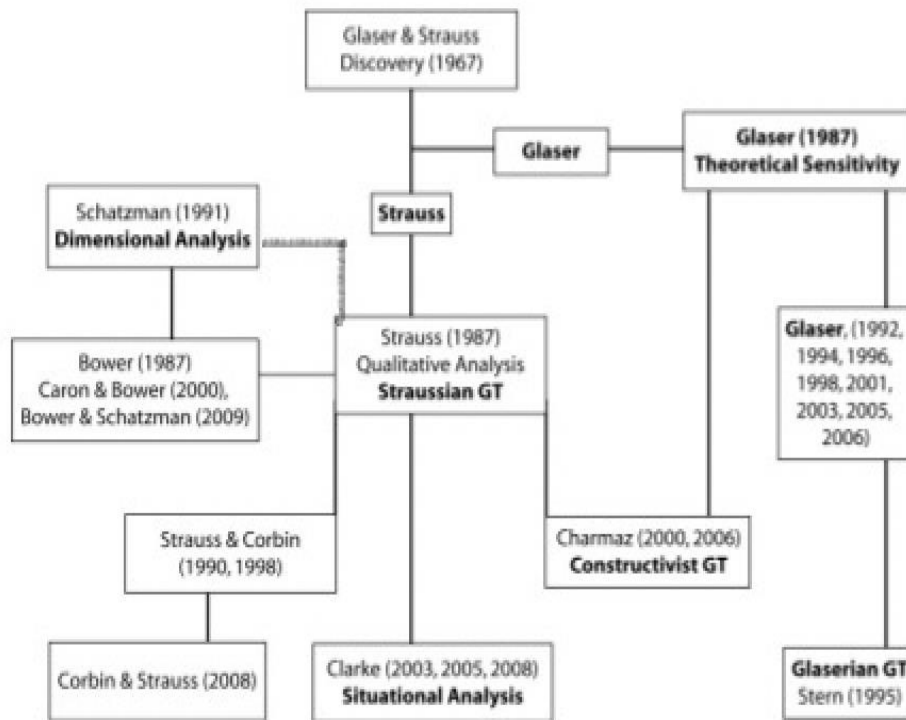
Figure 6. Development of grounded theory methodology adapted from Morse et al. (2016, p. 17)

The history of grounded theory represents a shift from positivism to constructionism (Charmaz, 2014a). Tracing the developing shifts in grounded theory, I noticed that, despite sharing the fundamental grounded theory elements of inductive logic, comparative analysis, and developing theory, there are three dominant and divergent configurations of the grounded theory methodology: 'classic', Straussian, and constructivist grounded theory. These variations often create confusion for the novice researcher. So before embarking on the grounded theory research study, I examined the reasoning of the three variants. I perceived that the divisions were, firstly, their different philosophical positions; secondly, their contrasting coding procedures; and thirdly, their different use of literature (Gibson & Hartman, 2013).

Paradigms

Glaser primarily developed grounded theory as a conceptualising research methodology and kept it away from philosophical considerations (Kenny & Fourie, 2015). Charmaz

(2000) argued that classic grounded theory inclined towards objectivism due to the influence of Glaser's rigorous quantitative and positivist training.

Strauss and Corbin adopted the sociological perspective of symbolic interactionism, which originated out of pragmatist philosophy and were influenced by the philosophical writings of Dewey and Mead (Urquhart, 2012). They argued that a theory comprises of interpretations made from a given perspective. Accordingly, a person responds to the situation through how they define that situation, rather than how the situation is objectively presented to them (Corbin & Strauss, 2014).

Charmaz (2014a) accepted the sociological principles of symbolic interactionism and philosophical principles of pragmatism but resisted integration of its principles into the coding procedures. She defended that that the overly prescriptive regulations influenced creative analysis. Thus, Charmaz introduced a constructivist paradigm to rediscover the pragmatist significance in meaning, language, interpretation, and interaction. Charmaz's constructivist grounded theory presumes the existence of various social realities (Charmaz, 2014a). Her epistemological position accepted the researcher and participants' co-construction of knowledge and mutual interpretation of meaning, with the aim of designing an interpretive depiction of participants' experiences (Charmaz, 2014a; Kenny & Fourie, 2015). However, I must admit that as a novice researcher, it is confusing as Charmaz was unclear about differences between constructivist grounded theory and symbolic interactionism which is also about meaning, language, interpretation, interaction and shifting social perspectives and realities. Even Charmaz's epistemological position was similar to Schatzman's (1991) dimensional analysis about being aware of one's perception and considering participants' perspectives.

Coding

The three approaches to grounded theory characterise three different coding structures (Kenny & Fourie, 2015). The classic grounded theory coding procedure emphasises the principle of the 'natural emergence' of a theory, where theory is discovered from the 'essence' of the data (Kenny & Fourie, 2015). Two stages of coding lead the discovery of a classic grounded theory: substantive and theoretical coding. By contrast, Strauss and Corbin identified three coding stages: open, axial, and selective. This coding structure was framed to develop (rather than discover) an approach that understands the data (Glaser & Holton, 2004). The third approach, constructivist grounded theory, endorses a more implied coding procedure that is intended to shape a theoretical

understanding of the phenomena being studied. Charmaz's constructivist epistemology includes her two staged, flexible coding structure of initial and focussed coding (Charmaz, 2014a; Kenny & Fourie, 2015).

Use of literature

Classic, Straussian, and constructivist grounded theory frameworks also have different stances on the use of literature in research (Kenny and Fourie (2015). Glaser et al. (1968) recommended that the researcher consult the literature at the end of the study and have an open mind, free of undue influences, to avoid contamination of the natural emergence of theory from data. His positivist position influenced his proposition of removal of the researcher from the research (Kenny & Fourie, 2015).

Strauss and Corbin disputed Glaser's position. They advocated the suitable adoption of literature at every stage of the study, demarcating the difference between an empty mind and an open mind (Kenny & Fourie, 2015). Their argument was congruent with the impact of interpretivist philosophy that acknowledged that the researcher apparently influenced the research (Corbin & Strauss, 2014). Charmaz supported Strauss and Corbin's recommendation of literature but took it a step further. She advised delaying writing the literature review chapter until after the data analysis to defend against the risk of becoming over-involved in literature and spoiling one's creativity (Charmaz, 2014a). Charmaz's position is in agreement with the constructivist philosophy, which maintains that the research is shaped and altered by the conditions in which the researcher is engaged and involved (Kenny & Fourie, 2015).

Regardless of the disparity, the three approaches affiliate with the original methodological techniques. All grounded theory designs include conceptualisation towards a theory that is emphasised by the method of constant comparison. Significantly, these coding disagreements emerged from contrasting philosophical positions confined to the contending grounded theory methodologies (Kenny & Fourie, 2015).

Comparing the different variants of grounded theory furthered my understanding and comprehension of both the principles that unite and differentiate grounded theory. All approaches appeared to me to be impressive and seemed at various moments to be a safe methodological destination. McCallin (2003) recommended that once the researcher makes a genuine connection with a version of the grounded theory, the researcher could go ahead and adopt that approach to his/her study. Charmaz's

constructivist epistemology of co-construction of participants' experience and meaning from their perspective resonated with me the most.

Methodological congruence

Once I had chosen the methodology, I began studying the philosophical background of the different grounded theory approaches to compare the various types of grounded theory inquiry. As a grounded theorist, it is essential that I understand my philosophical position. Birks (2014) described philosophy as "a view of the world encompassing the questions and mechanisms for finding answers that inform this view" (p. 18). Everyone has a unique conceptualisation of existence and reality. Our history and the conditions in which we find ourselves influence how we understand the world. Our philosophy impacts on what we consider to be real and how we can legitimately acquire knowledge about the world.

Paradigms are a set of beliefs that represent worldview. Understanding the differing paradigms is important for the researcher to connect the paradigm selected with personal epistemological influence and the research problem. Nathaniel (2011) noted that the suitability of a paradigm lies in its ability to solve a problem or question more successfully than another. The philosophical foundation contributes to binding the epistemological, methodological, and the ontological. Guba and Lincoln (2004) stated that all paradigms included three major foci. These are *ontology,* the study of being that involves concepts of reality and existence (Birks & Mills, 2015, p. 179); *epistemology*, the nature, origins, and limits of knowledge; and *methodology*, the strategies that directs the research study design (Mills & Birks, 2014). Heron & Reason (1997) added another dimension: *axiology* that is the ethics and the values central to the research process. The authors explained that the ontological, epistemological and the methodological questions addressed the truth, whereas the fourth and axiological question is about values of being.

Denzin and Lincoln (2011) highlighted that all qualitative research is interpretive and guided by the researcher's set of beliefs and feelings about the world and how it should be understood and studied. According to Birks and Mills (2015), the methodological framework, with its philosophical justification, influences the researcher's position in a study. The philosophical beliefs and adopted methodology affect the degree of participants' involvement in the research process and outcome. To summarise, the foundation of credible qualitative research is in its methodological congruence. In other

words, coherence between philosophy, methodology, axiology and the application framework are the basis for a good research outcome (Annells, 1996).

Having a personal philosophical position before beginning the research study is important. I will begin with the pragmatist perspective, as the philosophy of pragmatism influenced the inception of grounded theory. Then I will describe the constructivist perspective, underpinning the grounded theory approach used in the study presented in this thesis.

3.3 Pragmatism

Pragmatism is a North American philosophical viewpoint; an open and flexible perspective that shaped grounded theory. Pragmatism assumes that notions of society, reality, and self are all shaped through interactions and built on language and communication (Charmaz, 2014a). This perspective accepts that interaction is essentially dynamic and interpretive and directs how people construct, perform, and shift meanings and actions (Charmaz, 2014a; Strübing, 2007).

Peirce (1905) coined the term pragmatism and developed many of the major ideas. Mead, Dewey, and Cooley contributed to the concepts (Nathaniel, 2011). Pragmatist underpinnings accept that every concept has conceivable practical effects (Campbell, 2011). 'Reality', from a pragmatist perspective, is adaptable, indefinite, and open to multiple interpretations (Campbell, 2011). Pragmatists accept that there are multiple true answers or conclusions to every question and each answer adds to reality and truth (Nathaniel, 2011). Pragmatism regards the results and outcomes of scientific inquiry as measures of truth. So 'truth' evolves with discoveries and is linked to time, place, and the purposes of inquiry.

Pragmatists acknowledge that there are various ways of interpreting the world, and of undertaking research, and that no single point of view can ever give the full picture when there are multiple realities (Strübing, 2007). Meanings originate through practical actions to solve problems. Through action, people become aware of the world (Charmaz, 2014a). From the pragmatist perspective, facts and values are connected, rather than separate, and scientific truth is comparative, conditional, and evaluated through empirical practice (Charmaz, 2014a). Pierce (1905) emphasized the continuous character of perceptual experience and added that we directly perceive external things as external, as 'other', and perceive connections between events and that experience.

Dewey (2008) expanded on Pierce's ideas regarding the relationship between experience and nature. Naturalism for Dewey does not mean fixed things or beings. Rather, nature indicates open, changing, and conditional processes in which identities and relationship emerge in the condition of interaction due to construction of meaning (Hickman, Neubert, & Reich, 2009). Thus, experience is not a passive event. Rather, experience is identified by progression and interaction, wherein experience is a connection between performing and encountering through meanings that are actively constructed (Hickman et al., 2009).

Dewey (2008) suggested that experience is always encapsulated in cultural practices and create meaning by bringing beliefs and actions in contact with each other (Dewey, 2008; Morgan, 2014). He further differentiated between 'primary' and 'secondary' experience. The experience that represents a whole situation without any discriminant element is primary experience. However, in a problem situation, where a habit of action and interpretation fails, people reflect and construct new meanings of behaviour and experience. Secondary experience constitutes a process of reflection, construction, knowledge and theory that answers a problem within philosophical and scientific inquiries (Hickman et al., 2009).

Axiology of pragmatist paradigm

The axiology of the pragmatist paradigm flows directly from its core assumptions about the nature of inquiry. The pragmatist paradigm constructed worldviews and social contexts that have had an extensive impact on research inquiry (Morgan, 2014), and has specifically influenced constructivist grounded theory. Pragmatism values 'abduction logic' to uncover new knowledge (Charmaz, 2014a). Pierce conceived abduction as a type of analysis that builds on inventive explanation and conclusions that follow inductive discoveries (Charmaz, 2014a). Knowledge develops from problem solving. The pragmatist view of the problem-solving is abduction; that is, making inference and explanation from previous knowledge to make sense of the new information which was unknown to that point (Strübing, 2007).

The pragmatist origins of grounded theory presupposes that theory can change according to social realities at any given time (Nathaniel, 2011; Strübing, 2007), thus allowing the researcher to focus upon new fields of study that are constantly occurring and changing in a dynamic context. Pragmatism cannot be abridged to a mere philosophical discourse. Building on pragmatist ideas of interactive human being,

dynamic process of culture, and Dewey's notion of experience, the constructivist philosophers founded the constructivist notion of knowledge (Charmaz, 2014a; Hickman et al., 2009).

Having described the ontological perspective, next I move to epistemological assumptions underlying grounded theory and describe the constructivist perspective and examine its relationship with pragmatism.

3.4 Constructivism

The constructivist paradigm views people as actively constructing or creating their own subjective representations of objective reality (Hickman et al., 2009). The construction of realities emerges from transactions with the existing social and cultural contexts in which they are already embedded (Hickman et al., 2009). The work of developmental psychologist, Piaget, set the paradigm for constructivist thinking by questioning whether direct teaching methods were responsible for students' learning or the students constructed meaning from their environments (Lee, 2012).

The constructivism paradigm recognises that those who experience the reality, construct it (Gergen, 1985). As a perspective, constructivism accepts that human life exists due to social and interpersonal influences. Constructivism highlights the complications and interrelatedness of individuals within their community and regards individuals as integrated with cultural, historical and political changes, in specific time and place, and positioned cross-culturally in social and physical contexts (Owen, 1995).

Constructivism is interchangeably described by the different terms 'constructionism' and 'social constructivism' by different authors, potentially confusing new researchers. Constructivism points to the unique experience of each person, whereas social constructivism emphasises the influence of culture in shaping the way we view the world (Crotty, 1998). Von Glasersfeld (1991) summarised the epistemological tenets of constructivism as follows:

1. The process of active cognition forms knowledge;
2. Cognition is an adaptive process that makes an individual's behaviour more acceptable in the environment and context;
3. Cognition aids in organising and making sense of one's experience instead of rendering an accurate representation of reality; and

4. Knowing originates in biological constructs along with social and cultural interactions.

These four fundamental principles of teaching, learning, and knowing contribute to the understanding of the constructivist perspective (Doolittle & Camp, 1999). However, these tenets can be highlighted differentially, resulting in three forms of constructivism. The three theoretical positions of constructivism are described as a continuum (Cruickshank, 2011; Doolittle & Camp, 1999), as follows:

Cognitive constructivism, at the one end of the constructivist continuum, relates to information processing and is part of the cognitive process. Thus, cognitive constructivism emphasises only the first two tenets above, acknowledging the learner's active role in the construction of a personal and coherent reality (Doolittle & Camp, 1999).

Radical constructivism lies at the opposite end of the constructivist continuum from cognitive constructivism, accepting the first three epistemological tenets; that the cognitive process is an adaptive process emerging from the active assimilation of experiences by the individual learner. Radical constructivism focuses on the 'meaning-making' activity of the mind (Crotty, 1998). Currently, radical constructivism also accepts the fourth epistemological tenet in acknowledging social interactions as a source of knowledge (Doolittle & Camp, 1999).

Social constructivism lies in the middle of the continuum, between cognitive and radical constructivism, emphasising all four epistemological tenets. Social constructivism highlights the social nature of knowledge and reiterates that knowledge is a shared experience emerging from social interaction and language usage (Doolittle & Camp, 1999). Social constructivism asserts the importance of socialisation and enculturation among people. It points to the significance of both individual and social experience in the creation process of knowledge, with the recognition that knowledge will reflect an accurate representation of reality (Doolittle & Camp, 1999). So, social constructivism focusses on collective generation of meaning as shaped by the conventions of language and social processes (Crotty, 1998).

Social constructivism integrated the concept of individualism and collectivism and developed contextual thinking, where individuality and social forces are viewed as co-constructions of individuals within their communities (Owen, 1995). Social

constructivism evaluates the degree to which people operate at individual and collective levels, or intersubjectivity, where people reflect shared collective goals, beliefs, and experiences. So when a person says "I", it implies the emotions and thoughts positioned within the individual (Owen, 1995).

Social constructivism is based on an exploration of the ways that events, contexts, and processes are presented and modelled in language. People learn and change across time. Social constructivism asserts that we construct the social world by acting on our beliefs and suggests meaning and knowledge as culturally and historically positioned in the social context (Kuhn, 2012).

Axiology of constructivism paradigm

Constructivism axiology acknowledges that researcher's values and experiences are inseparable from the data. So it is imperative to recognise these biases and examine the participants' meanings thoroughly. Constructivist research, therefore, aims to explore and elucidate the values, hopes and expectations of a research project along with examining for researcher's biases and experiences (Charmaz, 2014a).

Based on the knowledge of constructivism, epistemologically, my stance is towards social constructivism. As previously stated, an epistemological position refers to how the researcher understand or knows the aspects of the world (Denzin & Lincoln, 2011). My comprehension of reality is constructed through multitude of perspectives and I believe that reality is developed through engagement with participants. I accept social constructionism acknowledgement of the participants' constructing meaning as interacting together, and that the meaning is influenced by culture (Crotty, 1998). Epistemology acts as a lens through which the research topic is approached (Denzin & Lincoln, 2011) and the methodological stance that is built upon the ontological and epistemological positions provides direction towards using suitable methods and tools to generate and analyse the information obtained within any study (Denzin & Lincoln, 2008).

Having defined my ontological and epistemological orientations, it was necessary to adopt a specific research approach that could fit within my intellectual orientation as well as the research study. Constructivist grounded theory has strong connectivity with the epistemological and theoretical starting point of constructivism, consequently enhancing the theoretical position of this research. Accordingly, it became clear that adopting Charmaz's constructivist grounded theory was most appropriate for the study.

Now, I explain Charmaz's constructivist grounded theory, and end the section by citing my reasons for choosing the methodological framework for this study.

3.5   Constructivist grounded theory

Constructivist grounded theory, a contemporary grounded theory method, like other interpretive approaches, emerged against positivism as a substitute to objective research designs. Constructivist grounded theory perceives abstract understanding of data and analysis as generated from shared experiences and relationships between participants (Charmaz, 2014a). Shifting the epistemological foundation, constructivist grounded theory revived and renewed the inductive, comparative, emergent, and open-ended approach to the original grounded theory methodology discovered by Glaser and Strauss (Charmaz, 2014a; Kenny & Fourie, 2014).

The constructivist grounded theory method is situated within the interpretive paradigm. Constructivist grounded theory aims to achieve an interpretive understanding of participants' meanings. Having said that, a constructivist approach means both looking at how people view their situation, and theorising the interpretation of what the participants are doing – accepting that it is an interpretation and the theory depends on the researcher's awareness of their views and working to make sure that their interpretation is as close to the participants' interpretation as possible (Charmaz, 2014a).

Constructivist grounded theory is a process of reconstructing the reality of the participants, but acknowledging that it happens under specific conditions of which the researcher might not be aware, or might be influenced by the researcher's perspectives, privileges, and experiences (Charmaz, 2014a). Co-construction of theory occurs within the analytical method wherein the researcher becomes aware of his/her own subjectivity to view, engage, and interrogate the data, and how the presuppositions affect the research. Thus, constructivism encourages the researcher's reflexivity about own interpretations (Charmaz, 2014a).

Constructivist grounded theory research is a fluid, interactive, and flexible methodology. The reconstruction process and the product create the researcher's developing conceptions grounded in the data (Charmaz, 2014a). Constructivist grounded theory researchers consider social phenomena as meaningful and as the focus of research. Constructivist grounded theory focuses on explaining the things that have particular meanings for people and the consequences of these meanings. In achieving

this outcome, constructivists study the manner in which, and always the ways in which, research participants construct meanings and actions in particular events.

Charmaz (2000) asserted that constructivist grounded theory acknowledges that the viewer and the viewed come together to create knowledge. Constructivist grounded theory accepts that the theoretical analysis of categories and concepts originates from the interplay of the researcher with the research question, the topic, and the data. Charmaz (2014a) accepted subjectivity and researchers' involvement in the construction and interpretation of data. The relationship between physical, cultural, and systemic conditions conceives the reality. Charmaz (2014a) also affirmed that the researcher's perception and viewpoint become part of the research process and the result.

3.6   Why constructivist grounded theory for this study?

Charmaz (2011) posited that constructivist grounded theory offers a methodical approach to social justice inquiry by integrating subjective experience with social conditions. In addition, a constructionist grounded theory recognises the constraints that historical, social, and situational conditions exert on these actions and acknowledges the researcher's active role in shaping the data and analysis. Constructivist grounded theory enabled interpretive understanding of historically situated data and co-construction of theory (Charmaz, 2011). Accordingly, the historical, cultural, contextual, and situational underpinnings of constructionist grounded theory approach looked appealing for addressing the research question for this study, which is understanding the process of recovery for South Asian people accessing mental health services in New Zealand.

Furthermore, constructivist grounded theory seeks to understand the worlds of people by analysing their situations, thoughts, feelings, and actions and represent the research participants' lives and voices. The participants' meaning of the situation shapes the direction and form of the research. The researcher learns to analyse participants' experience through their actions, intentions, beliefs, and feelings (Stern & Pyles, 1985).

According to Charmaz, the analytic procedure in a constructivist approach does not necessarily depend on a single basic process as indicated by Strauss and Corbin or a core category as advocated by Glaser (Bryant & Charmaz, 2007; Glaser et al., 1968). Instead, it recognises diverse local worlds and multiple realities and addresses how people's actions affects their local and larger social world. In the literature review, I have discussed the multiplicity and dynamic nature of culture and recovery. The logical extension of the constructivist approach means learning not only how people construct

meanings and actions but also why they act as they do (Charmaz, 2014b). The constructivist paradigm has the potential to help understand the socio-historical contexts that shape the experiences of participants. Accordingly, I was confident that by using the constructivist philosophy and procedural steps of constructivist grounded theory; I could address the research question and capture the concepts underpinning the process of recovery from a cultural perspective of South Asian participants.

Constructivist grounded theory's subjectivist epistemology acknowledges the involvement of the researcher in the development and analysis of the data – another factor that drew me closer to this method (Charmaz, 2014b). I agree with Charmaz that subjectivity is inseparable from social existence. Constructivist grounded theorists accept a reflexive viewpoint toward the research process and outcome. In the end, the subjectivity and apprehension as represented in constructivist grounded theory create a process of outward inquiry, and yet reflections pull us inward. Subsequently, constructivist grounded theory leads us back to the world for a further look and deeper reflection, again and again (Charmaz, 2014b). As a researcher, I had to accept that my personal experiences of being a South Asian immigrant in New Zealand, combined with extensive mental health knowledge and work experience, have led me to form opinions and biases that could potentially directly or indirectly influence the research process. It is not plausible to completely isolate my own views, but adopting the appropriate research approach should ensure theoretical and practical relevance while accounting for them.

Conducting a constructivist grounded theory needs a high level of self-insight and understanding. The concept of reflexivity has increased implication in social work literature about social work education, theory, and practice (D'Cruz, Gillingham, & Melendez, 2007). Social work training teaches reflexivity as a learning tool and as a process for guiding social work practice and enhancing practice wisdom. By learning the reflexive tools, I have been reflective and mindful of my attitudes, beliefs, perceptions, and interpretations; and their effect on my relationship with people. So this philosophical perspective and methodological alignment fitted well with my worldview.

Throughout data analysis, the iterative process of constant comparison led me to ask many questions about cultural values, conflict, and their importance to the participants and me. Listening and analysing participants' stories of conflict, trauma, and intensity of pain was overwhelming. It occurred to me that if I introduced the concept of perspective, it would balance the connection between the data and the emergent

confusion and questions. A perspective is a viewpoint on the reality that allows the individual to look and to understand the reality (Mills et al., 2006). As people interact over a period, they come to share a perspective, and they start interpreting through that perspective. Each perspective tells us something significant about what is true (Charon & Hall, 2009). Some participants in this study came to New Zealand as a child and were of my daughter's age; whereas, like me, some participants came to New Zealand as adults. Like my perceptions, participants had their own perception of moving to New Zealand and becoming well depending on their conditions and privileges. The subjective perspective of constructivist grounded theory allowed me to analyse the relationships between the participants and myself as the researcher (Charon & Hall, 2009). Through reflection of my own personal experiences as a South Asian immigrant to New Zealand, and supervision, I became aware of my privileges, values, and perceptions that enabled me to unfold the depth and richness of the data.

Constructivists emphasise entering the participant's world of meaning and action. They examine assumptions on which participants construct their meaning and action. Sharing an incident when entering the participant's world of implicit meaning enabled me to learn shades of participants' language and meaning. As I was interviewing one participant, I asked her about her family. She was from Pakistan. She said that she had six siblings. Being Indian, having one child myself, and accustomed to single child families in India, I looked a bit amazed. I tried to hide my amazement, but she noticed. She immediately said 'Masha Allah'. In English language, Masha Allah means as per God's will. I asked her why she said Masha Allah. She explained that in Pakistan it is customary to utter Masha Allah as people believe that it may help protect them from jealousy or an evil eye. The shared moment of meaning and wisdom advanced cultural meaning and helped me achieve an empathic bond through understanding and reaffirming her meaning.

The researcher analyses data to develop concepts and theory out of participants' stories and into explanatory theoretical interpretations. The conceptual analysis of constructivist grounded theory provides an opportunity to understand the relationship between participants' meanings and actions. It also explains how global, national, social, and economic conditions shape and are shaped by collective and individual meanings and actions (Charmaz, 2011). This perspective fitted with my research purpose and with my personal view of the world.

Constructivist grounded theory acknowledges multiple truths and the reality of subjectivity (Ryan, 2014). Charmaz (2014a) pointed out that thinking theoretically could take the research to new analytic places where they discover new ideas and different ways of looking at studied life. She concluded that when we use general concepts to launch our studies, then we must be open to the unexpected (Birks & Mills, 2015; Charmaz, 2014a). By adopting a position of mutuality and sharing assumptions with participants, I embarked into participants' world of cultural conflict and trauma that enhanced understanding of the complexities of the process and developing a subtantive theory of moving towards mental wellness by shifting cultural connectedness.

The flexible guidelines of constructivist grounded theory enabled me to be reflexive, view, engage, and analyse the data through my subjective, cultural, and professional perspectives. In this way, I had the opportunity to voice my viewpoints and perspectives whilst allowing the voices of participants to be heard. In the analysis, by using conceptual memo writing and diagrams, I was able to connect the what, why, and how of participants' encounters with cultural difference and trauma. Constant comparison and deeper examination of the data demonstrated the relationship between participants' shifting strategies, conditions, and the consequences. By constructivist positioning, I was able to understand how participants shifted their connectedness to manage the conditions that were contributing to them becoming mentally unwell.

I conclude this chapter, with an acknowledgement of grounded theory as a valuable methodology tool for cultural study.

Grounded theory and cultural context

Grounded theory bears the distinct stamp of a North American logic and approach to an investigation (Charmaz, 2014a). Nonetheless, grounded theory has spread across the globe. Researchers in various disciplines and professions throughout the world have adopted this method for qualitative inquiry.

Cultures are diverse, changeable, dynamic, and increasingly becoming mixed. The cultural background of both the participants and researcher in the present study differs from the culture in which grounded theory originated. According to Charmaz, language, more than culture, influences social science studies (Charmaz, 2014a). The essence of specific languages influences the characteristics of cultural traditions and norms. Being

Indian and bilingual, I was able to connect with the South Asian participants, understanding the meaning of their behaviour and actions. However, translating the native language and coding in English was difficult. Searching for an exact English translation was often demanding. Receiving culturally sensitive support and guidance from my supervisors, I sometimes described an action with additional words. I also kept a few original quotes to maintain the flavour of the participant's conversation and meanings. It was challenging, no doubt, but the complicated process of translating and transcribing helped me to reflect more on the analytical process. On reflection, the challenges helped me to develop a critical stance towards the analytical codes.

Co-constructing data with the participants and recognising the subjectivity that influenced their lives was in keeping with my focus in the study. Embracing Charmaz's constructivist grounded theory assisted me in examining the process of South Asian people accessing mental health services in New Zealand.

3.7 Summary

The aim of this chapter was to describe the methodology used in this study. Firstly, I explored the history of grounded theory development followed by examination of differences between the classic grounded theory, Straussian grounded theory, and constructivist grounded theory. Then, I discussed my perception of the ontological, epistemological, axiological and methodological underpinnings of the research. Through this discussion, I identified Charmaz's constructivist version of grounded theory as my methodological tool as my beliefs aligned with the constructivist paradigm. Accordingly, I acknowledged that the data collection within this study was a co-construction between myself and the participants. I also accepted the implications of my perspectives, biases, privileges, and experiences on the data analysis. Consequently, recognising my values and beliefs, its relevance to this study, grounded theory methodology was identified as an appropriate strategy of inquiry for uncovering new understandings of the mental health recovery process from a South Asian perspective.

Presenting the rationale for constructivist grounded theory as the research methodology, this chapter has provided background for the next chapter, which details the research design of this study. Chapter four explains the steps taken to collect, analyse, and generation of a substantive theory about moving towards mental wellness by shifting cultural connectedness.

Chapter 4 Research methods

4.1 Introduction

Charmaz (2014a) described grounded theory methods as "systematic, yet flexible guidelines for collecting and analysing qualitative data to construct theories from the data themselves" (p. 1). The research methods provide the tools for interpreting the data and accomplishing the research goal (Mills & Birks, 2014). In general, grounded theory methods is the research design that assists the development of the theory (Charmaz, 2014a).

This chapter addresses the methods and procedures that produced the theory of shifting cultural connectedness. The chapter begins with description of the sampling and recruitment approaches. Next is an overview of the processes of the initial data collection, initial coding, focused coding, establishing saturation, and memo writing. Thereafter, the processes of theoretical sampling, theoretical coding, sorting and integrating memos to develop the theory of shifting cultural connectedness are explained. The chapter concludes with an outline of ethical considerations in the design and conduct of the study.

4.2 Sampling process

The sampling technique adopted is an important element of the overall sampling strategy. Sampling in a grounded theory study is unique as it does not adhere to a prescribed routine and the sample size is not accurately defined at the outset (Birks & Mills, 2015). A grounded theory sample is purposive, where the sample is chosen according to specific inclusion and exclusion criteria that are relevant to the purpose of the research and ensure selected participants have the desired qualities or abilities. Purposive sampling, requires the researcher makes a critical decision about what or who will provide the most information-rich source of data to meet his or her analytic needs (Liamputtong, 2013).

The data collection methods proceed from the research question (Charmaz, 2014a). Acknowledging the role of the researcher in the construction of theory, Charmaz (2014a) suggested that the researcher's personal and professional background assumptions might also shape research topics at the beginning of the study. Therefore, it is appropriate to expand upon the researcher's background before data collection.

I wanted to study the process of becoming mentally well for South Asian people who had accessed mental health services in New Zealand. Being a South Asian immigrant to New Zealand, I chose to study South Asian people as I wanted to do research with those with whom I share a social, cultural, and linguistic background; also known as cross-cultural research (Birks & Mills, 2015). Song and Parker (1995) concluded that cultural commonality reduces cultural and linguistic barriers; thus, giving researchers unique insights to conduct the research in a more sensitive and responsive manner. The researchers are able to ask more meaningful questions and read non-verbal cues, and, most importantly, be able to project a more accurate, authentic explanation of the culture under study (Song & Parker).

Adopting a grounded theory methodology in my study meant adapting and integrating global perspectives with the cultural practices of South Asian people settled in New Zealand. The constant comparative processes that direct the grounded theory approach produced a new way of perceiving emergent categories and added value to the theory construction. For example, during data analysis, I was making the comparison of South Asian cultures with New Zealand cultures from the participants' perceptive. I was defining the process of cultural dissonance within the culture of the new country. As I was constantly comparing incidences, I discovered the process of dissonance within the culture of the birth country. The constant comparative process of the grounded theory gave more depth to the findings. Grounded theory methodology gave me a pragmatic way of constructing a theory of social and cultural dimensions aligned with participants' social and cultural dimension.

4.2.1 Location of the research

The study was conducted in a local District Health Board (DHB) region, which reflects a melting pot of cultures from around the world. The location is comprised of residential and industrial suburbs, attracting South Asian migrants to settle in this part of Auckland. Working in a DHB for 20 years means that I am familiar with the health needs of the South Asian population in New Zealand. I also had existing relationships with key workers and General Practitioners (GP) working in the local DHBs. As a result, I anticipated that these connections and the familiarity would facilitate the recruitment of potential participants able to provide rich data.

4.2.2 Participant selection

Adults were recruited as participants upon meeting the following criteria:

1. Aged 18 years and over;
2. Identified as South Asian (South Asia includes the countries of Bangladesh, Bhutan, India, Pakistan, Maldives, Nepal, and Sri Lanka);
3. Migrated to New Zealand;
4. Had contact with mental health services in the last five years; and
5. Had a diagnosis of a major psychiatric disorder in the DSM system. (The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V) is the 2013 update to the American Psychiatric Association's (APA) classification and diagnostic tool).

The following exclusion criteria were used in the study:

1. Diagnosis of a personality disorder (personality disorders previously belonged to a different axis in DSM-V, than almost all other disorders, but are now included as Axis 1 with all mental and other medical diagnoses);
2. Acutely unwell at the time of interview;
3. Second generation immigrant; and/or
4. Known personally to the researcher (e.g. family, friends, or clinicians).

A maximum of two adult family members were recruited as family participants, as selected by the participants.

4.2.3   Recruiting participants

Locating potential participants can be a challenging and often problematic task. Cross-cultural research can be further complicated because of language and cultural differences (Liamputtong, 2010). Liamputtong noted that people from immigrant or minority groups might not understand the nature of research and hence refuse to participate. Considering the potential social and physical barriers to participation, I attended local adult mental health team meetings and involved the key workers' support in locating potential participants. I also visited General Medical Practitioner's (GPs) clinics in Auckland and sought assistance of the GPs and the clinic nurses in recruitment. I displayed an Auckland University of Technology Ethics Committee (AUTEC)-approved invitation for the study in the GP clinics and the adult community mental health clinics (see Appendix C). I distributed AUTEC-approved information sheets (Appendix D) to colleagues to pass on to South Asian service users.

4.2.4 Cultural sensitivity

With increasing immigration, societies are becoming multicultural; creating complex research relationships that could affect grounded theory methods of data collection (Charmaz, 2014a). Conflicting cultural beliefs, rules, and values might shape the research relationship. Sheridan and Storch (2009) noted that researching people who are culturally different, particularly when some of them have had tragic experiences, is difficult, emotionally draining, and time-consuming. Using grounded theory enables exploration of new or deeper interpretations of intercultural experiences, and Sheridan and Storch (2009) have suggested intercultural competencies for consideration in cross-cultural research. At this stage, before describing the characteristics of the participants, I would like to point out some important practical issues I considered for this study. These practical matters, which I have learned doing the study and through reflections, are essential for performing cross-cultural research.

Respect

Respecting the cultural values and practices of research participants is an essential part of performing cross-cultural research (Preloran, Browner, & Lieber, 2001). I used greetings like Sat Sri Akal (Truth is ultimate God) for Sikh participants and Allah Kareem (God is generous) for Muslim participants. Greetings were necessary for opening and closing the conversation.

Observing day-to-day practices commonly carried out in the culture is also a way to show respect. I always left my shoes outside the house. Refusal of food offered is considered rude, so I asked for water when offered any food, to avoid being disrespectful. It is also respectful to bow in front of a senior. I kept in mind the religious calendar and avoided recruitment during the festivals of Ramadan and Diwali for Muslim and Hindu participants respectively.

Developing a trusting relationship

Researchers work to develop a good rapport and maintain cultural sensitivity to collect quality and reliable data from individuals of different cultures (Liamputtong, 2010). Before starting the interview, I spoke to the participants about my background. I told them my story of coming to New Zealand, my family, and the story behind my doing this research. Disclosing my story helped to open up a trusting relationship with participants. My first participant was anxious and fearful about being recorded. To gain

rapport and confidence, I recorded my voice and played it. She slowly developed trust and agreed to be recorded.

Dressing is important in cross-cultural research studies, as dressing neatly and formally is a way of showing respect. A female researcher should not reveal too much of her body (Liamputtong, 2010). I realised the importance of wearing appropriate clothes when I was interviewing Sonia. I was dressed in a western outfit whereas she was wearing salwar kameez (a traditional outfit originated in South Asia that comprises of salwar (pantaloons) and the kameez (shirt) combined to form the salwar kameez). She had dastar (turban) on her head. A dastar is a symbol of honour, self-respect, spirituality, and holiness in Sikhism (Sikhnet, 2010). Therefore, from her dressing, I recognised that she was traditional.

Sonia was reserved and bit distant during the interview inspite of interviewing her in Hindi language. After the interview, when I reflected on the process, I realised that perhaps being dressed in a western outfit made me an outsider. Liamputtong (2010) recognized that an insider endorses the unique values, perspectives, behaviours, beliefs, and knowledge of his or her community and culture. In contrast, an outsider holds values, beliefs, attitudes, and awareness of the community and culture but is not assimilated into the community (Banks, 1998). The researcher becomes an external outsider when socialised within a community that differs from the one in which he or she undertakes the research (Banks, 1998). When I visited Sonia again, I wore a traditional outfit and noticed that she was relaxed and comfortable with the interview.

Considering the needs of participants: Interview location

Researchers need to carefully consider the location where they will carry out their research so that the needs of the participants can be taken into account (Banks, 1998). The participants were more comfortable being interviewed in their houses so, except for one participant; I interviewed all others at their homes. A common issue in this approach was the background noise made by other family members, making it difficult to hear the participant. I ensured placement of the microphone to facilitate clear recording.

4.2.5 Participants' characteristics

A concise table of participant characteristics, taken from the demographic data forms, is presented in Table 2 (p.83). There were 16 participants, out of which, five family

members were interviewed. Five participants were interviewed twice to deepen the conceptual development and verify that the theory developed from the interviews was reflective of their recovery process.

There were seven female participants and four male participants. All major South Asian religious groups were represented: Christians, Hindus, Muslims, Parsi, and Sikhs. Details of participant profiles are described in Appendix E.

.

Table 2. Profile of participants

Name*	Age	Gender	Education	Country of origin	Length of stay in NZ	Marital status	No of children	Living situation	Employment	Religion
1. Tanya	39	F	B Com	India	14	Married	-	Lives with family	Casual	Hindu
2. Sarah	27	F	BSc	Pakistan	12	Separated	-	Lives with family	Beneficiary	Muslim
3. Rose	18	F	1st year University	India	10	Single	-	Lives with parents	Student	-
4. Blondie	32	M	BSc	Sri Lanka	20	Single	-	Lives with parents	Beneficiary	Hindu
5. Sonia	44	F	Primary	India	10	Married	2	Lives with family	Housewife	Sikh
6. Suzie	49	F	Masters	India	16	Divorced	2	Lives with family	Self- employed	Sikh
7.Angela	51	F	Year 10 (Secondary school)	India	27	Married	3	Lives with family	Housewife	Sikh
8. Sunny	40	F	BSc	India	12	Divorced	2	Lives alone	Beneficiary	Hindu
9. Ajay	23	M	Masters' degree	India	22	Single		Lives with family	Beneficiary	Christian
10.Bob	61	M	Year 13 (Secondary school)	India	5	Married	2	Lives with family	Not working	Hindu
11. Rob	26	M	B Com	India	17	Single		Lives with parents	Working	Parsi

*Pseudonyms

4.2.6 Data collection

As noted previously, grounded theory researchers aim to create robust grounded theories from rich data (Charmaz, 2014a). Diverse kinds of data can be used to build grounded theories. The type of data the researcher gathers depends on the topic of study (Charmaz, 2014a). Intensive qualitative interviewing is suitable for grounded theory as this approach helps to learn about the world and advance progress in constructing a theory (Charmaz, 2014a).

Data collection strategies must be suitable for the particular culture and individual research participants (Charmaz, 2014a). The approach to interviewing, precise word choice, and the interactional style of the interviewer during the interview need to respect the traditions and context of the interviewee. Constructivist grounded theorists' attention to language and discourse facilitates participants to reflect upon their experiences during the interview in productive ways for advancing theory construction (Charmaz, 2014a). In this study, semi-structured interviews helped to uncover the actions, intentions, and practices of South Asian people accessing mental health services in New Zealand.

I had devised broad, open-ended questions, encouraging unanticipated statements and stories to emerge (see Appendix F). I asked each participant to choose a pseudonym. Before the interview, I explained the terms of participation and obtained consent. I started each interview with a brief introduction to the study and the process of the interview. I obtained written consent and recorded their verbal consent. Each interview was 45-60 minutes in duration and was digitally audiotaped. Interviews were then transcribed, and a copy of the transcription offered to participants, to read and make any changes they wanted. Two participants asked to read the transcript. Data analysis commenced after the first interview but I did not commence data analysis of these participants' transcripts until they were approved.

Participants made the decision about the location of the interviews, time, date, and place. I submitted to AUTEC a home visit safety plan to address prevention and intervention of any adverse event that I might encounter during data collection (see Appendix G). I conducted 10 interviews in English and the remaining interviews in Hindi. I am fluent in English and Hindi. As the sole researcher, I also translated the interviews, and then transcribed them verbatim. Finding appropriate English words and exact meanings for some terms and concepts used by participants was time-consuming

and delayed the research timeline, but it was important to retain the essence of each participant's voice. I collected data from October 2015 to June 2017.

From a grounded theory standpoint, asking a few interview questions allows participation of the research participant to tell his or her story, barring the researcher from preconceiving content or the direction the interview will take (Charmaz, 2014a). I started the initial few interviews by asking the participant, 'Tell me what made you come to New Zealand?' This general question helped me to develop a rapport with the participant and build comfort. Then I asked, 'How did you come in contact with mental health services?' After a few interviews, I realised that I was not giving enough time to participants to reflect and answer. I had to learn to sit back and let the participant take control of the interview. It was difficult as, being a clinician, I had become habituated to asking structured questions. Many of the participants found it difficult to voice their experiences. I learned to use less clinical terminology that they were able to understand. I started asking, 'What does getting better look like to you as an Indian in New Zealand?' and 'What would help you to live a life which is satisfactory to you?'

I am aware that story telling is a powerful data-gathering tool. The life story is especially important for studying how individuals sense social changes, along with social and personal problems emerging from these changes. The collaborative generation of knowledge, between participant and researcher, can be an empowering experience for participants, as they can gain insight into pivotal moments in their lives. Individuals narrate their memory through their story (Liamputtong, 2010). The story-telling process allows participants to validate their experiences. Such an approach has the advantage of giving voice to a person who has felt silenced. It allows participants to feel safe and supported enough to talk through any difficult circumstances surrounding, for example, the loss of their identity. I tried using story-telling prompts to explore illness beliefs; such as, 'What do they call the illness?' 'How do you deal with it?' 'How do you adjust and respond to these changes?' and 'How have your family, marriage and other traditions/practices influenced these changes?' I slowly started asking questions to assist with the developing patterns of emerging concepts. This approach provided for complete narration of participants' experience with minimal interruption from me.

4.2.7 Memo writing

Memo writing is a central step in grounded theory linking data collection and theory development (Charmaz, 2014a). A critical analytical process, writing memos includes the recording of processes, thoughts, feelings, insights, decisions, and ideas about a research project. In grounded theory, writing memos involves analytic thinking by recording thoughts about the codes and emerging categories. It is an important method because it gives hints to researchers to analyse the data and develop the codes into categories in the research process. By writing successive memos, the researcher stays involved in the analysis, improving the level of abstraction of the developing concepts (Charmaz, 2014a). I wrote the following memo after interviewing Ajay. At that stage, feeling confused and facing conflict was a theme emerging from the interviews. I delved into its dimensions and its relationship with other concepts.

> 20.03.17. Ajay is feeling ostracised within Indian community and feeling like an outsider among Christians. Ajay must be feeling torn between two worlds. Dhobi ka kutta, na ghar ka na ghat ka. (This is a Hindi proverb that means a person who is respected nowhere). He must be confused where do I belong? Do I connect with my family or with my school friends? How does it feel to be an outsider? It must be so confusing and stressing for him. He perhaps must be experiencing a huge sense of loss, feeling of alienation. The feeling is making him angry with his parents for putting him in this conflicting situation. How does he deal with this conflict? I need to explore the feeling of being an outsider and what strategies people use to deal with this feeling.

Writing memos on conflict helped me to make sense of the struggle and confusion the participants encountered. When I was engaging in constant comparison, the memo writing led me to define and develop the category of encountering differences. It also directed my subsequent coding and moved me toward conceptualising the relationship between encountering differences and engaging strategies to manage the differences. Memo writing, thus, helped me maintain analytic momentum.

4.3 Overview of the grounded theory process

In this section, I outline the grounded theory research process used in this study. This section explains the process of conceptual development, which includes the tasks of coding and categorisation, and moves into the final phase of theory development.

In constructivist grounded theory, theory development is a continuous activity. The researcher and participant join to build a theory that provides abstract understanding

rather than only concrete explanations of the studied phenomenon (Charmaz, 2014a). The researcher aims to comprehend meanings and actions, and how people construct them. Thus, the theory brings in the subjectivity of the participants and identifies the subjectivity of the researcher. Rather than explaining the reality, the researcher moves beyond the participants' conception to build theoretical interpretation that makes sense of the studied phenomenon (Charmaz, 2014a). Figure 7 below (p. 110; from Birks and Mills, 2015) illustrates the continuous and evolving nature of data collection and analysis in grounded theory.
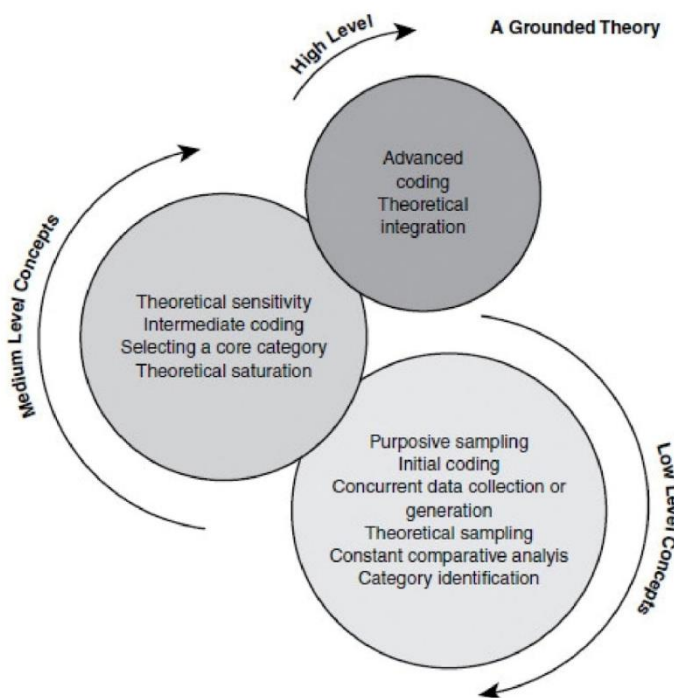
Figure 7. Stages of grounded theory (Birks & Mills, 2015, p. 110)

Data analysis, in constructivist grounded theory, begins with coding. Constructivist grounded theory coding consists of initial coding and focussed coding. I started data analysis with line-by-line coding and then moved to focused coding with developing tentative categories. Using theoretical sampling, constant comparative analysis, diagrams, and memo writing, I advanced the established categories into major theoretical categories, raising a major category to the main concept and assimilating the whole theory by constructing explanatory links between theoretical categories and the main concept.

4.3.1 Coding

Coding means the process of studying, defining, and labelling small segments of data for analytic purposes (Charmaz, 2014a). According to grounded theory, data analysis proceeds together with data collection to ensure that the final theory is grounded in the data (Charmaz, 2014a). I began the process of coding with line-by-line coding. I built a coding sheet (Appendix B), with space for the transcript, for coding on one margin and room for short memos on the other. While I coded, I wrote brief analytical memos directly onto the transcript for later follow up. Initially, I worked out the coding with my supervisors' input, which supported me to understand the analytic process involved in grounded theory. I started reflecting on 'What process or action is happening here?' I highlighted significant phrases and sections, and inserted first-level codes in the form of either gerunds or in vivo codes. Charmaz (2014a) emphasised use of gerunds (verbs used as nouns that always end with 'ing'). She asserted that gerunds promote theoretical sensitivity by initiating thinking about actions that aids coding to classify sequences, processes and making connections in the data. "Codes are a type of shorthand that researchers repeatedly use to describe conceptual recurrences and similarities in the patterns in the data" (Birks & Mills, 2015, p. 88).

After completing four interviews, I discovered emerging patterns including 'encountering hurdles', 'fitting in', 'taking a stand', 'maintaining cultural connections', 'leaving behind', 'feeling confused', 'having no choice', 'conflicting parental ideas', and 'losing respect for parents'. Table 3 presents an example of initial coding. I have provided additional examples of initial coding in Appendix H.

I kept invivo codes (coding using participants' special terms) where possible, for example 'fitting in'. Some participants mentioned this phrase to refer to their behaviour of trying to belong and feel accepted by the new country. "In vivo codes serve as symbolic markers of participants' speech and meanings" (Charmaz, 2014a , p. 134). With subsequent interviews, the number of codes and memos increased. I then used qualitative analysis software NVivo to help organise, rearrange, and manage the interview data. However, for coding, I preferred to keep the code summary in a Microsoft Word table form. The manual method aided me in remaining close to my data and thinking through each change.

Table 3. Example of a line-to-line coding

Data	Initial codes
This is the around the time when I was 13 to 18 years. This is the damaging part as I freaked out as well. I wanted to live the good life. I realized that I could not get that life adhering to their strict Christianity belief. And my parents made no sense for me. We were not even going to the church at that time. (Ajay)	Freaking out Becoming damaged Wanting to live the good life Feeling restricted by Christianity

As tentative categories were emerging, I began to question connections between the processes. Theoretical sampling prompted me to go back and collect more data about the properties and fill the gaps between ideas.

Theoretical sampling allows the researcher to develop the analytic properties of a developing category or theory (Charmaz, 2014 a). Theoretical sampling guides the next stage of data collection in the process of concurrent analysis (Hogan, Morse, & Tasón, 1996). "Theoretical sampling is not just about what you do, it is also about how you do it" (Birks & Mills, 2015, p. 68).

Theoretical sampling is a crucial aspect of grounded theory studies (Birks & Mills, 2015). The rationale behind theoretical sampling distinguishes grounded theory from other types of qualitative inquiry (Hood, 2007). Theoretical sampling means exploring appropriate data to develop emerging theory. The primary aim of theoretical sampling is to expand and refine the categories constituting the theory. Theoretical sampling is achieved by sampling of data to improve the properties of the categories until a pattern emerges and no further categories emerge (Charmaz, 2014a).

Theoretical sampling guides initial sampling, assembling tentative ideas about the data, and then analysing the data through empirical inquiry. As I was studying South Asian phenomena, I decided to include participants' families, as families are usually important to South Asians. During initial coding, I identified the category of family support. Theoretical sampling prompted me to fill the gaps by exploring where and how I could get further data. In the beginning, I had interviewed few female participants, so I interviewed male, young, and older participants specifically to seek clarification about the issue of family support. Theoretical sampling, memo writing, and constant comparison helped me to describe the category of family support and I realised that family support was a condition that was leading to cultural dissonance.

Theoretical sampling is emergent. Theoretical sampling in grounded theory is a valuable tool for developing analysis and correcting trouble spots. It encourages following up on analytic leads. Thus, adopting theoretical sampling helps raising theory to a formal and abstract level that identifies diverse substantive areas (Charmaz, 2014a).

Theoretical saturation

When do you terminate data collection? Theoretical saturation specifies the point when gathering more data about a theoretical category does not lead to any new properties nor give additional theoretical insights about the emerging grounded theory (Charmaz, 2014a). In other words, the theoretical categories are saturated and robust and new properties are not emerging (Charmaz, 2014a).

Theoretical saturation is not similar to observing recurrence of the same event or stories.

> Saturation is not seeing the same pattern over and over again. It is the conceptualization of the comparison of these incidents, which yields different patterns, until no new properties emerge. This yields the conceptual density that when integrated into hypotheses make up the body of the generated grounded theory with theoretical completeness. (Glaser, 2001, p. 191)

At the beginning of the study, the number of participants needed in order to reach theoretical saturation was unknown. AUTEC and the Health and Disability Ethics Committee (HDEC) ethics committees approved an educated guess of a maximum of 30 participants. I stopped data collection after 21 interviews.

Constant comparative analysis

Data analysis in grounded theory depends on the constant comparative method. Comparing new data with earlier data helps to reveal similarities and differences and facilitates the identification of patterns. Comparisons are made across incidents, between incidents with categories, and across categories (Charmaz, 2014a). As advocated by Charmaz (2014a), I looked for differences within each transcript to observe how participants changed their strategies/actions when conditions shifted and also started comparing the codes with the data in subsequent interviews. The constant comparative analysis deepened my understanding of the emerging concepts. I gained new insights about how people managed themselves to deal with their conflict. The comparative method also guided my theoretical decision-making. As mentioned in the section on theoretical sampling, constant comparative analysis directed my theoretical

sampling. In my initial interviews, I had interviewed participants who had migrated to New Zealand at a young age, so I later recruited participants who migrated to New Zealand as an adult. I also recruited male participants to get different perspectives on the emerging code of encountering cultural difference when the participants migrated to New Zealand. Then during the initial interviews, I perceived that the participants lived in the family with fairly prescribed gender roles. So I looked for and found two female participants who had shifted from the prescribed role of homemaker to working and financially supporting the household. Furthermore, I found a family where the father moved into housework to support his unwell wife, which helped to add further complexity to the category.

4.3.2 Focused coding

Focused coding means combing through the most significant and frequent earlier codes and examining a large amount of data (Charmaz, 2014a). It is reflexive activity where the researcher constantly interrogates themselves about the earlier analytical decisions. It needs analytical skill (Charmaz, 2014a). I was overwhelmed by the task initially and my thinking was blocked. With my supervisors' guidance, I went back to Charmaz's text. Around the same time, I had the privilege of attending Kathy Charmaz's master class on grounded theory and talking to her about my research study. She suggested to go back to the data and to make a coding tree (clustering). Charmaz (2014a) advocated use of the clustering technique for focussed coding. Clustering is a doodle pre-writing method, which gives pictorial, flexible, and changing techniques to understand and organise data (Charmaz, 2014a). Clustering and going back to the data led me towards a spiralling process the participants were engaging in to become well. I started labelling and expanding the categories. Because of the spiralling nature of the participants' process, I placed the central category in the centre and built defining properties showing the relationship and relative significance. I used Inspiration computer software for organising the clustering process. The following figure 8, p. 93 is an example of clustering. I have provided the other clustering diagrams in Appendix J and K.
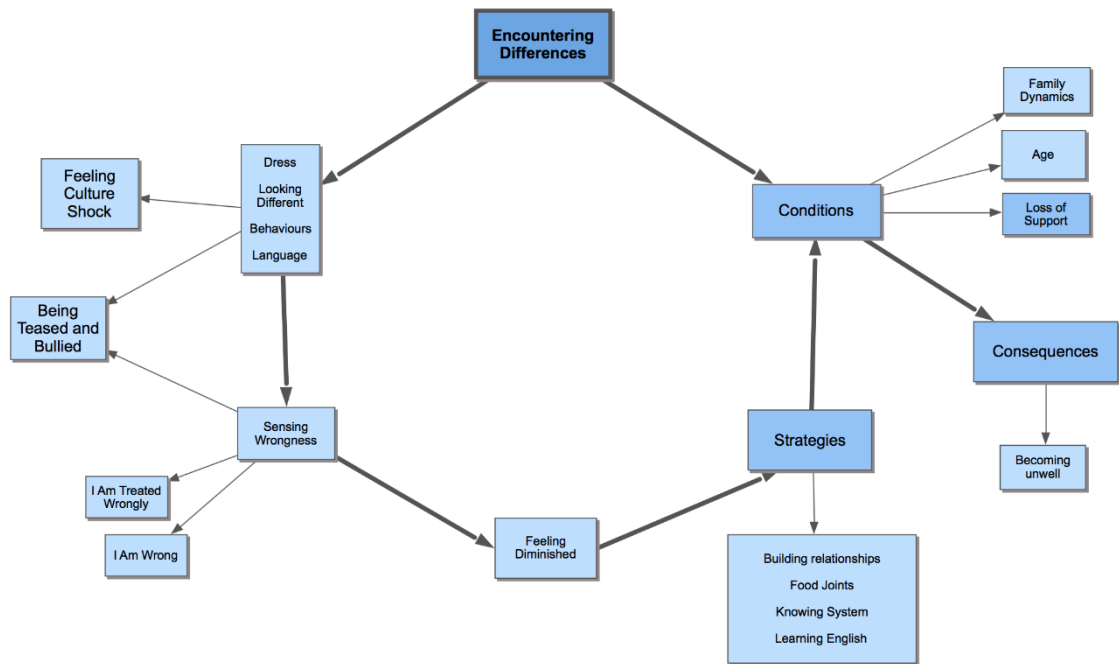
Figure 8. Coding tree diagram

I followed the clustering process with free writing and memo writing. Free writing encouraged me to write without restriction of grammar and constraints. Clustering, free writing, and memo writing helped me to draw connections between the codes and raise the focussed codes to conceptual categories.

4.3.3 Developing a theory

Thornberg (2012) stated "theory describes the relationships between abstract concepts and may aim for explanation or understanding" (p. 41). Theorising means determining what happened, how it developed, and a possible explanation for why that happened. Constructivist grounded theory constructs research processes that occur under previous systemic conditions, emergent situations and are influenced by the researcher's viewpoint, beliefs, privileges, positions, and environment (Charmaz, 2014a). Asking an analytical question about the data provides the researcher with a new way of seeing, examining, and engaging with the data that aids in converting the main categories into concepts. The researcher constructs theory by explanation, grouping, and presentation of the data (Charmaz, 2014a).

Theoretical sensitivity

Theorising in grounded theory means pausing, contemplating, and thinking again. Glaser, Strauss, and Beer (1968) posited *theoretical sensitivity* as the researchers' deep

and personal insight into themselves and the area of research. Gaining "theoretical sensitivity involves seeing possibilities, establishing connections and asking questions" (Charmaz, 2014a, p. 244).

Throughout the present study, I have applied various tools, as suggested by grounded theorists, to foster theoretical sensitivity. Theoretical sensitivity brings analytical precision to the data. From a constructivist grounded theory perspective, theories reflect the processes and explain the conditions inherent in varied experiences (Charmaz, 2014a).

As I was theorising, I probed the fundamentals and questioned the major categories "*encountering cultural difference*" and "*experiencing trauma*" that I had formulated. But I tussled, as I was unable to understand the connection between the different processes. I was engrossed in the codes and could define and explain the shock the participants were experiencing when they migrated to New Zealand, but was unable to move forward. At this stage, my supervisor suggested to reflect on "*What was happening? All immigrants' encountered cultural difference". So* I realised that I was interpreting the data from my perspective. Being a South Asian parent and social worker, I was interpreting the data as systemic issues like discrimination and marginalisation and not acknowledging the dynamics within the family. Through going back to the data, memo writing, clustering and diagrams, I probed into my viewpoints, attitudes, position, and my privileges. I was able to understand the participants' meaning of their experience and finally realised that the conditions of age and family dynamics were leading to conflict and influencing the meaning, strategies, and outcome. I started seeing the emergence of the process of *shifting cultural connectedness* to manage the dilemmas. I also accepted that every individual experiences the world in a unique way. The process of *shifting cultural connectedness* is continuous and changes depending on the circumstances. That realisation helped me to achieve integration of my theory.

I end this chapter by highlighting the ethical considerations that must be canvassed in designing a study to determine the rigour of the research process and quality of the theory.

4.4 Ethical considerations

Ethics is a group of moral principles that aim to avert researchers from harming the participants, communities, or themselves (Birks & Mills, 2015). There are four principles that researchers must conform to in their research:

1. Respecting autonomy means the participants make an informed decision about involvement in the research.
2. Beneficence is accountability to provide benefits to the participants and the public.
3. Non-maleficence is prevention of harm or discomfort.
4. Justice implies benefits, risks, and costs are equally distributed (Liamputtong, 2006).

These basic ethical principles should form the basis of all research. However, since I was undertaking sensitive research, I applied for ethics approval from AUTEC and HDEC and locality approval from the relevant DHB. I received ethics approval on 6th May 2015 (15/95) from AUTEC (Appendix I). I received locality approval from the DHB on 4th June 2015 (Appendix J) and from HDEC (15/CEN/88) on 10th July 2015 (Appendix K).

There are debates about moral issues regarding sensitive research. Should we carry out research with some people who are vulnerable and marginalised, such as individuals who have a mental illness, or migrants, when these people are already vulnerable in so many ways (Liamputtong, 2006). However, Morse (2000) argued that doing research with extremely vulnerable people is good in the moral sense. For example, she maintained that it is morally imperative to gain knowledge about people with terminal illness if we aim to achieve a service provision of high quality that meets their needs (Morse, 2000). Three key areas requiring ethical consideration were the possible benefits and risks for the participants, maintaining confidentiality, and Te Tiriti o Waitangi. I will discuss each of these ethical aspects as considered in the study.

4.4.1 Minimisation of risks

Research participants often reveal highly personal and intimate details about their lives. Nevertheless, there are some positive outcomes in participating in sensitive research. Participants may gain satisfaction by voicing their stories and knowing that sharing their experiences may help others, for example, in recovery (Morse, 2000).

The participants in the present study were advised at the beginning of the interview, for maintenance of my professional integrity, that in case they might need help for their psychological discomfort or disturbance during the interview session, I would refer them to their treating clinician. If they disclosed that they were currently at risk of significant harm or of harming others, then first, I would stop the interview and would encourage them to share the information with their treating clinician, to ensure that they received appropriate support. I was aware that the participants could utilise counselling support from the AUT counselling team. However, as continuity of care is important, I would involve the treating clinician or GP who would be familiar with their circumstances. The participants were encouraged to bring a support person to the interview, to help them feel more comfortable during the session.

Being an immigrant and immersed in the research relationship can be emotionally exhausting for the researcher (Copeland, 1997). Listening to people talking about highly personal aspects of their lives can cause emotional strain to the interviewer. Accordingly, I sought regular cultural supervision for debriefing and personal reflection.

4.4.2 Maintaining confidentiality

The South Asian communities throughout New Zealand are relatively small and people seeking mental health services comprise a minority cultural group. Throughout the research, all audiotaped and written data were available only to my supervisors and me. I gained participant consent to use parts of the anonymised transcribed interviews with fellow researchers for analytic purposes.

I maintained participant's confidentiality by having participants choose pseudonyms and anonymising any identifying details in the transcripts and thesis. I avoided participant identification in any reports, presentations, or publications arising from the research. Materials about the study, including typed transcripts of interviews, were stored in a locked filing cabinet at my home address that has a secured alarm system. I will destroy the materials after six years, as required by AUTEC. Consent forms were separated from data and kept by my primary supervisor in a locked cabinet.

4.4.3 Te Tiriti o Waitangi

As the study took place in New Zealand, it was important to recognise the unique significance of Māori as tangata whenua (people of the land or Māori people), the essential nature of the bicultural partnership between tangata whenua and tauiwi (non-

Māori people), and the meaning of Te Tiriti o Waitangi/The Treaty of Waitangi. Though the present study does not involve Māori, in New Zealand any research study needs to reflect our commitment and the obligations under te Tiriti o Waitangi. I sought consultation with a DHB kaumatua who agreed to provide supervision/consultation if any issues arose regarding the principles of Te Tiriti o Waitangi (Appendix N). However, no issued arose during the study.

4.4.4 Ensuring rigour

Rigorous research is authentic so that researchers can rely on it (Liamputtong, 2006). Corbin and Strauss (2014) identified conditions of fit, understanding, generality, and control to foster quality in research. They maintained that vividness, congruence, and sensitivity are all important for developing theory (Corbin & Strauss, 2014). Drawing on the concepts of creditability, transferability, confirmability, and dependability, I have ensured rigour in the study.

Credibility inquires whether the explanation of the presented data fits the description of the participants' experiences and if the description is credible (Liamputtong, 2013). Credibility in grounded theory is based on how data collected through research accurately reflects the multiple realities of the phenomenon. Glaser et al. (1968) stated that the reader of research should "almost literally see and hear the people" (participants) (p. 228). Beck (1993) explained that a study was credible when it illustrates a vivid and faithful description, so that both participants and readers will recognise the reflection in the process of researcher's conceptualisation. I ensured the credibility of this study by following the usual procedures of grounded theory for questioning, constant comparison, sampling, analysis, and record keeping (Cooney, 2011; Liamputtong, 2013).

The first step to ensuring research credibility is countering the researcher's potential biases and revising hypotheses that do not fit the reality of the participant's situation. I critically examined my potential impact as researcher on the research process by having a pre-assumption interview with a person familiar with qualitative research. Before commencing a doctorate, I had spent over 20 years working in the field of mental health. My subjectivity and perspective could have skewed interview processes or data interpretation as a result of existing prejudices and biases from my previous experience and personal insights about the research topic. Conceivably, this could have

subsequently affected the integrity of the findings if not adequately addressed (Hall & Callery, 2001).

I also used supervision and grounded theory monthly group meetings to strengthen the research credibility by reflecting upon the research process. Taking a reflexive approach to the data analysis assists the researcher to avoid subconsciously employing preferred theoretical codes during initial coding, and instead developing theoretical sensitivity at the same time (Birks & Mills, 2015). Theoretical sensitivity refers to comprehension and description of the phenomena in abstract terms and a demonstration of the abstract relationship between studied phenomena (Charmaz, 2014a).

Member checking assesses credibility, whereby the other clinicians recognise the reflective processes in their health service. Member checking requires going back to the research participants, with the researcher's interpretations, for their confirmation or otherwise (Charmaz, 2014a). I interviewed five participants a second time to check an emerging category: 'fitting in'. In the second interviews, I asked the participants about 'fitting in' to seek expansion, clarification, or confirmation of that category. I also asked clinicians and researchers working in mental health to review the findings and theory. I asked them if the theory was detailed, clear, fitted with their experience, and was useful. The clinicians commented that they were able to relate to the study findings.

Transferability relates to the degree to which the study findings can be transferred to other individuals or settings (Glaser, 1978); that is, whether the results of the research have meaning to others in a similar situation. Transferability could be demonstrated through clear descriptions of the research, the participants' diverse perspectives and experiences, methodology, and interpretation of results (Liamputtong, 2013).

A clear description of the demographic information about the sample and characteristics of the study setting enables the readers to judge the similarity of the study setting to other settings or contexts (Cooney, 2011; Chiovitti & Piran, 2003). To enhance transferability of the findings, I have described the research context and assumptions central to the research in the Chapters one and two and in this current chapter, I have illustrated the research process and methods involved with developing the theory.

Confirmability shows the way the inquiry led to data interpretations (Koch, 2006). Confirmability is determined by whether the researcher has sampled well for the phenomenon under study, and by the conceptual density of the theory. Hall and Callery

(2001) argued that reflexivity–the awareness and documentation of the impact of researcher-participant interaction on research–is an important part of ensuring confirmability. I applied all these aspects while planning and conducting the research.

Dependability raises questions about whether the research findings fit the data collected. Auditing of the research activities and process make the research dependable (Koch, 2006). Auditability is about maintaining a comprehensive record of all methodological decisions, such as a record of the sources of data, sampling decisions, and analytical procedures and their implementation (Cooney, 2011). I maintained detailed memos to record all methodological and analytical decisions. Using the techniques described for transferability, credibility, and clear description of the context and documentation, I established dependability. In an overall sense, keeping the theory grounded in the data ensured rigour in the study.

4.5 Summary

This chapter has described the research method used in the study. A detailed explanation of the research methods, an analytic method based on Charmaz's methodology, and ethical considerations was presented. The chapter began by describing the iterative process of data collection and analysis concurrently through interviews, initial coding, focused coding, theoretical sampling and theoretical coding. Following constructivist principles, the data was co-constructed with the participants. Reflexivity, memo writing, and member checking developed credibility and trustworthiness of the study. Rigor and validity within the constructivist paradigm were also discussed, together with how ethical integrity were ensured throughout the research process. Birks and Mills (2015) commented that data analysis is perhaps the most daunting aspect of grounded theory for the beginner researcher. The process was challenging, but seeing the theory developing before my eyes gave me an immense sense of accomplishment. Chapter Five follows and presents the overview of the theory shifting cultural connectedness.

Chapter 5 Overview of the theory of shifting cultural connectedness

The aim of this thesis was to generate a theoretical explanation of the process of recovery for South Asian people accessing mental health services in New Zealand. The research question that directed the study was: "What is the process of recovery for South Asian people accessing mental health services in New Zealand?" As recommended by Charmaz (2014), this first findings chapter presents an overview of the theoretical process – shifting cultural connectedness, the process South Asian people engaged in to recover from mental distress. Chapters Six and Seven explain the process of shifting cultural connectedness by providing details of each dimension of the theory, supported by participant quotes. Chapter Six explores the complex cultural conflict and dilemmas faced by South Asian people that resulted in mental distress and Chapter Seven explains the process of moving towards mental wellbeing. I begin with explaining the concept of shifting cultural connectedness. Following this, I present the relationship between the category of encountering cultural conflict and the conditions of life stages, support and family dynamics that shifted the participants to construct new connections and regain mental wellness.

The theory is represented in the form of a diagram (Figure 9, p. 100) explaining the shifting process experienced by South Asian people in New Zealand, from becoming mentally unwell and moving towards mental wellbeing. The round shapes represent the theoretical categories and explain what was happening for the participants. The arrows show the relationships between categories. The spiral movement depicts the direction of the participants' journey, beginning with the cultural conflict and moving towards mental wellness. The participants' movement was not linear or sequential, as shown by the arrows between mental distress and working to become well. These demonstrate shifting between making meaning of the experiences as participants worked through the spiral in their efforts to regain wellness. The process continued shifting from becoming mentally distressed to mental wellness depending on the combination of categories and the conditions.
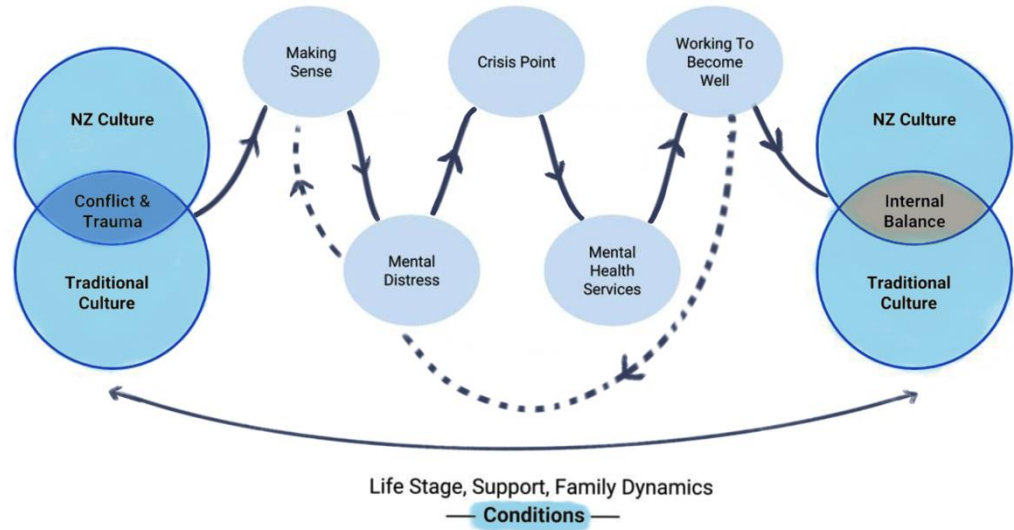
Figure 9. The theory of shifting cultural connectedness

5.1 Introduction

Shifting cultural connectedness is conceptualised as the participants' process of blending strategies from traditional South Asian and New Zealand cultures to manage and recover from their mental illness, achieve personal growth and resolution of cultural conflict. Becoming unwell was the participants' odyssey through the unfamiliar emotional and social terrains of mental illness. The participants entered the world of mental illness with concerns and doubts. As they became immersed in their illness, their goal was to keep the illness contained. During the journey, their perspectives and priorities changed. These changes flowed from experiencing illness and a simultaneous reflection on the experience, and developing insight into their circumstances, perceptions, thoughts, beliefs and practices. They shaped strategies from renewed insights. This primed them to anticipate problems and cultivate a personal transformation, along with a balance of compromise and compliance related to their traditional cultural norms and fitting in with the New Zealand way of life. The process of becoming well was not continuous. Some participants did have setbacks and moved back and forth in their efforts towards a balanced life in recovery. For some participants

the balance remained precarious as they cycled around making sense and mental distress.

The participants viewed culture as the languages, values, customs, practices and world views that identified them as being from distinct social groups. Cultural connectedness was the sense of belonging that the participants had with their own culture. When the participants shifted to New Zealand, they came with those cultural values, beliefs and practices that gave them their cultural connectedness and provided connection to their country of origin. They considered cultural connectedness important for their sense of self and how they related to others, as the connectedness provided them with support through social networks and shared values.

The process of shifting cultural connectedness began when the participants migrated to New Zealand from their home country in search of a better life. After moving to New Zealand, they experienced the usual struggle of immigration and resettling in a new country, which involved getting to know the new culture and the challenges of continuing lifelong beliefs and practices. Accustomed to religious, caste and norm differences in their home country, participants' experience of immigration to New Zealand entailed a move from the collectivistic culture of South Asia to unique New Zealand with multiple ethnic groups within a dominant individualistic culture. This is shown as the coming together of the circles representing the traditional and New Zealand cultures on the left hand side of Figure 9, p.101. At the interface of these two cultures, the participants experienced cultural conflict as well as trauma, which is outlined next.

Encountering cultural conflict and trauma

As the participants were adapting and learning new ways of building a harmonious life in New Zealand, they faced cultural difference and trauma both between the cultures and within their own culture. They perceived a cultural difference in language, clothing, and the norms of the host country. The young participants knew the English language, but still received contempt and taunts from their peers due to their South Asian accent and pronunciation. In contrast, the adult participants endured a sense of guilt about burdening their families, as they could not speak the local language.

Lack of family support, reversal in family structures and roles, difficulty in getting suitable employment, and financial dependence-related resettlement stresses further

increased family tension. Under these circumstances, some participants experienced family violence. The participants could not sustain the isolation and loss and were traumatised by the grief.

Making sense

Faced with cultural turmoil, the participants navigated the negative experiences by constructing different meanings to understand the dynamics and tensions. A few participants recognised that shifting cultural connectedness became achievable when they established connection with local friends and communities. Some participants internalised the negative perceptions; whereas others sensed that somehow, they were wronged. Thus, responses to cultural conflict, whether it was embarrassment, anger or self-blame, influenced participants' negotiation of their cultural identities. A few participants sensing awkwardness became sad and withdrawn; while others, disenchanted with the traditional norms, became disconnected from family support, leading to ambiguity and mental breakdown.

Mental distress

Some participants became increasingly angry, disillusioned and frustrated with traditional cultural practices, and more and more isolated and disconnected from their original cultural norms. The participants who resisted self-sacrifice and conformity developed a sense of resilience. They shifted their connectedness towards the values of New Zealand, thereby consolidating social support from their peers. However, the anger and resentment led to sense of shame, guilt and enormous remorse causing more distress and turmoil. For others, understanding that something was wrong with them led to increased loneliness and loss of self-confidence. Some participants sensed helplessness to challenge the expectations of their families and stayed within their traditional culture while becoming increasingly mentally distressed.

When their emotions interfered with daily work and functioning, such as deliberately avoiding going to college or neglecting daily routines, participants recognised that they were not coping and sensed an internal change. The participants adopted diverse strategies that they were familiar with from their traditional culture such as fitting in, praying, maintaining daily routines, connecting with people and learning new skills to manage the mental distress.

Conditions

Along with each person's perspective of what was happening for them, there were certain conditions, such as life stage, support and family dynamics that influenced their strategies and outcomes. These are depicted at the bottom of the diagram in Figure 9. The stage of life when the participants immigrated to New Zealand shaped their cultural connectedness and influenced their adjustment. Coming to New Zealand as adults, participants' cultural identities were connected to maintaining traditional values; hence adapting to the new language, values and norms became a challenge. Whereas younger participants, sensed being pushed and pulled by opposing cultural values at home and the diverse values of the new country.

Loss of connections, familiar support, extended families and friends added adjustment dilemmas. Challenging family dynamics exacerbated participants' internal turmoil and confusion. When the participants asked for help from family to deal with the challenges, rather than support, they sensed their concerns were dismissed. Hence the participants perceived invalidation and powerlessness. However, participants recognised that withdrawing support was a face saving strategy adopted by the family and was only a portion of the complex interactions within their families. Concurrently, they were cognisant of the involvement of significant acts of love and caring. The pressures of these contradictory beliefs, interactive processes, as well as the strategies, pushed participants to a crisis point beyond coping, and all participants became mentally unwell.

Crisis point

As the participants became increasingly distressed they invariably reached a crisis point. However, through the crisis they found a way to shift their cultural connectedness towards increased mental wellbeing. The participants first reflected on their thoughts, perceptions, distress, cultural dilemmas and actions. Reviewing their choices and responsibilities, participants managed their illness by adopting diverse strategies that led them to hope and mental wellness. They were frustrated with their ties to traditional cultural norms but sensed guilt and worry about losing family support. They constantly shifted their cultural connectedness backward and forward to construct a balance between the two conflicting cultural ideologies, until they learned a new way of living that was acceptable to their family as well as giving them personal satisfaction.

Moving towards mental wellness

Balancing negotiation, resistance and compliance, most participants managed to become well. When participants experienced compliance with traditional cultural identity as dissatisfying, they began to seek new ways of understanding their situations and themselves. In sensing frustration and failure with traditional strategies, participants sought a new way to feel empowered to build satisfying lives. For example, by writing her perceptions and thoughts in a university blog, a young lesbian participant achieved validation of her distress and sensed acceptance from her peers, without hurting and shaming her parents' traditional beliefs about her sexual preference. Similarly, another woman participant, who was abused by her husband, divorced him but chose to not disclose it to her father. Her devotion in bringing up her children retained her honour and respect from her family. By hiding her divorce, the participant protected the conventional identity; however by focussing on her mothering role, she transformed her marital problem and redefined the shame of divorcing her husband to an important caring role that gave her positive sense of empowerment. By connecting with local community, services and friends in New Zealand, participants redefined the meaning of their struggle and liberated themselves from cultural dilemmas and moved towards mental wellness.

In contrast, some participants were pulled by traditional cultural expectations and the constant juggling of demands and pressures, maintained their mental illness. A young Pakistani participant, who was forcibly married by her parents when she was mentally distressed, returned to New Zealand and refused to sign immigration documents for her husband. Consequently, she sensed her parents' disapproval and loss of respect in her family. When participants struggled with managing their mental distress and keeping up with their parents' expectations, they were unable to break the cultural trappings and remained mentally unwell.

Mental wellness involved a combination of challenges, participants' perspectives, and adoption of strategies. By shifting cultural connectedness, the participants adopted strategies without shaming anyone in the process, and cultural ideologies were reinforced and strengthened so that participants achieved recovery. Mental wellness for participants meant hope, faith, achievement and conflict resolution with acceptance and support. The process of shifting was continuous. Whenever the participants faced any challenge, they negotiated by making meaning of the challenge and choosing connection – either shifting to a new connection or finding a place in the old

connections. Each participant experienced a unique process dependant on the combination of the situation, strategies and conditions. The participants concluded that recovery was possible when the shift of cultural connectedness led to resolution of conflict without tilting the balance. One participant stated that mental wellness taught her to "*Never give up. Think positive. Move up in life. Just look at the positive side of life. Those who love you, just care for them*".

5.2 Summary

This chapter has outlined the theory of shifting cultural connectedness that shaped the way to recovery for South Asian immigrants in New Zealand. The chapter provided an overview of the strategy and the process of shifting cultural connectedness that the participants adopted to preserve a sense of self-worth, balance and agency within an environment of cultural dissonance. The consecutive chapters of the thesis provide a deeper and nuanced description of the categories: encountering cultural conflict and trauma, and moving towards mental wellness. The next chapter introduces the concept of encountering cultural conflict and trauma and describes the strategies and the conditions that lead the participants to become mentally unwell. Chapter Seven presents the strategies and conditions that shaped the way to mental wellness.

Chapter 6 Encountering cultural conflict and trauma

In this chapter, I present the theoretical category '*encountering cultural conflict and trauma*' which underlies the theory of shifting cultural connectedness. This chapter begins with a description of cultural conflict and trauma, and then explores the sub-categories of '*sensing wrongness*' and '*experiencing isolation and disconnection*'. Next, I explain the coping strategies adopted by the participants to manage the distress caused by the conflict and trauma. The conditions of life stages, support and the nature of family dynamics, influencing the categories are discussed. I end the chapter by presenting the consequences of the participants' responses to the conditions.

6.1 Introduction

During their interviews participants reported that they shifted cultural connectedness to negotiate the cultural conflict and complexities they confronted in recovering from mental illness. When the participants immigrated to New Zealand, they encountered cultural difference and experienced trauma which resulted in participants reporting that they felt diminished and sensed wrongness in relation to the adverse reactions to their cultural difference. Consequently, the participants developed mental distress. Life stages, support, and the nature of family dynamics shifted the participants' perspectives and influenced the outcome of the recovery process. Figure 10 presents the category and sub-categories of encountering cultural conflict and trauma.
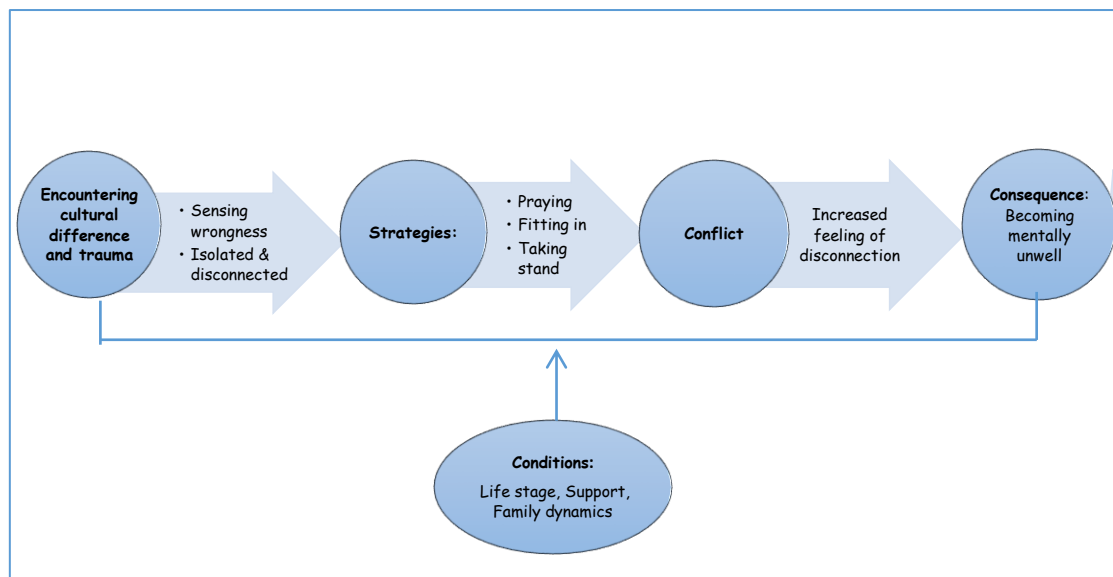
Figure 10. Diagram of encountering cultural conflict and trauma

6.2 Encountering cultural difference

Encountering cultural difference was a central challenge faced by South Asian participants adjusting to the new country. Moving to New Zealand, from South Asia, the participants discovered differences between the new country and their home countries. They perceived that they looked, and dressed, differently. They also observed differences in the physical, economic, and cultural systems; and needed to adapt to climatic and financial differences. Participants' perceptions and construction of the meaning of cultural difference shaped their experiences and conditions, including factors such as life stage, level of support and family dynamics, turned their encounter with the new country into a challenge.

Participants immigrated to a major city in New Zealand for diverse reasons, but all were in search of a better lifestyle, work opportunities and education.

> *New Zealand we thought would be a new beginning. Yeah, all of a sudden we're in a dream country. (*Tanya*)*

Most participants reported that they were attracted to New Zealand for better opportunities, so all arrived with hopes of a better future. They were excited about seeing a new country and eager to learn and experience a new culture. However, the initial excitement of experiencing a dream country quickly became disheartening as they began to encounter differences from their home countries.

Adapting to the new country, participants noted that there were multiple differences compared to their respective home countries. These cultural differences operated outside the experiences they had cultivated during their lifetime. As participants navigated new systems around banking, education and housing, they reported difficulties with language, clothes, behaviour and norms.

> *I think the environment is just very different. We used to live like in a complex with a lot of other families with whom we were friends. So everything I did was with other people. (*Rose*)*

Participants perceived that their living situation had been substantially different in South Asia. All participants had lived in small towns in South Asia, typically in complexes that were bounded by commonalities of caste and religion. Most of the participants came from the extended family arrangement as is prevalent throughout South Asian countries. Some participants shared agricultural land or business with their extended

family or were engaged in a shared livelihood with family or people of their community. Sharing activities with their family and the community gave them sense of value and status. They sensed support from the strong presence of extended family and friends. For example, Angela highlighted the importance of family support when in India with her children, while her husband was making arrangements for the family to move to New Zealand; views supported by her husband.

> *Yes, I stayed with my in-laws. I had a young baby, so I was busy. Then I had my housework and family, friends and relatives. It was more difficult for him. He was alone here. (*Angela*)*

As participants settled in New Zealand, they encountered diverse cultures within the dominant individualistic structure of New Zealand. Participants implied that they were accustomed to encountering diverse cultures; they had faced religious, caste and norm differences in their home countries and could understand the context of cultural difference. Accordingly, their cognizance of cultural difference in their birth country affected their perception of cultural difference in New Zealand. For example, Bob explained that his parents formerly lived in Pakistan, but the family moved to India during the India-Pakistan partition of 1947 and started their family business. Similarly, during the partition, due to mass migration, a few Muslim families were unable to move to Pakistan and were forced to settle in India. Despite differences in religious background, they were connected to the people of the home country by traditions, languages, cultures, history and economic interdependence. Furthermore, the participants reported that the nurturing care and bonding of extended family, relatives, friends, and people of the community in their home country balanced the cultural difference. However, when participants interacted with people in New Zealand, they sensed condemnation and ridicule towards themselves. Participants began to perceive that the connection with one another and the community was culturally different from their life in South Asia.

6.2.1 Language difference

All participants communicated at home in their native language. Most participants were reasonably proficient in English, which they spoke as their second language in South Asia. Participants asserted that South Asian cultures shaped their ways of communicating their thoughts in speech. When participants talked with New Zealand locals, they sometimes experienced an adverse reception to their English language expression.

*It was hard to settle in as the [local] children spoke very fast English. In the start the language was difficult. I didn't understand what they were speaking. I have learned English in Pakistan from the age of five years as I studied in English medium school, but the way we speak English is so different from the way the [local] people spoke. The accent. They speak so fast, so it was difficult to understand what they were saying. Then I thought in Urdu but spoke in English, so it sounded different. (*Sarah*)*

The participants acknowledged that knowledge of the local language was essential for settling in New Zealand. Though some of the participants were familiar with the English language, differences in pronunciation and accent challenged them.

Most participants were keen to immerse themselves in the new culture. They strove to close the gap between the two different worlds through language; but language itself became a barrier.

*I preferred speaking in Tamil because I prefer knowing another language. But my sister doesn't like to speak Tamil because it embarrasses her. Now she can't speak Tamil. (*Blondie*)*

Language, rather than becoming a means to bridge the gap between two cultures, became a source of embarrassment and ridicule. Thus, a few participants stopped speaking their native language altogether which became another source of conflict as parents expected the participants to speak in their native language at home to maintain cultural ties.

In South Asia, knowing the native language provided autonomy for some participants. They were able to use public transportation and shop independently. However, after moving to New Zealand, they became dependent on family members who could communicate in English.

*I can't drive. I went to work with my husband, and so I am not familiar with roads. I can't go out without others. In India, I could catch a bus and go to the market. But here I have to wait for Saturday and Sunday, so my husband or sons can take me to the shop. (*Sonia*)*

Loss of independence and autonomy created embarrassment and sense of guilt for some participants. Sonia talked about her work colleagues trying to be friendly, but her poor knowledge of English and associated awkwardness stopped interaction with local people.

> *In the factory, there are [a] few white ladies, and they try to talk and become friends. But I can't speak English, so I feel bad. At work, we have many Indian friends; I speak to them in Hindi. (*Sonia*)*

Constrained and embarrassed by her inability to speak the English language, Sonia retreated into herself, choosing to relate only to people of her ethnicity and culture. She decided to remain with familiar and traditional cultural connections.

Encountering the new country, participants realised that communication shapes culture and culture shapes communication. Both knowing the language and not knowing the language could result in cultural conflict. When participants knew the local language, they received condescension and were teased by their peers due to their South Asian accent and mispronunciation. Conversely, when participants could not speak the local language, they experienced embarrassment and a sense of guilt for burdening their family. As participants perceived language differences, they also noticed a difference in clothing.

6.2.2 Clothing difference

Participants understood that local culture and geographical setting, including urban versus rural settings, influenced clothing styles and preferences in South Asia. Thus, a few participants, who migrated to New Zealand as adults, accepted traditional clothing. Sonia highlighted the importance of traditional dress in her culture.

> *We have been brought up in this culture. I don't mind. See, I don't wear a dress like you or go out and talk openly with others. (*Sonia*)*

Sonia explained that cultural, geographical and religious factors influenced clothing in South Asia. Wearing a sari or salwar kameez (types of female garments), gold jewellery and hijab or dastar (headscarf) gave her a form of self-expression and a cultural identity. Sarah, a younger participant, wore the traditional dress in New Zealand because she was comfortable and familiar with wearing such clothes; yet her choice made her feel like she stood out and looked different. She was confused and conflicted by others' reactions, even though they were positive. The conflict emanated from participants' inner struggle to retain their traditional and familiar values alongside their wish to meet new people.

6.2.3 Difference in cultural norms

In addition to language and clothing differences, the participants perceived a fundamental difference in the cultural norms between their home and adopted countries. Participants understood that cultural norms were sets of behaviours, values, beliefs and attitudes that people learned from childhood as acceptable and essential. They were cognisant that their every action, for example ambition, career and interests, were strongly influenced by cultural norms. They acknowledged that cultural norms like respecting elders and parents, valuing honesty and obedience, and maintaining family honour and traditions were learned and reinforced from childhood so that they had assimilated these norms. However, when they moved to New Zealand, participants noticed different cultural norms.

> *Life was confusing, Kaberi. It was damn confusing. I will tell you why. I grew up with parents. He grew up in a village. He was very conservative, very traditional. (*Ajay*)*

On reflection, the young participants observed that their parents' cultural norms were rigid and constrained compared to the New Zealand cultural norms, and they were angry and frustrated with the cultural restrictions placed on them by their parents. Participants became conflicted, constantly negotiating between their internal resentment with their parents and traditional cultural norms on the one hand; and the contrasting independent and influential peer pressures.

> *There's way more discipline in our country than like developed countries. I remember when I came here, when they called my name, I always stood up and say 'present' and then everybody will laugh at me because nobody stands up and says 'present'. They just say 'hi', or 'yep', that's it. So that was a big difference for me. (*Blondie*)*

Encountering the new culture was confusing. Participants discovered that behaviour acceptable in one culture could be considered rude or funny in another. They remarked that culture influenced educational beliefs and participation in the classroom. Blondie had been bought up with the cultural belief that active participation in school and making eye-to-eye contact with the teacher were disrespectful. However, the same behaviours were a sign of engagement or competence in New Zealand. His local school peers were surprised and found his response funny. He was confused by their reactions but gradually learned to accept the differences.

Participants noticed other differences in the education system. For example, the New Zealand education system encouraged students to study independently, engage in discussion and think critically. However, participants were encouraged by their parents to practise obedience, respect and non-assertiveness at school. Their parents also expected them to bring honour and pride to the family by achieving academic success. Due to high academic expectations, South Asian parents accepted financial and upbringing responsibilities until the participants completed studies, sought a job and were married. Blondie talked about his upbringing and how it created difficulties in adjusting to life in a New Zealand university.

> *I was practically nurtured when I was here [New Zealand], so living alone [at university] for the first time was very difficult. (*Blondie*)*

Participants perceived pressure from their parents to maintain their cultural traditions and prioritise family loyalty before self-interest. They witnessed their family emphasising the importance of family status (izzat), and knew that moving away from established South Asian norms would affect a loss of family izzat. They recognised that, due to the traditional practices of interdependence and family harmony, they had become reliant on their families for nearly all life decisions around higher studies, career choices, marriage, and even living apart from the family.

> *I played around a little bit when I started going to university. I stayed in a hostel. I wanted to get into medicine, but the problem was that all the people in that hostel were not into studying. They like to play around. You know, my parents didn't like much of this partying and stuff like that. I mean they didn't approve of it. (*Blondie*)*

Blondie's parents did not appreciate him '*playing around*' and labelled his behaviour as rebellious. Participants noticed that their local peers' parents permitted personal freedom in matters of hairstyle or clothing choices. In contrast, they were sceptical about making choices about their career and personal looks, as they were aware of the unacceptability of those choices to their parents. Blondie was conflicted over the sense of enjoyment, in adapting to his local friends' values, and guilt in going against his family values. Participants were constantly worried about losing familial security if they made choices that did not match their parents' beliefs and experienced constant dilemmas around losing familial security in exchange for personal freedom.

Participants reported that diverging from traditional norms was not tolerated either by their family or friends. Rose disclosed her concerns about informing her father and extended family about being lesbian.

> *Being Indian I think the reaction would be lot worse. The intersection that I am gay and I am Indian. I think the intersection makes a huge difference. Only my mum knows. I haven't told anyone else in my family. She is trying to be more accepting. I think she says she's okay with it, and I think she is okay with it, but it's just sometimes the things she says are a bit, like, she says 'I always wanted grandchildren', just like little things like that kind of hurt, but I think she's been quite accepted. I think my dad would be okay with it, but I'm just, I just don't want to deal with coming out right now, I'm just like, I can't deal with it. Telling my extended family, I don't think I can do that because they're all in India and obviously it's not an accepted thing in India, so that, that's a scary thought yeah. (*Rose*)*

Being both South Asian and a lesbian, Rose acknowledged that she had multiple isolating aspects within her identity. Having different identities across contrasting cultures, she perceived that she was more different than others who had, in her eyes, only one point of difference. Informing her family about being lesbian was a stressful decision and Rose assessed the potential consequences. Rose might be accepted and not have to hide her identity, or she might face family and community rejection. Her worries were around the discrimination and lack of acceptance of same-sex relationships in South Asian cultures. Rose's distress emerged from the conflicting cultural values of her parents who did not tolerate divergence from traditional values.

Immigrating to New Zealand, the participants' family values and expectations regarding local people, native language and traditional dressing clashed with those of the new country. The participants faced the constant tension of fitting in with both their families and the outside world, leading to sense of being lost and confused. Along with conflict due to cultural difference, the participants reported multiple unresolved trauma that they faced after moving to New Zealand.

6.3 Encountering trauma

Participants narrated their trauma as deeply distressing experiences that overwhelmed them when they were settling in the new country. They described trauma of various types including emotional and physical violence, cultural isolation, mismatched expectations and disconnection from family. The trauma was compounded over time through repeated adverse experiences and conditions that overwhelmed the participants

and led them to become mentally unwell. There were significant differences across participants in their perception of trauma, but also similarities and patterns in their responses across the variety of stressors, such as abuse of power or control, perception of helplessness, confusion and loss.

6.3.1 Bullying

As the participants were undergoing substantial personal, social, familial and academic transitions during the immigration process, some participants reported enduring bullying and harassment from other students because of their cultural and linguistic difference. They recognised that the bullying was a reaction to their divergent appearance. One participant, under peer pressure from his classmates, even colored his hair, so that he would be more like his classmates.

> *Ah, I had to [dye hair] because they [peers] started looking at me weirdly because they thought that I was, like, weird. (*Blondie*)*

Some participants revealed that their peers bullied them because they had different accents and looks. Bullying was experienced as painful, and as the participants narrated their stories and experiences, they recalled their interpretations.

> *I had some bad experiences. I told you about being bullied. People would, like, if I said a word wrong, they'd often repeat it and laugh and that sort of thing. So that made it hard to talk to people and make friends. I'd just be alone, and I used to get, like you know, laughed about and teased about not having any friends and always being by myself, yeah. (*Sarah*)*

Confronted by bullying, participants were confused. When they had spoken English in their birth country, their peers did not laugh or make fun of them. Being bullied had different meanings for participants. Sarah was ashamed, frightened and hurt when her peers made fun of her accent. When Rose's peers taunted and laughed at her accent, she felt insulted. The experience was painful and it left her with a sense of being diminished. However, Blondie interpreted the bullying as his fault for being different.

6.3.2 Traumatic loss

Angela faced the trauma of losing family members. She explained that her loss of close family members was intense and experiencing grief after a significant death was a normal and appropriate reaction.

*I feel I have worries. I think it is normal to feel sad after someone dies. My husband's brother died in a road accident. Along with him, there were five people. Two people died, and others got hurt. I got the news when I was working at the glasshouse. I kept worrying about it. Then my brother died. I feel sad for losing close relatives. I miss them. I worry about my family and can't sleep. Before that, I used to be a happy person, but now I worry about small things and can't be happy (*Angela*)*

Angela's husband and daughter agreed that she was grieving. But the family participants concluded that her grieving became problematic when Angela stopped working and was unable to organise her day-to-day necessities. Both Angela's husband and daughter agreed that the traumatic event was stressful and that everyone copes with trauma and stress in different ways, but they perceived Angela's behaviour as unusual and they sought mental health help.

6.3.3 Family violence

Moving to a new country was reported to create family stress. Suzie explained how she and her husband migrated with a young baby and no wider family support, which made settling into the new country challenging.

*I was working as a lecturer in a government college. I was blessed with a son. My husband was a veterinary doctor. We had our house and family. But still, we wanted a better opportunity. So when we made the application for immigration, our qualification was accepted, but when we came here, it was difficult to get a job in our field. At least my qualification was okay, but he was asked to study again. His whole education, degrees were not accepted here. It was like, when we came, we felt that it was easy to get jobs as a labourer. But if you had a specialised qualification, it was very difficult. Most of my friends were working odd jobs, so we were not sure what to do. Then I had a young baby. It was very difficult to manage. (*Suzie*)*

The difference between their expectations and the reality of migrating to a new country challenged Suzie and her husband. Encountering career difficulties and limited family support, Suzie and her husband shifted their connection back to India. After going back to India, Suzie had another child and she was content with her life in India, but her husband still wanted to move to New Zealand. So they shifted back to New Zealand with two young children and were effectively resourced by mother-in-law's support.

We had to put a stamp on our passport before we completed two years. You know the immigration rule. If we had not come back, then we would have lost our New Zealand residency. My younger boy was just one and a half months, but still, we just rushed to re-enter New

*Zealand. It was a difficult decision, but this time we were more prepared. I had a young baby, so we organised a visa for my mother-in-law. She came and stayed with us. Due to her support, I started working part-time. But my husband, he never worked here. He studied a little. But he was just focused on going to America. He could not work as a veterinary doctor, so he was frustrated. Our fight started, and then we got divorced. (*Suzie*)*

Suzie mentioned that they came prepared with social support, but she was not ready for the changes in family roles and dynamics. The family support was insufficient and family conflict increased, leading to violence, including physical and emotional abuse. Suzie acknowledged that she had pre-migration marriage difficulties that were intensified by adjustment problems after landing in New Zealand.

*I never had a healthy relationship. Even in India, we had our arguments. We both had a very different set of priorities and thinking. He always was focused on going to America. I didn't realise it when we were in India. Once he came here, he almost got obsessed with going there. I was happy here. I was happy in India too. His nature was so different. We have two lovely boys, but he was not good as a father to them. (*Suzie*)*

Another participant, Sunny moved to New Zealand after her arranged marriage. She was excited to come to a new country and expected only a few adjustment difficulties as her husband was a resident and already settled in New Zealand.

*My husband was a resident of New Zealand. He came to India for marriage. He had given an advertisement in the local paper. So we met and got married with both parents' approval. (*Sunny*)*

However, when Sunny arrived in New Zealand, she became dependent on her husband for financial and emotional support. She mentioned that her friends were all his friends and he controlled with whom they had a friendship. Being newly married, cultural expectations and ways of dealing with challenges added to her adjustment difficulties. Sunny was familiar with family violence, as she had witnessed it between her parents and realised that her husband was emotionally and financially controlling her.

*My father was very strict and violent. He was very abusive to my mother. Throughout childhood, we saw their fights and arguments. It affects children. Due to the stress, I got depression. (*Sunny*)*

Sunny identified specific acts and behaviours like verbal abuse, controlling behaviour and emotional abuse as family violence. Sunny had disclosed to her husband that she

had depression due to the family dynamics at her parents' place. He teased her and called her crazy. She became angry and frustrated but chose to stay in that relationship, as leaving him meant jeopardising her opportunity to become a permanent resident in New Zealand. She started working, but became pregnant and stopped working after having her first child. In addition, her husband threatened her continuously with deportation and having her children removed.

> *I had no help in New Zealand. I just kept getting angry. But when we went to Melbourne after my daughter was born, my depression was becoming worse. So he [ex-husband] took me to GP, and I was started on medication. But then he filed for divorce and left us. He stopped paying rent. We were homeless. I flatted with someone for a few weeks. I didn't have any friend or family. I didn't have money. I had New Zealand residency, so Australian government didn't give any help. I came here and applied for single parents' benefit. I had limited money with two young kids. (*Sunny*)*

Sunny acknowledged that her depression was due to the accumulation of stress. She gave birth to two daughters in New Zealand and became depressed after both pregnancies, but her husband refused to let her seek mental health help. She informed her parents about the violence, but they suggested she stay with her husband to avoid separation and shame. Though people, including family, surrounded Sunny, she perceived herself as alone due to disconnection in cultural values and beliefs. When her husband decided to shift to Australia and divorced her, she became increasingly isolated. Sunny commented that, after returning to New Zealand for the first time, she received practical support and mental health care. As she was settling with her children, her husband continued harassing her and threatening her regarding custody of the children.

Making meaning

Faced with an adverse reaction to their cultural difference, participants composed various meanings to manage the situation. Blondie comprehended that his peers perceived his different appearance as weird, making him an easy target for bullying. As a result, he accepted the derogatory opinion of him and took the blame for the abuse he experienced. He had an intense sense of worthlessness and rejection but still strived to be socially accepted and included. He wished to change from being weird to normal, as he considered this would help him to fit in with his peers. His parents perceived shifting towards his peers' views as a rejection of his cultural values. Blondie was distressed by

having to balance the confronting new environment, conflicting cultural values and an internal yearning to fit in with his peers.

> *My first year in university, my flatmates, they compelled me to bleach my hair. Then, when I came back here, back to my parent's place, my friends, they called me Blondie. Then it stuck around. (*Blondie*)*

Though bullying hurt and diminished the participants, they each gave an individual interpretation of its meaning, and their interpretation shaped their reaction. Blondie lost his self-confidence. He considered that he deserved the treatment. When I asked him to choose a pseudonym, he chose Blondie. When I asked why, he remarked, "*Yeah, at first it was quite scary or different, but then, I became that person*". He rationalised his sense of fault to the point that the nickname Blondie became entirely reasonable in his mind. For some, the pain from being bullied caused a loss of a sense of purpose, hope or motivation to do anything about it. Sarah could not complete her studies. She perceived that the bullying had left lifelong emotional scars on her.

> *I see myself as a failure. I could not graduate. I see everybody else wearing the black robes and hats and graduating and laughing and having a good time, and I was sick, and I'm still sick, and I'm still sick, and I'm still sick, and I'm still sick! So oh my god when am I, when do I get to the end? (*Sarah*).*

Losing significant people was traumatic for Angela. She went on to describe how she perceived that she was actually mourning for her inability to participate in the funeral rituals. The tragedy took place in India and Angela was unable to go to India and participate in the funeral rituals, interacting with family and sharing their sorrow. During funerals in India, relatives and friends gather and they talk with others about the death and the person who died. Angela perceived grieving and mourning not as a subjective interpretation but as an interaction between people, and thus interpreted her inability to participate in the funeral as powerlessness and incompetence. The grief of losing a family member and the associated loss of cultural rituals exacerbated Angela's perception of helplessness. Angela apprehended shame in letting down herself and her family by not participating in the cultural ritual. Whereas, Bob was shamed about losing the family's respect and honour due to his son's relationship break-up.

> *My son and daughter-in-law started having relationship problem. They had no understanding. She wanted to go back to India. So my son took her back to India. But her relatives who are in New Zealand have been saying to the community that I asked for dowry. I had nothing to do with the break up. I tried to patch up. They decided to*

> *break. When they started talking about me, I started getting upset. I have many relatives in India. I started worrying about how I will face my brothers and relatives, when I go to India. My sons are not worried. They have moved to New Zealand 15 years back. But I have relatives. (*Bob*)*

Bob interpreted his son's relationship break-up as not living up to cultural expectations. He, being the head of the family, internalised the shame and was worried about the tainting of the family's reputation. Bob's worries and sense of shame were intricately tied to the fear of rejection and loss of cultural community support, which led him to become mentally unwell.

Suzie and Sunny had a common understanding of family violence. They both established that the violence was due to power and control and the emotional abuse contributed to their mental illness. They recognised that the increased stresses due to continuous threats, verbal abuse and constant control of behaviour made them feel depressed, lost and confused. Both emphasised their perceived lack of choices and sense of powerlessness.

> *It was a mutual divorce. I was so naïve. I hardly went out. I didn't know about anything about the [New Zealand legal] system, but I took the decision. I didn't know how to manage, but I was so angry. I just signed the form. I didn't consult anyone. I didn't tell my father too. I didn't have a sister. I had an elder brother, but he had passed away at a young age. Then my divorce. It would have broken my father. I didn't want to disturb him. I had a younger brother, but he was too young to understand. So I didn't disclose my problems to him. Just a few friends knew about it. Here anyway I had no relatives. My friends helped me. And then started my struggle. Life got easier for him and difficult for me. But I never argued with him. Just filed the case. (*Suzie*)*

Suzie chose to divorce her husband to reduce the distress, but decided to conceal her situation knowing that divorce would not be acceptable to her family. However, Suzie's husband, like Sunny's, continued abusing her even after separation. Suzie could not share her problems with her family, as she did not want to burden them with her problems. Suzie recalled the difficulties in deciding to divorce her husband and bringing up her two young children that led her to become mentally unwell.

These participants were at a loss and confused; they had a traditional upbringing where they were encouraged to consider family as the essential part of society and source of strength, and to comply with the gendered family roles. Challenging the traditional

cultural ideologies was difficult, especially as the participants perceived themselves as powerless and disadvantaged being women. When they faced violence, they blamed themselves for their inability to balance and harmonise the relationships of the family unit.

Suzie and Sunny reported that initially, due to their traditional values, they tolerated family violence and even defended the abusive behaviour. On reflection, Suzie concluded that facing violence was not her fault, but the problem was with her husband's personality. They felt pressured by societal norms to accept the husband's authority and blamed themselves for the abuse. In moving to New Zealand, the participants noticed a mismatch between the cultural values of their birth and host country. The participants' awareness of their rights about love and violence gradually increased, and they adopted a different set of values from the new country. But the participants were confused and conflicted about the cultural ambiguity and were uncertain of making changes. They were concerned about their parents and relatives' acceptance of their shifting between cultures and new attitudes and ways of behaving.

> *He [ex-husband] argued with his brother and his brother had kicked him out of his house. I didn't want to talk to him too. Sometimes I didn't answer his call. But as an Indian lady, you know being Indian, you will understand. He was my husband. So I kept worrying maybe he is really in the problem. (*Suzie*)*

These participants perceived that immigrating to New Zealand had changed their family structure, roles and dynamics, and led to family tension and stresses. They recognised specific acts and behaviours like verbal abuse, controlling behaviour and emotional abuse as family violence, but continued living in the abusive relationship due to their sense of family obligation, social norms of their birth country, lack of support from their family and lack of knowledge of the local legal system. They concluded that a few cultural norms precipitated and prolonged the family violence. They highlighted that their husbands' traditional attitude of control and power became an issue, especially when the husbands extended their control over the participants as a last hope to protect their cultural values and traditions. Consequently, as the stresses accumulated and the abuse continued, the participants became mentally unwell.

6.4   Sensing wrongness

All participants acknowledged that there was a cultural difference between their South Asian and New Zealand homes. Each interpreted the cultural difference from their

respective viewpoint, so there were various reactions to their encounters with cultural difference. Though there were diverse perceptions of the cultural dissonance, they all perceived harassment as wrong. By sensing wrongness, some participants understood that somehow they were wrong while other participants conveyed that others had wronged them.

When the participants sensed wrongness, they all perceived that they had been victimised or picked on through their personal experiences, values, beliefs and attitudes. Rose and Sarah reported that, when other people were being unfair, they became angry and frustrated. They sensed the wrongness as "I am being wronged". They perceived wrongness as unjust, improper and not right. In contrast, Blondie sensed wrongness, as "I am wrong". He understood that he was deviant from other. Blondie and Sarah became powerless to change and retreated into depression.

Sarah sensed wrongness because of "*crazy stupid people who just don't have any respect for me or even understanding of my culture*". Sarah perceived that the wrongness was due to lack of understanding of her culture. She sensed that her different culture led to discrimination. Sarah suggested that by judging her culture, her peers were discriminating against her. She was angry with them for being discriminatory and making her a target.

Rose had a similar "I am being wronged" interpretation of wrongness. She believed that racism was prevalent in both New Zealand and South Asian cultures. In her view, racism was built into social systems and relationships that led to stereotypes and stigma about South Asian people, youth, mental illness, and lesbian people.

> *Definitely. There is a stigma about mental illness. If you see the portrayal of psychotic characters in Hollywood or anything it is just always the murderous villains and things like that. It is just created a mind-set that psychotic people are obviously really evil and need to be scared, need to be feared when that is obviously not the case. ... However, I think the stigma is more especially among South Asian families. And there is just a huge stigma especially with teenagers that we are all just really over emotional. (*Rose*)*

Ajay acknowledged that stereotypes occurred but did not perceive it as wrong. He viewed stereotypes as a standard practice among children. His opinion was "*You get angry and upset, and you fight. You get over it*". However, Ajay did sense wrongness in his parents' shifting parenting styles. When they came to New Zealand, his parents converted to Christianity to find meaning, purpose and identity in the new country.

Later they shifted their religious affiliations. Ajay was frustrated and became disillusioned. He lost respect for Christianity and his parents. As he was trying to come to terms with the changes, his sister left home in defiance of her parents and married a local person. Consequently, his parents became controlling towards Ajay. He was not permitted to make friends unless approved by his parents. Ajay sensed wrongness in the restrictions that he had to face due to the strict family environment and Christian influence. Sensing wrongness, the participants gradually disconnected from their traditional cultural values.

6.5 Experiencing cultural isolation and disconnection

In the process of resettlement in New Zealand, some participants became isolated from their usual support systems and cultural norms. Initially, the participants grieved for the loss of familiar people and support. However, when the participants could not sustain the isolation and loss, the grief of losing close family and support turned into trauma and they required assistance from mental health services. Paradoxically, a few participants became disillusioned with the cultural approaches towards significant events and disconnected from the family support due to differences in values, beliefs and expectations. This increased isolation and ambiguity led to mental breakdown.

Sarah experienced conflict and trauma within her arranged marriage. She sensed burden in following the cultural ritual of arranged marriage and started disconnecting from her own cultural values.

> *Obviously in Pakistan getting better is getting married. I don't understand why people expect you to actually get married and then live with somebody who is horrible and be nice to them because they [her parents] still expect me to be nice to them [husband and in-laws], still expects me to go back to him [husband] even though, I'm, I'm not well and they're not good. You know there is huge cultural difference in attitudes. I know, I should listen to my parents and sometimes they make some decisions. But it is my life. But at the same time, they are your parents and they know more about you, life. So it is a conflict.* (Sarah)

Sarah expressed her frustration with the traditional cultural norm of arranged marriage and associated expectations. Being forced to marry, she was conflicted between fulfilling the normative expectations associated with being a dutiful daughter and daughter -in-law at the expense of losing her voice, freedom and identity.

> *At that time my problem was gold. I had to wear gold. They expected me to wear gold and I had no support. So, my, I can't say that going to Pakistan was so interesting, so much fun, I would love to say that, I would love to say that I like my country more than New Zealand, but I can't say that. Because in New Zealand I've been stable, I've been with my family, their support, everything is good. I don't have my family over there [Pakistan]. I had not my family and then the other thing is I wasn't well and on top of that I'm married to an ass hole! (*Sarah*)*

As the arranged marriage was associated with important life decisions, Sarah was left with a difficult and painful dilemma. She perceived her loyalties towards her parents and committing to the marriage arranged by them were intimately tied to each other. Sarah apprehended that going against the cultural norms would be letting her parents down. Sarah recognised that by refusing to obey her parents' decision, she could bring dishonour to her family, provoking being ostracised and rejection of their support and connection, leading to Sarah experiencing immense distress and becoming mentally unwell.

When the participants experienced conflicting situations due to conformity to traditional cultural norms, they were angry, dissatisfied and frustrated with the cultural practices. However, the participants perceived the isolation or going against cultural norms as letting down their family and sensed shame and guilt. They internalised the sense of remorse for their behaviour, which led to immense internal distress and turmoil. Faced with cultural conflict, the participants sensed negative reactions, which left them experiencing a sense of being diminished. Participants' perception shaped their interpretations and apprehension of their situation. They managed unfavourable responses to them by engaging in various strategies.

6.6 Strategies

When challenged and feeling diminished by encountering cultural conflict and trauma, the participants engaged in strategies of praying, fitting in or taking a stand to manage the distress. Their construction of the meanings of the dissonance guided the selection of their respective strategies. They adapted and shifted their cultural connectedness towards the home and host countries, depending on whom they were interacting with. The shifting allowed them to choose an approach that was acceptable, tolerable and comfortable.

6.6.1 Praying

The participants who experienced cultural dissonance reported that by shifting towards their traditional culture, particularly faith in God helped them cope with the distress of the conflict and trauma. They described how spirituality and praying played a significant role in dealing with their trauma.

> *Now, I enjoy praying. It gives relief. I feel good when I pray. In the morning I get busy with packing lunch boxes and getting them ready for school. I pray after the kids go to school. In the afternoon I have free time, so I pray. In the evening when the kids are busy with their studies, I pray. I do work first and then in my spare time I pray. (*Angela*)*

Prayers provided comfort. Being lost and confused, the faith that God controls what happens in their lives alleviated the participants' perception of distress. Angela explained that prayers allowed her to let go of trying to control or understand things outside her influence. For Angela and Sarah praying meant letting go and handing over to God what they could not control or understand. Both acknowledged that prayers lightened their burdens and restlessness. Praying was strengthening and comforting and became an essential part of their daily routine. Sarah said that '*I cope by praying. I pray. I say 'God please help me'. I don't have anyone other than God whom I go to.*'

Sunny prayed when she was distressed by her relationship issues and she noticed personal growth, resilience and maturity from observing and understanding spiritual beliefs. Suzie added that her belief in God highlighted to her the importance of work and routines. She explained that working was her way of offering or praying to God.

> *I believe in God. I am a religious person. You know in our culture work is worship. I pray daily, go to the temple. But work is most important. Keeping myself busy is important. (*Suzie*)*

Being a solo parent, Suzie reasoned that working was not for her personal gain. Supporting her children to settle was her priority. She explained that the satisfaction she gained from taking care of her children was the blessing of God. She believed that her job and supporting her children became worship as she did her duties as a mother without getting distracted by the consequences of her actions.

6.6.2 Fitting in

When faced with cultural difference, some participants selected fitting in as a strategy to move forward and adapt. They associated the strategy of fitting in with acceptance.

*It is a necessary thing to be able to fit into a new culture. If you don't fit, then it is a problem. So at one point in time, you do have to fit in. Yes, then I fitted in. (*Sarah*)*

By fitting in, Sarah meant that one should adapt oneself or conform to settle into the new country. She believed that fitting in eased the way to better settlement. Most participants, like Sarah, strongly believed in fitting in and conforming. Sarah recounted how she fitted in by becoming familiar with the new country.

*But then the teachers were always there to help. I didn't have any more problems with the clothing. I didn't have any problem with language or food. Even if you eat halal food, you learn where halal food is available and get food from there. Many places don't advertise that they sell halal food. I learned that Burger Fuel sell halal burger so you just go there and able to eat food and don't feel different. (*Sarah*)*

By fitting in, Sarah established a connection with friends and communities. Her frustration and initial sensation of shock subsided when she was able to locate her familiar halal food (halal is Arabic for permissible). Connecting and mingling with familiar people and finding permissible food in the new country helped Sarah to adapt and gain confidence to become comfortable with the new surroundings, culture and people.

Sonia had a few relatives in New Zealand. Suzie had no relatives in New Zealand, and as her husband was unable to get suitable work he returned to India, leaving her alone in the new country. Sonia's relatives and Suzie's friends assisted them in staying connected with their own culture, while also supporting them to shift their connection to the local culture by renting or buying houses closer to Indian friends and relatives. Being close to familiar people and culture helped them to feel at home in the new country.

Bob noticed that overcoming the language barrier was an essential factor in fitting in and becoming a part of the new culture, so he enrolled in an English-speaking class to communicate with the local people. He connected to New Zealand culture by undertaking educational courses.

Fitting in for Blondie meant belonging with his classmates and being accepted by them. Blondie aspired to become 'cool' and 'normal' like his classmates. He presumed that, because of his different looks, he did not fit in with his peers. Blondie continued

colouring his hair, wore clothes like those of his friends and partied with them. For him, becoming like his classmates was fitting in.

Rose and Ajay found that South Asian culture affected the way they coped with challenges.

> *In South Asian families we don't focus on emotions and like we don't allow people to talk about them openly. My parents brought me up with the idea that other people's wellbeing was just more important than my own and I had always to put other people in front of me. (*Rose*)*

According to Rose, South Asian people are encouraged from childhood to be mindful of others and place priority on self-sacrifice. She perceived that, when challenged, South Asian people tend to conform to the family or community's expectations. She concluded that South Asian people obey because they internalise cultural values. Rose acknowledged that she also submitted to her parents' values and expectations, but adapting to their values led to frustration and anger. She resisted and shifted her connectedness towards the values of New Zealand to consolidate social support based on peer support. She engaged in volunteering and got involved in developing websites for helping others. Rose found that taking a stand promoted her personal growth and led her to the path of recovery.

6.6.3 Taking a stand

When the pressure of cultural dissonance became too great, participants took a stand. They reported being faced with cultural confusion in situations where they had to conform to traditional values. They resented conforming to those values and faced dilemmas resulting in frustration, anger and conflict. The cultural confusion prompted resistance and shifting their cultural connectedness to the values of the host country. In shifting cultural connectedness, the participants refused to participate in traditional activities or challenged the traditional values.

Taking a stand as a strategy was a defining moment for many participants. These were the moments when they decided enough was enough; went against their cultural values and shifted their connectedness towards the host country to manage the differences and conflict.

> *Styling. I always wanted to look good, but my dad never allowed me. He objected when I tried to remove my mono brow. I joined a forum of*

*radical third wave feminism. They tell you how to style and groom. So I became obsessed with masculinity. (*Ajay*)*

Ajay perceived himself as a sensual person. He wanted to present himself stylishly. But his parents did not approve of his aspiration. So he took a stand, by moving to another university. He joined a radical third wave feminist group and started self-grooming. By joining the group, Ajay became cognisant that "…*women like to be around men who are well connected and popular*". He refocussed on self-care that was prohibited by his parents. Ajay made friends, continued studying and achieved a business qualification. Taking a stand gave him immense pleasure, as he spent his time on what mattered to him.

Blondie, like Ajay, took a stand by moving to another city in New Zealand for further studies. Sarah took a stand by refusing to wear gold. She returned to New Zealand and refused to support her ex-husband's visa application to New Zealand.

> *I have a problem with wearing the gold. So I stopped wearing them. I lived there [Pakistan] for a while. My husband and in-laws were terrible and horrible. So I came back here. Then he had applied for a visa to come to New Zealand but then like Immigration New Zealand asked me questions about it, told them I didn't want to live with him, they declined his visa. (*Sarah*)*

By taking a stand, participants made bold decisions, achieving a crucial step. Being raised in a strict environment, they were acquainted with the significance of their behaviour on their social standing. They broke down harmful walls and challenged the rules by being themselves and trying to stand out. For Blondie, moving to a different city was an escape. Sarah freed herself from the shackles of the centuries-old tradition of wearing gold jewellery that her traditional in-laws forced her to wear to exhibit their wealth, power and status. She returned to New Zealand and convinced her parents of her decision to embrace independence of choice by refusing to sponsor her husband's visa application.

Praying, fitting in and taking a stand, supported the participants to cope with the challenges of experiencing cultural conflict and trauma. However, as the participants were managing their challenges, some conditions influenced their coping strategies and had spiralling effects on their lives.

6.7 Conditions

When the participants immigrated, they encountered cultural dissonance in the process of leaving behind their social networks and settling in the new country. Sensing wrongness and perceiving they were isolated and disconnected, the participants tended to make shifts in the presence of particular salient conditions. While individual variations were common, three key conditions of life stage, social support and family dynamics, affected the strategies participants adopted.

6.7.1 Life stage

The life stage at which the person immigrated influenced the way participants dealt with cultural conflict. When they came to New Zealand as adults, their cultural identities, family traditions and family honour were connected to maintaining traditional values; hence, adapting to the new language, values and norms was difficult.

Bob proudly told me how his sons sponsored him and his wife to move to New Zealand. It was a matter of izzat (respect and honour) that his sons honoured him for being immersed in family and community life.

> *I worked hard whole of my life. I send my boys to private schools. I sent them to NZ to study. You know how expensive it is to study in NZ. The fees are double or three times more for international students. We pawned our jewellery and house to pay the fees. (*Bob*)*

When one of Bob's sons had a relationship break-up, his izzat (status and respect) shifted to sharam (shame), as he considered his son's behaviour did not conform to the expected response within the Indian community. Bob had a designated position in his family and the community hierarchy. As Bob valued family harmony and obligations, he expected his son to honour those and obey the family decision. When his son terminated his marriage, Bob, as the head of the family, considered the relationship break-up as loss of face in the community and became mentally unwell.

Thus, with Bob, the shift of condition lead to change in strategies and moved towards mental distress. When Bob was settled in India he was proud of his children's achievements in New Zealand. However, when the conditions changed i.e. his son's divorce, Bob, who was older and more traditional, perceived the loss of cultural status and was somewhat afraid of returning to India as he said "*he would be shamed.*"

Sonia was unable to master English and communicate with locals, so she experienced exclusion from the dominant culture. Being traditional, Sonia considered herself a failure. She sensed shame and guilt for burdening her family and others.

In contrast, when participants came to New Zealand at a younger age, they experienced an internal dissonance that also had a cultural basis. At home, they were expected to maintain traditional values and beliefs; whereas at school and university they wanted to fit in with their peers. In the struggle to balance these conflicting cultures, the young participants experienced increased family conflict and heightened emotional states. They became angry and frustrated with the strict family environment, high expectations and constant criticism. They reported that they were not allowed to be their usual self because they did not fit in with their parents' beliefs, nor did they fit into their peer groups.

Sarah's parents had a strong sense of belonging to their social contexts and relationships. When she became mentally unwell in New Zealand, her parents removed her from university, due to stigma about mental illness, and arranged her marriage to a person in her home country against her wish. After living and studying in New Zealand, she moved back to her home country and when adjusting to the values of the country became distressing for her, she became unwell again.

Ajay's father decided to convert to Christianity to adapt to the new country. Ajay, being young had no choice in the decision but felt frustrated with his parents' decision.

> *Oh yes, it was difficult. Being first generation migrant and then converting to Christianity. You are in such limited community. By converting to Christianity, you are ostracised by the Indian community, especially Hindu and Sikh ones. Then at the school among the other Christians, you are an outsider. (*Ajay*)*

The young participants faced interpersonal conflict with their parents' traditional values due to their dual commitments to both their parents' values and the diverse values of the new country. They sensed being pulled and pushed by competing values. Thus the conditions of the parents' shifting cultural connectedness led to family distress and ultimately, along with other conditions operating for Ajay, mental distress.

Engaging with the new country became challenging when the participants were rigid and held on to their traditional values. When there was a difference in the level of flexibility between the participants and their families and peers, tensions increased. The

young participants worked to relieve the constant internal struggle and tension between family and New Zealand values and norms by taking a stand. Comparatively, adult participants managed the cultural difference by fitting in to maintain their cultural ties with their home country with the exception of Ajay, however, who made a subtle shift to fit in with the host country by becoming Christian, though it was not his choice.

6.7.2 Support

When the participants moved to New Zealand, they left behind their connections, familiar surroundings, friends and relations. Back in their home countries, the participants were dependent on family members for their social needs. Relocating from their homeland brought changes in family relations and adult participants lost their social support. In New Zealand, family members were engrossed in their resettlement process and were not constantly available to respond to their social needs. This loss of social support caused loneliness and isolation for the participants.

> *Life was different in India. I was busy. Here, in New Zealand initially, I found it was quiet. No one talks. You know how in India neighbours are like relatives and we spent lots of time with them. (*Sunny*)*

Coming from community living, the social relationships that provided meaning for the participants were disrupted in New Zealand. Participants defined social support broadly as informal emotional support from family members, friends and neighbours, including listening, caring, empathy and sharing. Familiar with language and surroundings in their home countries engendered independence. In New Zealand, some participants struggled to take the local bus or go to the bank. They associated support from family, friends, relatives and society with peace of mind and a reduction in isolation, stress and loneliness. The simple day to day social interactions that helped reduce the daily burden of stresses were lacking in their new lives. They missed the company of extended family and friends, became homesick separated from family, and their sensation of sadness exacerbated.

> *I didn't have any problem after divorce. The only problem was I didn't have family support. (*Sunny*)*

Sunny and Suzie perceived lack of family support as a significant stumbling block when they faced trauma. Sunny's lack of social support constrained her settlement in New Zealand. She came to New Zealand on a spouse visa after her arranged marriage. Her husband controlled her financially and continuously threatened her with

deportation. Under these conditions Sunny continued living in the violent relationship and she lacked understanding of the support available in New Zealand.

> *So I didn't disclose my problems [family violence] to him [her father].*
> *Just a few friends knew about it. Here in New Zealand anyway, I had*
> *no relatives. (*Suzie*)*

Suzie also perceived the lack of family support as one of the conditions in New Zealand that made managing trauma difficult. Suzie chose to not disclose her problem to her parents due to fear of condemnation. While the participants missed family support, they also reported some family dynamics that stopped them from reaching out to their families.

6.7.3 Family dynamics

Family dynamics, described as the interactions between family members, influenced the outcomes of encountering cultural difference. Participants perceived that specific family dynamics affected their relationships, behaviour and wellbeing, and changed the way they viewed themselves and others.

Blondie noticed that his parents were stricter than his peers' parents regarding education. He perceived constant pressure to do better. He reported the conditions of family expectations restricted his study choices, career and who he could choose as friends. The young participants noticed that their parents were critical compared to their peers' parents, as Rose highlighted:

> *So whenever I used to tell my parents that I was getting teased or*
> *bullied, they'd just be like 'just ignore it because, you know it makes*
> *the other people happy, then don't worry about it'. And I was like, 'but*
> *that didn't help'. So when I used to get bullied, I'd just stop telling*
> *them because they'd just say 'just ignore it', when ignoring it doesn't*
> *work. Whereas here [New Zealand], you know a lot of, the parents*
> *just go and tell the teachers, talk to them about it and, actually*
> *validating your feelings, which I never got. (*Rose*)*

When faced with dissonance, Rose perceived invalidation from her parents as she was advised to ignore the conflict. She stopped going to her parents when she encountered difficulties but this caused frustration and anxiety. Lacking acceptance by her parents led to a sense of loss and isolation. The young participants perceived their parents as rigid and traditional as they valued the family honour (izzat) more than their emotions.

*I freaked out as well, and that was the damaging part. I wanted to live the good life. I realised that I could not get that life adhering to their strict Christianity belief. And my parents made no sense for me. (*Ajay*)*

Ajay became distressed and felt that the confusing environment at home damaged him. When family interactions were restrictive, participants experienced rejection and invalidation. Family dynamics made adapting to the new culture more challenging as participants faced a dual rejection, by their family and their peers. They perceived their family dynamics as a set of high expectations, strict beliefs, little acceptance and a lack of freedom in comparison with the family dynamics of their peers.

When Sarah divorced her husband and returned to her parents' house, rather than getting any support, she sensed a message of shame in letting down her family, their community and culture. So she insulated herself from family functions.

Constantly threatened and abused by her husband, Sunny asked for support from her parents. However due to the parents' cultural outlook surrounding separation and divorce, Sunny was forced to adjust and return to the same abusive relationship. The lack of support led to depression and perception of being lost and trapped in a traumatic and violent relationship.

*Whom to talk? My parents were in India. They were old. If I tell my story, they would have got worried about me. When my son was eight months old, I went to India. I told them about my problem. They were helpless. They said to stay with husband, make adjustments, listen to him and make it work. (*Sunny*)*

Sunny sensed invalidation, disillusionment and frustration with her cultural connectedness. She was confused by her parents' traditional values that tolerated family violence. In desperation and helplessness, provoked by her husband's threats, she attempted serious self-harm. In the hospital, by connecting with professionals and friends in New Zealand, Sunny received validation of her distress together with resources to rebuild her life free of violence.

Though Suzie had divorced her husband, he continued to torment her. Suzie was concerned that, due to her parents' patriarchal viewpoint about women, they would blame her for the family violence, so she chose not to tell them about the abuse.

Experiencing the trauma of violence and losses, and no support from family, challenged the participants. However, as the participants were adjusting and adopting strategies to manage the distress of trauma, family dynamics had the potential to stress the participants and their mental health.

6.8   Consequences

The cultural diversity participants encountered when settling into New Zealand left them confused and diminished. They sensed wrongness and strived to make a stand to fit into the new country. Participants' life stage shaped their cultural connectedness and impacted on their adjustment to immigration. Settling into the new country became difficult with the loss of support. Challenging family dynamics exacerbated participants' internal turmoil and confusion. The pressures of these various factors pushed participants to a point beyond coping, and they became mentally unwell.

> *I started becoming anxious about what my friends might be talking about me to others. I was ruminating. There was seriously something wrong with me. I went to my GP. He diagnosed me with depression, but still, my parents didn't want to acknowledge it. I got so anxious I took my jumper and tried to hang myself in the garage. My mother saw me and freaked out. We went to the crisis team. Yes, that's how I entered mental health. (*Ajay*)*

For some participants deciding to take a stand led them to become mentally ill. Ajay initially became angry and frustrated, but gradually lost interest in grooming and became discontented and depressed. Blondie completed his graduation but did not meet his parents' expectation of studying medicine. When he returned home, his parents sent him overseas to his uncle, which Blondie perceived as rejection and punishment for not fulfilling his parents' wish. Similarly, when Sarah returned to New Zealand, she sensed a loss of her position in the family hierarchy. Her parents were ashamed of her decision to divorce her husband, and gradually she became withdrawn and mentally unwell.

Experiencing trauma Suzie and Sunny perceived powerlessness. They worked to manage the challenge. However, loss of social support and difficult family dynamics together created a spiral from distress to mental illness.

> *When I was fighting and arguing with my husband, I felt like dying. I wanted to kill myself. I didn't want to live in these conditions. I had a lot of stress. I think it is the stress. I was scared of losing the kids, so I attempted [suicide]. I didn't want to die. My husband came from India. He had taken the children to his house [New Zealand]. He had*

*custody of the children during the weekend. If I had the children with
me, I would not have attempted. (*Sunny*)*

The stresses of cultural difference, rejection, criticism, invalidation, trauma and dysfunctional family dynamics contributed to becoming mentally unwell. The participants' strategies and emotional resilience were not always effective in the face of constant conflict of encountering cultural conflict and trauma.

6.9   Conclusion

In this chapter, I have explained the first category of encountering cultural conflict and trauma within the theory of shifting cultural connectedness. The sub-categories within the category of conflict – sensing wrongness and experiencing cultural isolation and disconnection – were presented. I described the conditions that influenced the strategies participants used and the consequences of facing cultural conflict and trauma.

Participants' stories revealed a pattern of response to encountering cultural difference. Each participant had a unique perception of their sense of cultural connectedness and of the various dimensions and complexities in encountering cultural connectedness. Their stories revealed disruptive, conflicting and complicating difficulties that participants experienced as making them mentally unwell.

Immigrating to New Zealand, participants noticed a contrasting cultural difference in language, clothing and social systems. The combination of cultural difference and an unfriendly reception precipitated perception of rejection. Some participants also experienced emotional and physical trauma within the family due to changes in the role and structure of the family and cultural isolation. The women participants noticed that their partners resorted to violence to reinforce control and power over them. Because of traditional cultural values and beliefs about women's roles, and fear of the stigma of divorce, these participants sensed that they were forced by their family to continue living in the violent relationship, leaving them helpless and powerless.

Each participant interpreted the meaning of the conflict differently. Based on participants' life stage, family support and family dynamics, they shifted their cultural connectedness to manage the dissonance. Depending on their management of the dissonance and conflict, the participants spiralled into becoming mentally unwell.

The following chapter completes the presentation of findings, focusing on the second category of moving towards mental wellbeing. It explains how the participants shifted their cultural connectedness to recover from mental illness.

Chapter 7 Moving towards mental wellbeing

This chapter concludes the findings of the study which explain the theory of '*shifting cultural connectedness*es'. The previous chapter described what occurred when participants became mentally unwell; this chapter explains the category of becoming well and outlines the strategies participants used to manoeuvre the conditions to stay mentally well.

7.1 Introduction

In the process of moving to New Zealand, participants encountered cultural conflict and unresolved trauma, including emotional, physical, mismatched expectations and disconnection from family and cultural norms. As noted previously, the participants strategized to manage the distress of cultural conflict and trauma. However, some salient conditions – life stage, support and family dynamics – influenced the selection and effectiveness of the strategies, with participants becoming mentally unwell.

Upon becoming mentally unwell, participants reflected on their thoughts, feelings and actions that led them to this situation. Participants' interpretations of their experiences and actions signified an ongoing process of *shifting cultural connectedness*. Participants worked towards recovery by balancing negotiation, resistance and compliance of cultural connectedness.

This chapter first provides an overview of how participants made sense of their experience of becoming unwell. Next, the strategies of maintaining daily routines, medication and accessing mental health services are explained. The salient conditions are discussed and, finally, wrapped up with explanation of the paths towards mental wellbeing. Figure 11 (p. 138) outlines the structure of the chapter. Referring to the diagram of shifting cultural connectedness on page 101 of Chapter five, this chapter describes the journey of the participant from reaching the crisis point to becoming well.
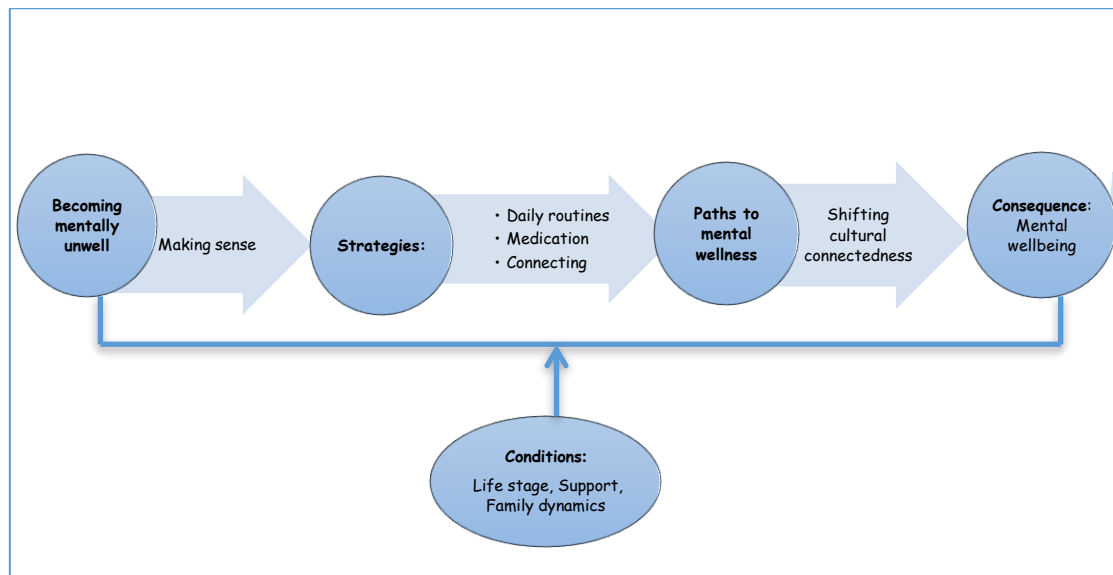
Figure 11. Diagram of moving towards mental wellbeing

7.2 Making sense of the experience of mental illness

Coping with cultural conflict and traumatic experiences, such as abuse, bereavement or divorce, influenced participants' mental and emotional state; which, in turn, induced mental illness. All participants described mental illness as circumstances that altered their daily functioning at school or work and they faced difficulties performing familiar tasks such as cooking and studying or working. Managing the day-to-day functions, demands and challenges of life became complicated. Sarah described how she became mentally unwell.

> *Okay what happened was I started screaming and yelling at my mother. I would stay in the house for like hours and hours and people, my family would go to somebody's house, I wouldn't go. They would go, my sisters would go to the supermarket, I wouldn't go with them. So that's how it started.* (Sarah)

Becoming mentally unwell impinged upon the participants' everyday life and disrupted their work and home life. Inability to handle routine tasks evoked dilemmas about self-worth. All participants reported that the combination of major stresses triggered their mental illness. Sarah and Blondie stated that they were distressed before becoming unwell and became anxious and started withdrawing.

> *The final year at the university was quite, like, practically anything made me anxious, but I didn't go to a doctor I thought it was just something normal from the stress of studying and stuff so when I came back here [parent's place] and I was trying to look for a job, I ended up staying in the room most of the time.* (Blondie)

Blondie described having a vague feeling of disconnecting from his surroundings and reality. He noticed that prior to becoming unwell he became anxious about practically everything that he perceived as different from or uncharacteristic of his usual self. Most participants' families recognised small changes and sensed that something was not quite right about the participants' thinking, feelings or behaviour, and sought help.

> *Bad days are like, generally just a huge drain of energy where I just can't do anything. I'm just feeling really tired or really panicky and I end up having a panic attack or those are the really, really bad days.*
> (Rose)

Rose defined her illness as interruption and wanted to seek guidance to manage her distress. She perceived that the stresses and anxieties were intruding into her life. She recognised that knowing about what was happening to her would help her to control it and so she sought help.

> *Yeah it was my choice. I told my parents that I really need to talk to someone so I saw the GP and then the GP referred me on to the psychologist.* (Rose)

Seeking a doctor's diagnosis ended Rose's search for an explanation. She explained that she was relieved to have a diagnosis as the explanation acknowledged and validated her distress. Though Ajay and Sunny recognised that they were depressed, they struggled to receive help. Both attempted self-harm; a crisis point that signalled the beginning of their treatment of mental illness.

> *I started feeling frustrated. Then I broke down one night. I didn't get the internship placement that I wanted. I thought that there must be something wrong with me. I became violent and thrashed my phone and the apartment. I was fully depressed. I felt so low that I requested a security person to be present when I was vacating the flat so that I don't harm myself* (Ajay).

Ajay reported that his anger and frustrations engulfed him and that his illness started in the background but moved gradually into the foreground as a crisis. Each participant perceived the experience of becoming mentally ill differently; and such differences influenced their entry to the mental health service. For Ajay, Suzie and Sunny, crisis landed them in hospital, whereas the other participants received community care. Rose chose to seek mental health help herself, whereas families sought help for the other participants.

Sunny and Tanya had experienced mental health issues prior to immigrating to New Zealand. Mostly, the findings relate to mental health issues as arising in New Zealand so perceptions of these participants are somewhat distinctive. They compared the mental health systems and mentioned that the New Zealand mental health system was different from the mental health system in their birth country. Tanya said, '*In India doctors they just give you medicines straight. Over here [New Zealand] they are little bit different*'. Tanya went on to describe that in her home country people have a paternalistic view of the doctor. She explained that a doctor in India holds dignity and honour so people trust the doctor to make decisions about treatment. She remarked that in India she relied on her family to support her with the treatment.

> *I like NZ. Here they have social workers, psychologists. They come regular to check your condition. In India the clinic had only doctor. He prescribed medication. When you finish the medication, you go to the doctor and they write script. There was no social worker. No one came to check regularly.* (Sunny)

Hence, the participants perceived the mental health system in New Zealand as individualistic with respect to the management of their treatment. Some of the participants had access to psychological treatment that supported better understanding of their thoughts, feelings and actions. Learning and talking about conflict and frustration assisted the participants towards acceptance and management of their conditions.

> *Like having therapy has helped me a lot. In the initial sessions, I learnt to accept the illness. Then I learnt to understand the signs and symptoms. I had lot of anger and guilt feelings. I felt it is bad to feel like that. I learnt to accept those feelings. It is okay to feel angry or being emotional. Now I am learning to manage those symptoms.* (Rose)

Becoming mentally unwell was a significant event for all participants and their families. Receiving help, whether hospitalisation or community care, signalled a series of changes for the participants. The mental illness had different dimensions and meanings for each participant; however, the event was a turning point that reflected the growth and resilience of the participants. Ajay stated that '*the psychologist at the hospital encouraged me to live life*'. The crisis and hospitalisation gave him relief; his problems were validated and addressed. In accessing mental health services, participants gained a sense of self or insights into the possibility that things could be different. It was a turning point in their determination to become well.

The path towards mental wellness, however, was uncertain and confusing. Initially the participants were in flux and overwhelmed by the experience of mental distress and conflict. Then they engaged in self-reflection for resolution of the internal conflict that led them towards mental illness. They acknowledged that the collective connection did not give them a sense of belonging. They discovered that shifting connectedness increased the distress and conflict. Thus they worked to reconfigure their connection to strike a balance of negotiation and compliance within cultural connectedness. The process of making sense of their illness and the contexts influenced their choice of strategies for becoming mentally well.

7.3   Strategies

All participants accepted that their journey to becoming well was neither smooth nor straightforward. Rather there were good and bad times, new learnings and setbacks. Participants sometimes applied the same strategies that they used before becoming mentally unwell, or else developed new strategies during their mental illness and on the way to recovery. The combination of strategies was shaped to a great extent by the participants' experiences, attitudes and beliefs. Angela explained that she prayed before and after her illness as a source of help but, as the quote reveals, not during acute episodes.

> *But when I was sick, I didn't even complete prayers. I used to sit to pray and then get up before finishing the prayer. I was very restless.* (Angela)

Regaining mental wellbeing made life more manageable. Hence maintaining a daily routine was significant to achieving a structure and sense of self satisfaction.

7.3.1   Daily routines and meaningful activities

The participants articulated that having a daily routine helped them to recover from their feelings of confusion and depression. They mostly described daily routines structured around housework and parenting responsibilities that provided meaning to them. Bob did gardening to keep himself busy '*I grow vegetables and it keeps me busy. I have grown chillies, bitter gourd and lot of other vegetables. It is satisfying*'. Growing vegetables gave Bob a sense of achievement. Angela explained how prior to her mental illness, having a structured routine kept her happy.

> *I was a different person before I went to the hospital. I was always happy. I enjoyed working and kept myself busy with work and family. I*

used to get up early around 5am and get the kids ready for school and left for work by 6.15am. I reached work by 7. I worked till 4 or 5pm. I was home by 6pm. Sometimes I worked until 7pm. After coming home, I cooked. I had no support. I did all work by myself, and it kept me happy too. (Angela)

Angela's family noticed a disruption in her routines. Her husband described how he changed his role to accommodate the disruption in their family life after the trauma. He sought to involve Angela and encouraging her to organise her routine, like cutting vegetables and helping him in making dinner. When Angela's husband took over most of her errands, his help provided a buffer for her self-esteem and self-worth. Though Angela was slow and sometimes distracted by her thoughts, cooking and supporting her family kept her involved and connected.

I need to support him too. He works in the factory and then come and cooks so I try to support as much as I can. Now I feel much better and can cut vegetables or roll rotis (bread) properly. (Angela)

When Suzie divorced her husband, she had no family support and was raising two young children. She started working and kept herself busy.

After the divorce, I had two young kids. I had no job. I could not afford to go and study further. Kids were used to the good lifestyle, but our lifestyle dropped. I come from sort of upper-middle-class family. I was used to the good lifestyle. I wanted to bring up my kids similarly, so I started working. (Suzie)

At first, Suzie's work routine was an economic necessity, as she had no choice. Suzie explained that her religious belief in karma and work as worship provided meaning to her daily routines and work, along with giving structure and distraction from distress. She viewed her work as her devotion to her family. She also mentioned how personal growth and resilience emerged from the pain of violence and divorce.

Work made me independent, and I could be home when my boys needed me. Work gave me pleasure. Circumstances made me strong. (Suzie)

These participants were committed to their traditional values and beliefs. Working and maintaining a daily routine were connected to their belief in work as worship. Daily routines helped them to accomplish an economic need and gave them satisfaction in doing their duty as a valued family member. Although depressed and invalidated by the

trauma, working and being of use to the family gave them a positive boost towards mental wellbeing.

7.3.2 Accessing support and resources

Confused and distressed, all participants shifted their connection towards family for support and help. When the participants became mentally unwell the family accessed support from the mental health services. As Blondie recalled '…*he was a doctor that guy, that's how he found, figured out that there's something wrong with me or something is affecting me*'. The participants received medical and psychosocial care from the mental health services.

Medical and psychosocial care

> *I am on mood stabiliser medication. It makes my mood stable. It is morning dose. It is the lightest dose. I was on the same medication but on a high dose. Now I am on a very, very light dose. I take it every day sharp at 11am. If I am going out also, I carry it with me in my purse. I have fixed this time mentally for this medicine. Exactly at 11am.* (Suzie)

Like Suzie, most participants viewed medication as a necessary and effective treatment for becoming well. Taking medication reflected the participants' perspective regarding the importance and purpose of taking the medication. Some participants, like Blondie, Angela and Sonia, had to live with severe side effects but, as a strategy, continuing to take medication was connected to the participants' hope to manage their illness and support their way to recovery.

> *Looking back, I think I learnt from each admission. I learnt about the medication, my illness and how to look after myself.* (Suzie)

Suzie reflected that she gained knowledge about her illness from her two admissions to the hospital, which helped her to become well. From her experiences at the hospitals, Suzie learned that awareness of herself and the condition helped with its management.

> *The doctor said that I had episodes of depression due to the stress and pressures on me. I was single person looking after the house, children and job. It was heavy pressure. Then he said that I didn't talk to people about my problems or stress. I need to open up. So that was a big change in me. And I decided to change. I wrote my weaknesses. I was thinking what are my weaknesses? I am not that type of girl. Who am I? I should not behave like that. I am not that type of person. You know.* (Suzie)

By learning about her illness, Suzie meant that she accepted her illness, understood its effects upon her daily life, and acknowledged the stresses that made her unwell. Learning about her illness merged with her belief about power in knowledge. She concluded that the new knowledge helped her to engage in profound self-awareness, particularly with regard to stressors and their effect on her mental health. This deep self-knowledge became the starting point for developing her motivation to get well. Subsequently, Suzie navigated her recovery by gaining self-knowledge which changed how she perceived herself and her situation.

During his hospitalisation Ajay discussed his symptoms, conflict and concerns with a psychologist. Through therapy, he noted his choices may not suit either culture and developed a new way of looking at his issues and managing them. The new learning helped Ajay to map out a different route around the obstacles to resolve his internal conflict and paved a way towards mental wellbeing:

> *I even started seeing escorts, visiting strip clubs and developing healthy perception of sex. I would say I owe my life to strippers and escorts. You might think it is unhealthy but I disagree. They are frowned upon. I don't want to put in efforts in relationships. I have made lifelong decision Kaberi that I don't want a girlfriend anymore. I am happy seeing escorts and having casual sex. And that's how my depression getting better. That is recovery for me. So lack of access to healthy sex life is addressed.* (Ajay)

Accessing support from family and taking medication were ways of connecting to South Asian forms of treating mental illness; whereas accessing other types of psychosocial support connected the participants to new ways of coping, as they learned about different world views. The participants shifted back and forth, choosing something known and something new; thereby combining bits of both cultures. As the participants shifted and connected with the right therapist and resources, they achieved mental wellbeing.

Connecting with resources

The participants reported that recovering from mental illness meant not only getting better, but achieving a full and satisfying life. The participants viewed becoming mentally well as learning to live with the illness and reconstructing new selves through connecting with services and resources.

> *When I came from Australia, one of my friends asked to contact a non-government organisation. I stayed at South Asian women's refuge*

centre. They arranged a room for my children and me. I had no money. So they didn't charge me. They organised me to get the benefit. They helped me to get a flat. At the women's refuge centre, I met a social worker from (the community mental health service). She referred me to mental health team. So I started treatment. I am thankful to them. They helped me a lot. (Sunny)

Sunny recalled the difficulties she faced when her husband divorced her. As noted previously, she returned to New Zealand for assistance with her illness and by connecting with friends she received emotional help and advice that encouraged her to seek practical help from professionals. By shifting her cultural connectedness, Sunny came to value her own emotional needs and mental wellbeing. She was able to access housing; a social welfare benefit and became more confident at recognising her symptoms and managing her challenges.

Yes in a way. I have rebuilt my family. I saved all my money for trip to India. I have booked my ticket for 1st June. In India they have summer holidays in June so I am going to meet my kids. I am looking forward to it. (Sunny)

Managing symptoms was a significant step towards mental wellness. But acquiring new support and skills was the key to self-satisfaction and mental wellbeing. Gaining new skills gave Sunny opportunities to connect with peers. She gained hope and insight, experienced acceptance, and received invaluable support by connecting with other people who shared her condition; all of which shifted her to reconnect with her children and family.

Seeking connection was not an easy process. Most participants shifted back and forth until they found a way towards wellness. Some families supported the participants through the process of becoming well. When Rob was occupied with his symptoms, his family introduced him to a training workshop. Rob's mother mentioned that attending the workshop taught Rob interviewing skills which helped him to get a job. She recommended the course for young participants as she considered that the workshop taught new skills, helped people to move into the workforce and normalised mental illness.

There was a place called Work Focus, which I found very helpful. They had a programme called personal focus. They met once a week. Rob was taught interviewing skills. It was very helpful. He is doing so much better. He is working, which is very important for getting back self-esteem. He interacts with other people, which is motivating. He

got back confidence that he can work. He has a routine in his life.
(Rob's mother)

Participants managed their illness by using strategies to move towards mental wellbeing. The participants shifted between cultures to access support as they grappled with the mental illness. Some participants used traditional resources such as medication and family support, whereas others shifted towards newer ways and gained understanding about the illness and themselves, accessed non-traditional psychosocial support, and learned new skills to navigate the process of recovery. Along the way, conditions shaped the adoption of strategies and subsequent outcomes.

7.4   Conditions

The participants' mental illness were dynamic, occurring within their particular social and personal contexts, including the mental health system. At various points, factors for each participant – life stage, support and the family dynamics – influenced their strategies and the outcomes of the illness.

7.4.1   Life stage

Participants' personal beliefs shaped their illness and strategies, and the experiences of conflict and trauma left an imprint upon feelings, actions and meaning. Most participants, who immigrated to New Zealand as adults, perceived the mental illness from a traditional cultural context and moved towards spiritual strategies. They lost hope and turned inward. Younger participants were more active in understanding their condition, taking responsibility for their own care and reaching out for help. The young participants shifted more towards the new culture and approaches to mental wellbeing.

Angela, an older participant, perceived her illness as an inability to perform her housework, cooking, shopping and looking after her children. As Angela became immersed in her illness, her family became supportive and undertook activities while encouraging Angela with simple tasks to keep her involved.

> *While cooking I don't feel like doing anything and just leave. So food remains uncooked or sometimes I put salt twice or burn the food. I could not roll rotis. My hand started shaking.* (Angela)

All participants perceived the illness as a disruption. How they managed the disruption was influenced by the life stage. As adults, their lives were structured around families and parenting, so they depended on family support and extended family for becoming

well. Adult participants recognised and accepted the course of the illness. They let go and continued to fit in with families.

The awareness of their situation prompted Suzie and Sunny, both older participants, to reach the point of readiness to relinquish the past and move on. They were angry with their husbands and sensed that the violence was wrong. Given their sense of frustration and anger, they shifted to seek a way to build satisfying lives. The participants acknowledged that moving on encouraged their personal growth and maturity from the experience of trauma.

> *I have such good friends. They supported me to stand again. I was renting a house. The house owners were running a business from home, so they encouraged me to get into that business. I had friends, and slowly life was getting better. I bought a house too.* (Suzie)

Moving on was letting go of past feelings of anger and resentment. Suzie reflected deeply on her experience and concluded that by divorcing her husband, she forgave him and let go of her anger. '*I have forgiven him too. I had become strong. I had forgiven him*'. As Suzie forgave her husband, she noticed a sense of peace within her that made her move forward.

Rose, a younger participant, on the other hand, wanted a diagnosis and sought immediate help. Younger participants sensed frustration with the disruption of the illness in their lives. They preferred connection with their peers to become well except for Blondie and Sarah, for whom the path to connection was complicated as their families had contrasting traditional views regarding seeking treatment. Thus, the participants' various life stages shaped their perception of the mental distress, treatment, and coping. Older participants had more of a spiritual outlook towards their distress whereas younger participants were more inclined to reach out to informal support networks such as family, friends and social network.

7.4.2 Support

The availability of social support was another condition that affected the strategies used by participants and their immediate families. Most participants lamented their extended family's lack of support of when they became ill. Some families stepped in to provide support, but the pressure of caring isolated them from other social interactions. Alternatively, stigma isolated some families. Still other families ignored the participant's condition as they had a different perception of the illness or they looked for

alternative treatment, which was not always available. Thus, lack of support disconnected the families and undermined recovery.

> *No it was something I wanted for Rob. As a family, we did feel bit isolated. We don't have our extended family over here. And we didn't involve our friend due to stigma. So we dealt with the whole situation ourselves. The group session or social support was little difficult.* (Rob's mother)

Rob's family preferred to keep Rob's illness a private family affair. The family was reluctant to involve the Indian community in New Zealand due to their fear of stigma. The decision was difficult. Being immigrants, Rob's parents had multiple commitments and shifted and adjusted their commitments to care for Rob. However, they chose to not disclose his illness to shield Rob from being rejected and stigmatised.

> *It was difficult. My younger son has also developed behavioural problems. So we just take one step at a time. In our Indian community, due to stigma, they tend to move away rather than supporting or engaging. I believe social support is very important. This support, by and large, is lacking in our Indian community.* (Rob's mother)

Angela's family also chose containment over disclosing Angela's illness to relatives in New Zealand. Angela's husband commented that due to Angela's illness they had drifted away from friends and relatives in New Zealand. He did not have the energy to make phone calls and social visits. He explained that he simplified their lives and made some compromises and sacrifices to trade off privacy over the involvement of relatives.

> *Sometimes when my mother [Angela] is alone at home, she is unable to communicate properly to the nurses. So it would have been better to have Indian staff. Otherwise father or I have to be there always for the appointment.* (Angela's daughter)

> *She [Angela] can understand English but can't speak very fluently. She can't explain properly. It is okay but see today she spoke to you for so long. She does not talk so much to the staff. She takes the injection and goes inside her room. We always had Indian doctor but other staff were not Indian. If you had the job. You know the society, you know about the culture. It would have been better if there were Indian staff but it is okay. Because of language she can't attend any other programmes of the clinic.* (Angela's husband)

The participants' families encountered difficulties due to a lack of social support. Yet as they highlighted their predicaments, they outlined key points about the mental health service. Family members noted that they were marginalised by the mental health system

due to cultural difference. Not knowing the English language became a barrier for some participants and the family carried the added responsibility.

> *Wish he [Rob] had a buddy system. Yes. That would have made a big difference. Even for the family. I wish there was service like education group. Where we could meet other families going through similar experiences. Interact with other families. Getting to know their contact, if they are willing to share. Buddy and support for the family. This is something lacking for families.* (Rob's mother)

Rob's mother reiterated the limited recognition of the cultural needs of South Asian people. She reported that the mental health service should understand the cultural difference to enhance family participation and partnership. She concluded that family involvement would support the family and create a sense of inclusion. However, the strong, positive bond between parent and child, which the parents viewed as a protective factor, was perceived by some participants as a challenge to seeking help.

7.4.3 Family dynamics

The third condition affecting the participants' progress towards wellness was the dynamics within their families. Ajay remarked that his family's cultural norm of not expressing emotion openly was frustrating and he considered their traditional values as a barrier to seeking help.

> *My family didn't even want to acknowledge it. You know how Indian parents are (speaks in Hindi) nothing has happened. "You are just bit sad". I went to my GP. He diagnosed me with depression but still my parents didn't want to acknowledge it. Despite the fact that both my parents are health professionals. They said that "keep yourself occupied".* (Ajay)

The young participants felt that their parents misunderstood their mental illness symptoms. The participants experienced feelings of guilt and being a burden to their families. They noticed that their parents typically had difficulty understanding their conflict and distress. The young participants reported that, unlike their immigrant parents who adhered to traditional cultural beliefs, they endorsed the dominant Western values, resulting in a cultural clash. The participants mentioned that their parents always brushed the subject of mental illness under the table due to a sense of stigma about the topic and reacted uncomfortably when offered support.

> *Oh there is a big stigma. I have many friends and I am sure, kind of sure that they noticed Rob's problem. I sort of socially isolated myself.*

We meet regularly like once in 3-4 months. As a family, we have socially isolated. You know we belong to small community. They are more critical. They have social functions and they meet regularly. But as a community they are not supportive. They don't ask if you have any problem or if you need any help. They don't offer any help. Their children don't say come out for a movie. They isolate us more. (Rob's mother)

In contrast to the participants, family members feared rejection from the community. They viewed maintaining distance and censoring information from relatives and friends as a way of preserving family stability. The young participants believed that their parents' different perception of the illness delayed seeking support, and sometimes cut off support, causing the participants to suffer in silence. Due to the cultural clash of perceptions, the young participants reported that they lacked family support, resulting in social isolation that further undermined recovery.

The only thing whether better or worse we can't say but then what we can say is we have never tried an alternative one, that's the one that's worrying me. Other than that, even I used to tell my wife I'm not sure whether it's going to give sort of cure for that one but only if we haven't tried and then we didn't know, we don't know then again that will, it's going to be a worry for us also in the future, we've never tried any other alternative treatments and only we rely on this treatment [medication] only. We have been relying on that one only and never tried any other treatment, that's also what, one of our worry but I don't know it will work, I cannot be sure. (Blondie's father)

In comparison to younger participants, family participants viewed medication as the focus for treating mental illness and reported a lack of diversity or consideration of social and cultural factors. They perceived the system as westernised which was a barrier to accessing health care. On the other hand, younger participants preferred shifting their cultural connectedness towards New Zealand ways of mental health care.

Shifting cultural connectedness was the process the participants used to manage the complex cultural conflict and recover from their mental illness. As the participants were recovering from mental illness, they experienced challenges and conflict, influenced by conditions, which directed the choice of strategies and the outcome of their illness.

7.5 Path to mental wellness

Mental wellness for all participants involved achieving a balance of health, relationships, work and self-achievement. Most participants described recovery as

reclaiming their former roles and activities. The participants viewed becoming mentally well as maintaining stability and returning to an active life based on their preferences and abilities.

> *Recovery for me is having consistently stable mood. Your anxiety and feelings of helplessness in relation to your ruminations are completely gone. You stop ruminating. So I believe that the symptoms are addressed and also the reasons for why you got depressed are also addressed.* (Ajay)

Ajay explained mental wellbeing for him was the resolution of symptoms and addressal of the conflict that caused the mental distress. The participants highlighted the importance of support in becoming well. The meaning of recovery, like the meaning of distress, was shaped by the support that the participants received. Ajay acknowledged that finding the right support from the right people who understood the struggle and frustrations that he was undergoing helped him to become well.

> *I was admitted to the hospital. I was there for 5-6 weeks. I met psychologist there. He understood me as he had similar struggle of growing up. He [psychologist] gave me permission to be myself. I could openly talk to him about my struggles and how I felt about it. I didn't felt judged. Yes, having an Indian psychologist helped. He understood me. I would say it was combination of talking to him and also doing my own critical analysis of my situation.* (Ajay)

Rose acknowledged that learning to trust contributed to her recovery. The keys to finding a strategy that supported Rose towards wellness was first recognizing the threats from her parents' perception that was distressing her. Then she carefully selected the strategies to align the disparity between the two cultures. By writing her feelings and thoughts in a blog, Rose gained acceptance from her peers without hurting and shaming her parents' beliefs. By trusting others and talking about her feelings, Rose sensed a change in her stance towards her illness as she received support and validation of her distress. By balancing negotiation, resistance and obedience to parental expectations, Rose manoeuvred strategies that shaped her way to become well.

> *I think lot of it is to learning to trust. I had an issue of trusting people. I have learnt to trust and open up to people. Talking to people when I need about how I am feeling. And distracting myself. When I am really upset, learning to get out of that space.* (Rose)

The participants' stories suggested an interpersonal and intrapersonal process of learning to accept and be oneself, and trusting others. The process of becoming well, as

viewed by the participants, started with medication and/or hospitalisation. Once the participants' physical condition improved, gradually the participants moved to connect with support and resources to improve their living conditions. Then the participants addressed their interests and potentials to develop their self-esteem and self-confidence. Yet, the process was not straightforward, simple or easy as the process occurred within the complex conditions as outlined previously.

Merged in the process was pain and sadness of losing one's way of being in the world, a constant struggle of appraising the gains and losses of shifting connectedness. Blondie and Sarah perceived connecting to peers significant for achieving mental wellness. But recognising and acknowledging their family's disapproval for Western mental health treatment, they decided to stop fighting, as Sarah stated '*So at one point of time, you do have to fit in. Then you fit in*'. Her dream of '*Get a degree and a job. And learn how to drive*' remained unfulfilled. She shifted her aspirations to fit in with her family's decision.

> *Have good family support. Seeing my family members happy makes me happy. Seeing my sister getting a job, seeing my sister getting married, seeing my brother getting married would make me happy.* (Sarah).

Similarly, Blondie gave up the long struggle with his family to have a say in his mental health treatment and accepted fitting in. He came to the conclusion that the expression of frustration, anger and taking a stand leads to being rejected and further suffering. As shown in Chapter Five (Figure 9, p. 101) when Blondie and Sarah came to terms with the reality of losing their voice, they reconciled and reconnected with their families. At this stage, they somewhat lost hope of changing their condition and remained drifting between staying mentally distressed and seeking mental health support. Feeling distressed, they gave up hope of moving forward to address their capabilities and interests. They adapted their perception and found a sense of mental wellness in the success and happiness of their families.

Angela, Sonia and Bob were engaged with mental health services but due to language difficulties were unable to convey the meaning of their distress. However they persisted, praying and maintaining daily routines that gave them a sense of value and connectedness towards their family. Rob enjoyed his work. His stress-free work environment and connectedness with his colleagues shaped his mental wellbeing. Suzie was grateful that her family and colleagues valued her work. She perceived mental

wellbeing in her success and contribution to the family. Sunny sensed calmness in her spirituality. Learning to swim and helping others connected her towards mental wellbeing.

Shifting cultural connection became a significant turning point with various shifts back and forth between the traditional and new cultures. Mental wellness became possible when the participants engaged in meaningful connection with others that involved feeling accepted and validated fostering the development of self-esteem and self-confidence through meaningful activities. The meaningful connection provided participants an opportunity to voice the meaning and perception of their conflict. Being listened to gave a glimpse of hope and motivation to become well. Meaningful activities strengthened participants' spiritual and emotional capabilities, and was further associated with balance between the cultural norms of the birth and new country, which moved participants towards mental wellbeing. By shifting cultural connectedness, participants balanced cultural distress and achieved a more positive sense of themselves and their lives.

7.6 Summary

This chapter concludes the presentation of the research findings. Starting with how the participants perceived becoming unwell and the move towards paths to recovery, the theory of shifting cultural connectedness has been outlined and shown the process of adopting strategies that shaped a way to mental wellness. The conditions that influenced the outcomes were also discussed. The final chapter examines salient arguments from the findings and considers the implications for practice, education and research.

Chapter 8 Discussion

"We shall not cease from exploration

And the end of all our exploring

Will be to arrive where we started

And know the place for the first time" (Elliot, 1943, p. 49)

This study began as an exploration of the process of recovery for South Asian people accessing mental health services in New Zealand. This, the final chapter, critically examines the study findings in light of existing literature to understand the contribution to knowledge about mental health recovery (Evans, Gruba, & Zobel, 2014).

Participants' experience of cultural difference and facing trauma is examined alongside existing literature, followed by a critique of the theory of shifting cultural connectedness. The shift in research focus that is needed to enhance understanding of recovery from a cultural perspective is examined. Following, there is reflection on the implications of this study for clinical practice, education, and further research. Finally, the strengths and limitations of the study are critiqued. The thesis finishes with some concluding thoughts about my research journey.

8.1 Introduction

This study commenced with clearly defined research objective to generate a greater understanding of the process of recovery for South Asian people assessing mental health services in New Zealand. My analytic interpretation of participants' recovery stories, views, strategies, and the conditions influencing their strategies have enabled me to understand the recovery process of South Asian people as one of shifting cultural connectedness. From analysis of interview data, I concluded that by shifting their cultural connectedness the participants resolved cultural dissonance and achieved wellness. Participants encountered cultural conflict within the family and with their peers. The combinations of salient conditions influenced each individual's strategies for managing the distress and spiralled participants towards becoming mentally unwell. In pursuit of recovery, participants learned new skills by connecting to the new culture and devised routines to manage their illness. The shifting of cultural connectedness was not linear and not always conscious. It took place through a backwards and forwards

dynamic that reflected the varied experiences participants had within their families and with their peers. Management of interpersonal conflict and the satisfaction of achieving a new skill led to the development of self-respect, positive self-esteem, and mental wellbeing for some but not all participants.

The theory of shifting cultural connectedness highlighted the way in which these participants strategized to manage their mental distress. The findings are important for the development of mental health services, practice, and research which may be improved by understanding the value of these strategies.

8.2 Encountering cultural conflict and trauma and the existing literature

"*No man is an island entire of itself.*" (Donne, 1967, p. 195)

The participants' data revealed that the environments in which they lived influenced their lives. The concept of mental wellbeing was enmeshed in the complex interaction between participants and the wider social context, their families, and their peers. Participants perceived that adjusting to a new way in a different country, post immigration, was challenging. Based on personal observations, Das and Kemp (1997) developed a cultural profile of Indians in America and reviewed mental health difficulties connected with counselling South Asian immigrants in the United States (US). Though the review is 21 years old, the profile has similarities to the South Asian participants in this New Zealand study. Das and Kemp noticed that although all South Asian immigrants had begun their journey to new country in search of a better life, many realised that their dreams in regard to a better life and career, travelling, and other vocational interests had a down side. Being displaced from a familiar world, moving away from families, relatives, friends, and all other emotional attachments was a painful experience (Das & Kemp, 1997).

8.2.1 Contrasting cultural values

Participants in the present study encountered cultural differences in language, dress, and other social norms. The cultural differences experienced reflected acculturation-related traits of first generation South Asian immigrants (Mathews, 2000; Sodowsky & Carey, 1988). Sodowsky and Carey's (1988) US study of 450 Asian Indians immigrants found that most adopted fashion, manners, and behaviour through their job or formal social contacts with the dominant US culture However, they usually held onto their food

habits, family ideals and values, practices and religious beliefs. Mathews (2000) reviewed the behaviour of South Asian students to aid understanding of their distinct behaviour and noted that the students, particularly from first-generation families, faithfully adhered to their own ethnic culture and tradition according to their parents' expectations. Immigrants' personalities are already shaped by the society, culture, and religion of their birth country (Wark & Galliher, 2007). Hence, when immigrants come to a new country, naturally they bring along combinations of behaviour, values, and attitudes; some of which are stable and some that shift depending on certain conditions. Consequently, those behaviours, values, and attitudes are learned, at least, by first generation children.

These results fit well with the model of acculturation articulated by Berry (2005). He noticed that societies considerate of cultural pluralism had positive multicultural ideologies. However, he noted that even in culturally pluralistic societies there were discrepancies in relation to acceptance of distinct cultural, racial, and religious groups. Berry (2005) concluded that those groups that were less well accepted often experienced hostility, rejection, and discrimination. The sudden shift in environment and the transformation from a 'traditional' society to a 'modern' one was a cultural shock for many. In cases where serious conflict existed, individuals experienced culture shock or 'acculturative stress' (Berry, 2005) if they did not change their behaviours.

The concept of acculturative stress has been explored extensively in the literature and is closely connected to psychological models of stress (Berry, 1997; Berry, 2005; Lazarus, DeLongis, Folkman, & Gruen, 1985) as a reaction to environmental stressors. Most of the participants in the present study encountered such stressors, noticing that stress existed in the presence of the person-environment relationship and the processes that explain this relationship. The environment affected the person, and the individual either adapted to fit the environment or attempted to change their context. This circular arrangement goes on in all adaptation encounters.

The construction of meaning in these adaptation experiences was an important element in understanding the difficulties that the participants encountered. According to the constructivist paradigm, socialisation plays a key role in one's interpretation as the construction of meanings is shaped by the values of the culture, education, customs, communication, traditions, social interactions, roles, and constitutional belief systems (Yeh & Hunter, 2004). Behaving in socially acceptable ways shifts across cultures.

Perceiving diverging conceptualisation of self and the shared interaction between culture and self is significant for socialisation as it shapes people's comprehension of socialisation in various cultures (Yeh & Hunter, 2004). For instance, standing when answering teachers and elders is a form of expressing respect to others in South Asian cultures. When Blondie's peers ridiculed his action of standing up to express respect to his teacher, he became confused about the constructed meaning of the behaviour of respecting. He made the connection that his behaviour was not normal, which lead him to feel insignificant and contributed to him becoming mentally distressed.

Gustafson (2001) questioned how mundane occurrences in the environment are related to the conceptualisation of a sense of community within social and behavioural science. In Sweden, using grounded theory methodology, Gustafson (2001) interviewed 14 people about the meaning of various places and how people related to these places. He diagrammed a three-pole model of self, others, and environment. Thus, the meaning of place changes due to the interaction between self, others, and the environment. The conceptualisation of the meaning of the place extends to the social and cultural views of place experience. Interestingly, the framework applied to the participants in the present study. Most study participants who came to New Zealand from small towns had self-related meaning and connections with their birth country, which influenced their perception of the new country. The meaning of being in New Zealand changed through the interaction of the participant with others and their new environment. They came with high expectations of a better life in this new place, but the meaning of the experience quickly changed as they interacted with their family and peers at home, in school or workplaces. New Zealand soon came to be a confusing and stressful place to be. However, when they found new environment to live, work or receive services in and new people to talk to (through peer support, mental health workers and supportinve employers) new meaning emerged and they developed positive views of themselves.

Mehta's (1998) study of 195 first generation Indians who settled in the US indicated that perceptions of acceptance by US Americans and cultural orientation played crucial roles in their mental health, irrespective of length of residency in the country and pre-migration adjustment. Agnew (2003) posited that an individual's sense of identity emerged through social relations in a social context. This includes the social, economic, and cultural surroundings, which give individuals an understanding of place; a subjective territorial identity. The relationship between a sense of identity and social and cultural surroundings explained how the participants in the present study formulated

different meanings from similar experiences of immigration, depending on the specific conditions they faced.

Thus, differential meanings are attached to behaviours depending on the cultural context in which the behaviour has occurred and how one is socialised to interpret events. Individuals' behaviours, thoughts, and emotions are influenced by cultural contexts and, in turn, shape the meaning of the experience within a cultural context. As a result, the same behaviour may have different meanings in different cultural contexts. When Rose's peers laughed at her accent, she was angry for being treated differently. In contrast, Blondie perceived his peers' teasing as something wrong within him and blamed himself.

As outlined in Chapter Two, research publications and policy documents from 1998 to 2018 have highlighted the importance of acknowledging and responding to the cultural diversity of immigrants in mental health service delivery. However, it is noteworthy that mental health sevices, both globally and in New Zealand, are still finding it challenging to work with immigrant populations. By adopting constructivist grounded theory, this study nuanced the meanings of the cultural values, norms, and resettlement perspectives that will support developing culturally appropriate mental health services and contribute to cross-cultural mental health research.

Intergenerational cultural conflict

In the present study, participants' perceptions were shaped by their age and lifestage at the time of immigration. Participants who immigrated as adults were oriented to the cultural values of the birth country and struggled to adopt the culture of New Zealand. On the other hand, participants who arrived in New Zealand when they were young faced conflict between family values at home and the values of their peers. The study findings align with two studies where similar intergenerational conflict were faced by second-generation immigrants (Klassen, 2004; Lalonde, Hynie, Pannu, & Tatla, 2004). Both studies compared second-generation South Asian immigrants and Canadians to understand the cause of intergenerational conflict. The first generation had experienced their heritage culture socio-structurally, through schooling and language; and interpersonally, through family and friends. Thus, their self-concepts were well rooted in the traditional culture. In contrast, second generation immigrants accomplised most of their heritage culture through their families. Most of their social structure and the most of their peers belonged to the host culture. Therefore, second generation

immigrants experienced an internal conflict that had a cultural basis wherein they sensed being a misfit within both cultures (Klassen, 2004; Lalonde et al., 2004). It is important to note that as the participants in this study, who immigrated at an early age, experienced more dissonance and discord between their traditional values and those of the host country. Perhaps by successfully navigating the process of shifting cultural connections, those younger participants would be well prepared to support their first-generation children.

Gupta, Johnstone, and Gleeson (2007) used Interpretative Phenomenological Analysis to explore the meaning of life-events of six young second-generation South Asian (Pakistani Muslim) women living in Britain. The authors explored the issues of cultural conflict related to separation and individuation. The concept of separation-individuation gained attention through Erikson's (1968) theory of psychosocial development. Individuation is perceived as an important part of the adolescent phase, wherein an adoloscent develops his or her own identity (Erikson, 1968). However, Kakar (1985), who was a former assistant of Erikson, argued that individuation is a Western concept. In collectivist society, human development is achieved in terms of relational orientation, where a person derives his personal nature interpersonally. Gupta et al.s (2007) research results reported that the pressure of living within fixed, prescribed boundaries of collectivist cultural values changed their perception of the meaning of adulthood, which contested the assumptions of the separation–individuation model and was a crucial component in cultural conflict.

Constant conflict and the associated tension were evident among the younger participants in this study. There was confusion and contradiction in the young participants' voices about exploring their identity and individuality or remaining connected to their family and traditional cultural values. When Sarah became mentally unwell in New Zealand due to bullying experiences, her parents removed her from university and against her wishes arranged her marriage to a person in her home country. The trauma of the bullying, lack of support from parents, and adjusting to the new role of wife and the values and expectations of her in-laws in India, distressed her. She was confused by the contradictions within her traditional culture so she disconnected from the traditional cultural values and tried to break away from the traditional trappings. However, she was then distressed about hurting her parents.

Many of the findings of the present study are consistent with studies on Indian elders migrating to Canada (Choudhry, 2001) and the US (Das & Kemp, 1997). The study findings also matched with other quantitative studies of immigrants in the US, including 35 Iranians (Lipson, Muecke, & Chrisman, 1992), 30 Jordanian women (Hattar-Pollara & Meleis, 1995) and phenomenological research study of 6 Korean women (Shin & Shin, 1999) that explored the effects of adjustment processes on immigrants' health. Studies among Indians and Pakistanis living in Britain revealed that the Indian and Pakistani elders experienced doubts and anxieties about losing cultural values due to acceptance of British values by family members. The elders also sensed detachment because of language problems. In addition, they encountered poverty due to loss of pensions and, at worst, rejection by their own families (Boneham, 1989). Although the sample sizes of the quantitative studies were small, these studies were congruent with the findings from the present study. Moreover, these studies highlighted the adjustment difficulties the immigrants encountered in a new country, similar to the participants of the present study. There were comparable themes of family conflict, isolation, economic dependency and settling in problems due to changes in traditional values and lack of social support.

Social support

The immigration experience impacts the whole family. Chadda and Deb (2013) noted that families of mental health patients in India, a collectivist culture, fulfilled the physical, spiritual, and emotional needs of their members. The family initiated and maintained growth for the mental health patients and became a source of support, security, and encouragement to the patient. Consequently, Chadda and Deb (2013) acknowledged that the collectivist values encouraged people from their societies to keep their personal problems to themselves and discouraged to seek support from outsiders. Help seeking is often perceived as a measure of failure of the family to solve the problem of their member. Though the family values are contrasting, coming from traditional families, the participants in the present study mourned the lack of support of extended family and friends.

Like the Choudhry (2001) study, the familiar daily social interactions that helped lessen the burden of day-to-day stresses were lacking in the lives of the participants of the present study, and all participants of the present study missed the companionship of extended family and friends. Additionally, as with the findings of Aroian, Spitzer, and Bell (1996), the present participants revealed that their family acted as a shield to the

demands of immigration, but could become too overwhelmed by the demands of immigration to provide support and instead generated additional stress for family members. However, some women participants in the present study reported family violence that emerged from the complexities of cultural circumstances was influenced by power relations and residency status problems. As in Das Dasgupta's (2000) study, a combination of personal, institutional, and cultural barriers formed roadblocks for the abused South Asian women participants and drove them towards mental distress.

Domestic violence is common to all economic, racial, and ethnic groups, and is regarded as a major health issue for women (Das Dasgupta, 2000; Gill, 2004; Shirwadkar, 2004). Nevertheless, Gill (2004) noted that South Asian immigrant women were doubly victimised. Violence was so deep-rooted in the institutional fabric of society that family violence became both a social problem and a personal issue. Violence was inflicted on them by their partner and a society that often failed to offer them effective support and intervention. Pillai (2001) accepted that conforming to the submissive roles of good wife and mother forced many Indian women to tolerate violence against themselves.

For most South Asian women abusive experiences are only a segment of the complex relationships with their husband. Many studies on domestic violence within South Asian women have highlighted the pressures of cultural idealism that promote values of self-sacrifice (Goel, 2005; Pillai, 2001). Should a South Asian woman choose to leave her abusive husband, she risks losing community and extended family support. Additionally, she was at risk of being ostracised by her own family, thus feeling guilty about her decision (Das Dasgupta, 2000; Pillai, 2001). As demonstrated in the findings, the present women participants experienced similar cultural dilemmas.

In a study of Indian, Pakistani, and Korean women in Chicago, abused women acknowledged their shame and dishonour over leaving their husbands (Supriya, 1996). Mama (1993) concluded that women in domestic violence situations were aware of their family's expectations and preferred to pretend that all was well. In this study, Sunny received no support from her family, returned to an abusive environment and finally made a serious self-harm attempt when she could not cope with the distress. Suzie, in this study, decided to leave her husband but chose not to inform her family.

Menjívar and Salcido (2002) contended that, in appraising their current situation, immigrants mapped their experiences using the circumstances in their home countries as

a reference point and evaluated their current situation consistent with what they had left behind. They noted that, often, women arrived from countries where domestic violence was simply not reported due to either an absence of legal protection or cultural norms that prevented women from reporting violence. Their study emphasised that violence against women was not a constitutional part of anyone's culture but it was an issue of power and control that for immigrants were provoked by issues such as isolation, changes in economic status, and language barriers (Menjívar & Salcido, 2002). Additionally, Pleck (1983) perceived that immigrant women feared seeking legal help in dealing with abuse because the women considered the issue a family affair and were concerned that seeking judicial protection might weaken or damage the traditional authority in the family. Thus the dominant cultural ethos and relative isolation silenced the immigrant women from seeking help (Pillai, 2001; Pleck, 1983).

As with other social problems, domestic abuse involves a complex dynamic interplay of relationship issues. There are cultural dynamics and then there are power differentials. In the present study, connection to the values of the new country shifted the balance of power within the family and caused distress to some participants. Ready access to information and the job market promoted the women participants' economic and social independence, which strained relationships with their husbands.

The present study also has parallels with a Canadian study by Ahmad, Rai, Petrovic, Erickson, and Stewart (2013) regarding South Asian immigrant women's perception of the process of achieving resilience following domestic violence experiences. Like the participants in the present study, the immigrant women in Canada transformed their collective-self and formed stronger feelings of belonging to their adopted country. By developing meaningful ties with strong agency, the women challenged the violence and stigma and achieved personal transformation (Ahmad et al., 2013). What was captivating in this study, was the participants' consistent strategizing to uphold a sense of honour, dignity, and agency within the conditions of violence and cultural dilemmas. The strategies of developing connections with professionals to deal with the violence in addition to preserving and enhancing agency were innovative and resourceful.

Cultural constraints like gender norms, nostalgia for one's home country, psychological dislocation, unmet expectations, divergent values systems, and the trauma of self-transformation through immigration as experienced by the present participants were similar to the concepts found in the novels of South Asian women writers. In her novels,

"The lowland" or "The Namesake", Jhumpa Lahiri, a second-generation Indian-American immigrant female writer, described the complicated process of acculturation and provided a deeper understanding of physical and cultural relocation and dislocation. According to Habib (2015), Lahiri's stories resemble the confusion, predicaments, and contradictions described by the participants in the present study.

Cultural constructs and recovery

Importantly, in the present study, cultural differences and trauma were both possible triggers to mental distress and impeding factors in the recovery process. The source of the trauma, either family or the broader society, also holds potential facilitators of recovery. Recovery, as mentioned in Chapter One and Two, includes developing hope, personal and social responsibilty that implies active involvement of families, communities and people with mental health problems themselves (O'Hagan, Reynolds,&Smith,2012). Thus, it is critical to emphasise the need for mental health services to focus on working with the identified individual using medication and talking therapies, but also targeting the family and broader societal systems to address issues such as domestic violence, family expectations/dynamics, bullying, and discrimination.

Chadda and Deb (2013) assessed the efficiency and scope of family focused psychotherapy for mental distress in India. In view of the Asian collectivistic culture, they proposed family focused psychotherapeutic interventions for better engagement of families in the management of mental distress. Several theorists have argued that the use of connective and interpretive language and meaning-finding are particularly helpful for recovery following loss or trauma (Charmaz, 1999; Davis, Nolen-Hoeksema, & Larson, 1998). Charmaz (1999) recognised that suffering from chronic illness or loss and trauma threatened one's world view and one's perception of self, so that the meaning of the suffering could lead to either self-development or diminishment of self. By telling their story, people reflect on past events and actions. Although this process takes time, the story makes past events real and believable and shapes the way to recovery (Charmaz, 1999). As it is imperative to understand the meaning of recovery, next, we move to the meaning of mental wellbeing as described by the study participants.

8.3   Moving towards mental wellbeing and the existing literature

Faced with challenges and dilemmas, the present participants considered the meaning of these experiences and assessed them, and then shifted their cultural connectedness to

achieve a balance of meeting others' expectations while meeting their own needs. Berry (1997) suggested that during major acculturation, individuals explored various strategies like assimilation, integration, marginalisation, and separation, and in due course settling on one strategy that was more useful and satisfying than the others. He concluded that this process encompassed three sub-processes–culture shedding, culture learning, and culture conflict. Culture shedding and learning involved coincidental or intentional loss of some behaviours and their substitution with behaviours that sanctioned the individual to fit better with the host society (Berry, 1997). The participants in the present study learned about the new culture, and although they were conflicted by the norms and the values of the culture of their birth country, they did not shed that culture. Rather, they shifted between the two cultures and enhanced their cultural connectedness.

Acculturation strategies

This study's findings aligned with the New Zealand study wherein Nayar (2015), applying an occupational perspective, reconstructed meanings and models of acculturation. Using three illustrations, Nayar argued acculturation is a transactional process enclosed within time and across social and environmental contexts. Given that experiences, meaning and conditions are constantly altering and changing, the models of acculturation (Berry, 1997) do not adequately describe the dynamic nature of immigrants' settlement experience (Nayar, 2015). When the participants encountered differences, in the present study, they constantly created meaning and depending on the meaning, they shifted their cultural connectedness.

The present findings fit with the context of social constructivism where cultural selves are constructed and recreated by cultural participation in various cultural systems and groups (Yeh & Hunter, 2004). Socialisation is the process through which social skills and knowledge are transmitted within a culture. Socialisation is an integral aspect of understanding the ability of the self to shift in a variety of social contexts (Jambunathan, Burts, & Pierce, 2000; Yeh & Hunter, 2004). Selves are shaped by context and culture, continually shifting, adapting and changing. In Western cultures such as the US, the goal of socialisation is the development of an independent and autonomous adult. In contrast, South Asian peoples possessed different conceptualisations of the self that included connectedness with others through shared relationships (Grills & Ajei, 2002). In this study, those participants who eventually withdrew into their traditional family had limited opportunities to shift their conceptualisations, or it also may be that at

particularly stressful times some participants simply did not have the capacity to engage with the family dynamics to develop an autonomous self.

Hare-Mustin and Marecek (1988) asserted that in constructivism, reality is not discovered but 'invented' through experiences. Markus and colleagues described socially and culturally embedded selves as self-ways (Markus, Mullally, & Kitayama, 1997). Self-ways involved understanding and internalisation of socialisation and culture; hence, shifting across multiple sociocultural patterns of participation (Markus et al., 1997). According to Markus et al. (1997), sociocultural processes are included in everyday practices such as linguistic patterns and proverbs.

The participants, in the present study, believed strongly in the principle that '*work is worship*', reflecting a strong cultural emphasis on moral values of respect for parents, elders, family, and God. In a general sense, the participants' belief in the principle of work is worship was rooted in the idea of social responsibilites and connected to a cultural value of collectivism. When the participants worked with a sense of devotion, dedication, and sentiment of respect, they considered work became worship. Furthermore, the participants accepted that hope, faith, and devotion to work moved them toward mental wellbeing.

Meaning of recovery

Becoming well has different meanings for everyone, as mentioned in chapter two (Davidson & Roe, 2007). Not needing to take medication was a common interpretation of recovery for most participants in the present study. Lam et al. (2011) analysed the meaning of recovery for Cantonese-speaking Chinese young people who were experiencing a first episode of psychosis in Hong Kong. Having a biological perception of psychosis as the result of unbalanced dopamine levels in the brain reduced the fear that they caused their own illness and broadened the outlook of Chinese young people. The Chinese participants in Lam et al.'s (2011) study were by and large positive, hopeful about their future and perceived recovery as being normal with no medication. Similar to participants in the present study, Lam et al.'s (2011) participants experienced feelings of loss and distress about stigma and uncertainty about whether to disclose their mental distress to friends and extended family.

In a cross-cultural study of self in Japan and the US, Yeh and Hwang (2000) described the Japanese self as multidimensional and situationally based. Shifting selves, for

Japanese, was integrated with their social and relational responsibilities and the selves reacted and fitted according to feelings, place, time, and social situation (Yeh & Hwang, 2000). A recurring idea in most research and theory on the interdependent and shifting selves in collectivistic societies is how meaning is given to the self through relationship and social interaction and the significance of meaning in varying social contexts and social roles, which differed from the way self was expressed in individualistic cultures where individuals develop an independent self-construal (Kanagawa, Cross, & Markus, 2001; Markus & Kitayama, 1991; Yeh & Hwang, 2000).

The findings about shifting selves' align with the present study. When adopting strategies, the participants were always conscientious about how their actions, behaviour, and reactions affected their family. When the experiences and views were inconsistent with the conventional values of the family, the participants sidestepped the traditional ideology and re-created ideological alterations that were positive for them and acceptable to the family. For example, Suzie chose to divorce her husband but decided to not disclose that to her elderly parents, and Rose disclosed her lesbian relationship to her mother but hid it from her father and extended family. Hiding might be considered as deception and wrong but hiding was not easy for the participants. It was difficult and complex as constant careful treading between many causes and outcomes of disclosing the truth to whom, when, where and how was stressful. Rose and Suzie opted to disclose to people they perceived would accept and support them. However, Sunny and Ajay, unable to find the right time and people to disclose became stressed and attempted to end their lives to reduce the mental distress. Though, when they were able to disclose their distress to the mental health workers in the hospital- that supported their recovery.

The present study's findings aligned with the Power Threat Meaning framework's description of difficult experiences and how making meaning of the experience shaped people's feelings of shame, self-blame, isolation, fear, and guilt (Johnstone, Boyle, & Cromby, 2017). The Tidal model (Barker & Buchanan-Barker, 2004), Re-covery model (Randal et al., 2009) and, recently, the Power Threat Meaning framework all advocate a holistic model of care promoting recovery through narratives. As Charmaz (1999) explained, telling the story of suffering may construct a process of understanding what happened. Storytelling is a means of negotiating changes and creating continuity and oneness in the face of disruption. When the family or a health practitioner or a friend guide, understand and accept a person's story, recovery becomes attainable. Narrating

their stories, Ajay and Sunny unpacked 'what happened to me' and 'how it affected me'. For Ajay and Sunny, the narration was therapeutic as it constructed their understanding of how the trauma of invalidation, entrapment and rejection shaped their mental distress. However, for some people a diagnosis might not be a story that fits or is useful. For example, in the present study Rose reported that finding a diagnosis was useful, not as a narrative, but as it helped her to develop her own meaning of her mental distress.

8.4   Implications for service delivery and research

The research presented in this study aimed to an explanation of how South Asians accessing mental health services in New Zealand shifted towards wellness. How South Asian people gave meaning to their challenges and acted in the context of shifting cultural connectedness is significant for increased understanding and learning for mental health clinicians and for improvement of mental health services. In the multicultural and diverse context of New Zealand society, the research findings inform the mental health system to contribute appropriate, approachable, and engaging services to culturally diverse groups. The recommendations emerging from this research have significance for clinical practice, education, and further research.

8.4.1   Implications for mental health practice

Many researchers have highlighted the need for cross-cultural mental health research to enhance understanding of the cultural and contextual influences on mental illness (Lal, 2010; Lam et al., 2011; Onken, Craig, Ridgway, Ralph, & Cook, 2007; Tse & Ng, 2014). This research suggested that by shifting cultural connectedness the participants in this study moved towards mental wellbeing. The participants first assessed and reflected on their situation and then reviewed their actions, values, strengths, and consequences. When that process shaped the participants to connect with resources and social support, the participants achieved a way of encountering the challenges, accomplishing self-value and balancing the cultural discrepancy to move them towards mental wellbeing. This research also emphasized the importance of focusing on specific conditions related to shifting cultural connectedness, such as life stage, social support, and family dynamics, for effective mental health practice. Some further key implications for mental health practice arising out of the study are outlined below.

Acknowledging diversity

Working across cultures becomes a challenge in understanding how a person constructs his/her experiences. When some of the participants in this study reported that they accessed clinicians who validated their interpersonal conflict and understood their histories of abuse, cultural dilemmas and loss of social support, the mental distress started to recede. Whereas, when other participants viewed the clinicians as very clinical, the relationship was not effective. However, service users' perceptions and understanding of experiences may not always match a clinician's assumptions and worldviews (Sue & Sue, 2012). The existence of multiple constructions and multiple truths emerges due to the tremendous increase in cultural diversity. In fact, multiple realities lead to cultural misunderstandings and conflict in cross-cultural social interactions and recovery processes (Heppner, Neville, Smith, Kivlighan, & Gershuny, 1999). The participants' perspectives might not align with clinicians' socially constructed assumptions that the participant is exhibiting 'resistant' or 'avoidant' tendencies. The clinicians might be socialised to sense a client's behaviour as negative, while the client might be behaving according to their cultural norms. For example, clinicians perceived Angela's behaviour as 'resistant' because they did not recognise or understand her concept of cultural grieving.

This study challenges a *"one size fits all"* approach to mental health and the monocultural presentation of the recovery process, by highlighting the construction of meaning in each service user's distress, concerns and efforts to seek mental health help. The treatment model worked well for the participants when they were admitted to the hospital. However, due to stigma associated with mental distress and seeking professional help outside of the extended family, the participants reported that they presented to clinicians when their symptoms became severe and they had reached a crisis point. When participants found the right clinician, who acknowledged the cultural dilemmas and connected the participants to the appropriate resources in the community, the participants achieved mental wellbeing.

The NZ Ministry of Health is committed to improving the mental wellbeing of all people and announced a 'Wellness' budget recently to help people access mental health support before the mental distress becomes a crisis (New Zealand Labour, 2019). However, due to the distinct cultural needs of South Asian people, it is important to understand the cultural disparities in mental health experiences. Mental health services

need to be informed by and cognizant of the cultural beliefs, meanings and stigmas that might delay or deter people seeking mental health support.

Noiseux and Ricard (2008) noted that only by comprehending personal and contextual needs could interventions be appropriately directed towards the *potential* of service users rather than concentrating on the deficits connected with their condition. People differ in how they perceive illness and treatment; no two people are exactly alike. Though all participants were from South Asia, they all had unique experiences and perceptions of their problems. Once the clinicians understood the meanings of their conflict, the participants were able to connect with them and moved towards mental wellbeing. Turton et al. (2011) analysed the meaning of recovery for 18 users of eating disorder, dual diagnosis, and forensic mental health specialist services. Though there were common themes in the findings, there were diverging emphases in the three groups. For instance, medication was less critical in recovery for those with eating disorders than those using forensic and dual diagnosis services. Another discrepancy related to the sense of conflict embedded in the recovery process. Participants with eating disorders struggled with losing a core aspect of their self-identity, self-esteem, and feelings of abandonment; whereas for dual diagnosis participants the craving for alcohol or drugs, unwanted side-effects of medication were distressing. In this study, life stage and the age of immigration influenced the perception of the mental distress that eventually constructed the strategies, the participants adopted to become well.

Accepting different perspectives

So what changes might be implemented in mental health services so connection can be promoted? Some participants, such as Rose, were keen to know their diagnosis, as the diagnosis was useful for gaining better understanding of her mental distress. However, most participants preferred emotional support within the context of their conflict and dilemma, rather than clinicians assessing symptoms and providing a diagnosis. For example, cultural grieving had significant cultural and moral meaning for Angela. The pain of not participating in the funerals of her close family members pushed her away from her day-to-day activities, a reaction that was reframed by clinicians as 'resistance'. Thus, when the participants sensed that the cause and meaning of their distress and conflict were not recognised by services, they shifted to their traditional cultural values and remained stuck in mental unwellness.

Furthermore, clinicians have the potential of bringing their own prejudices and ideas about people and mental distress. Overall, it is imperative that clinicians prioritise understanding different constructions of the meaning of mental distress, over symptoms and diagnosis. Reflecting on and addressing one's own prejudices related to people from other cultures, as well as people with mental health issues, is also an essential aspect of effective and safe practice.

Being aware of the construction of meaning meant understanding what the participants were saying. However, language was a barrier for some participants. They were unable to communicate how or what they were feeling and unable to understand complex medical jargon. There was a glaring gap in the service provided to the participants who were unable to speak English. Though that gap was not intended, these participants lost their voices in the mental health system. The findings highlighted that understanding participants' voices could reduce unintentional discrimination of people who are linguistically and culturally different. This requires mental health clinicians to critically examine their perceptions and constructions of their worldview and of participants' values and behaviour that might reinforce unintentional discrimination.

Involving families

In addition to the participants' perceptions, the participants' family involvement was important in the recovery process. Families reported that they perceived mental health services as focused mainly on the individual's care, rather than the family as a whole. The family members believed that the focus of New Zealand mental health services did not match their cultural expectations, noting that their religious and cultural beliefs were not acknowledged, and they felt excluded from treatment planning. As mentioned in the findings chapters, the family dynamics were an important condition for shifting cultural connectedness and affected the progress towards wellbeing. Though, some participants had conflict within the family, they were still living in the family, so there was a mutual sense of obligation and responsibility. Thus, involving the family and incorporating understandings of their perception of the distress would promote a sense of meaningful inclusion and caring in the mental health service. This would also provide an opportunity to break down some of the stigma and shame associated with mental illness within immediate and extended families.

It is important here to differentiate between clinicians' intervention and championing for participants' rights. Some clinician interventions were shaped by self-management

and prioritising the individual's need. However, even where the intervention was well intentioned, the action did not evolve from the participants' intention and priorities. Instead, these actions were derived from the clinicians' sense of what should be done. Therefore, an understanding of service user perceptions of the issues and of family dynamics must be incorporated into any intervention planning.

So is ethnic matching with the service user a way to address cultural differences? Bhui and Morgan (2007) pointed out that though there was some improvement in engagement with this approach, due to issues of confidentiality and differences in age, gender, educational level, and social class between the clinician and the service user; ethnic matching has not provided good empirical outcomes. Sawrikar and Katz (2008) noted that through awareness and appreciation of cultural diversity within society, inclusiveness and engagement could be enhanced. Recognising the cultural gaps, the present study poses the question, how is cultural competency training best implemented across mental health training in New Zealand?

Recognising the need for cultural competency training in New Zealand, a two-day Asian mental health cultual educational training was formulated in four cities (Nayar et al., 2007). Based on consultation with service users and cultural models of teaching, the initial evaluations were positive. With regard to enhancement of Asian mental health knowledge, the project was viewed as successful in starting a cultural competency training programme as it provided a foundation for more widespread professional development for mental health clinicians.

With the aim of instilling Asian mental health knowledge in the practice of undergraduate mental health students; Nayar, Tse, and Sobrun-Maharaj (2009) developed a three-module interactive, self-directed training package, which included Asian philosophies, self-reflection, and clinical issues. The training participants acknowledged the significance of the cultural training. It is envisioned that in the future, a similar kind of continuing education could be implemented for not simply individual mental health students, but as well as for encouraging the cultural competence of mental health services as a whole.

8.5   Implications for mental health education

There is a need to address the cultural transformation of mental health practice and services. The implementation of cultural competency training in a multicultural context

requires education about cultural difference and demands clinicians explore the perceptions that shape their knowledge and may have discriminatory effects. In an endeavour to advance the cultural competency of the mental health workforce, Appleby (2008) concluded that cultural competency training is a useful way to reflect on attitudes and assumptions about people from diverse communities. Others contented that an educational approach was appropriate to address institutional racism (Bhui, Warfa, Edonya, McKenzie, & Bhugra, 2007; Bradby, 2010). The authors recommended that cultural competency training should be embedded at the organizational level, within the infrastructure, as well as in the ethos of each individual service provider. Kirmayer, Groleau, Guzder, Blake, and Jarvis (2003) proposed cultural consultation as a process to enhance the provision of mental health services in mainstream settings for a culturally diverse population (Bhui, Ascoli, & Nuamh, 2012).

The present study outlined many socio-cultural determinants of mental distress, such as bullying, cultural exclusion, language difficulties and family dynamics. However, these determinants are not unique to immigration and mental distress. Most immigrants encounter such cultural challenges but do not necessarily become mentally distressed. Essentially, the theory of shifting cultural connectedness is not explaining causality as such between immigration and mental distress. The present study described a common approach to achieving mental wellbeing for a sample of South Asian people who had accessed mental health services. The theory of shifting cultural connectedness emphasised that using key interventions, such as understanding the cultural meaning of mental distress, and including family support, could shape structural changes for the wider mental wellbeing of South Asian people. Thus, the present study could prompt and inform cultural consultations and cultural competency training to work towards recognising and addressing cultural diversity within mainstream New Zealand mental health services. The theory of shifting cultural connectedness could be promoted through a range of forums including inservice trainings, professional journals and associations as well as community groups and publications.

In New Zealand, mental health clinicians are required to acquire recovery-based competencies that include cultural competency training. However, accomplishing the recovery-based competencies depends on the professional group. So how would the theory of shifting cultural connectedness shape the social work role and profession?

8.6 Implications for social work

The theory of shifting cultural connectedness emphasises that the core values of social work could be achieved through an understanding of cultural diversity. The global definition of social work (Hare, 2004) approved in 2014, as described in Chapter One, described social work principles, knowledge and practice. In the context of New Zealand, the Asian and Pacific Association for Social Work Education (APASWE) in 2016 amplified the global definition to highlight the significance of diversity within the Asia-Pacific region. Cultural awareness and knowledge, rightfully, have a stronghold in the values and ethical standards of the social work profession (Horevitz, Lawson, & Chow, 2013).

In Chapter Two, the review of the literature highlighted the relationship between the social work profession and the contribution to mental health recovery practice. Understanding the importance of the socio-cultural determinants of mental health recovery, as a social worker, it is important to recognise and accept the significance of culture and assessment of cultural dynamics, and to adapt services to accommodate culturally distinct needs. Recognising the significance of cultural competence for sound social work practice and profession, the theory of shifting cultural connectedness provides an opportunity to translate cultural knowledge into cultural competence skills for working with South Asian people.

Building on a systematic literature review of Australian and international literature and an ecological model of health, Paradies, Chandrakumar, Klocker, Frere, Webster, Berman and McLean (2009) developed a framework to reduce race-based discrimination and support diversity in Victoria, Australia. Paradies et al.'s (2009) 'Framework to reduce racial discrimination and promote diversity' acknowledged the complex interactions between individual, organisational, community and societal factors that contributed to race-based discrimination. Consequently, the Framework highlighted eight major themes that are critical for sound and effective implementation of interventions to reduce race-based discrimination and support diversity: increasing empathy; raising awareness; providing accurate information; recognising incompatible beliefs; increasing personal accountability; breaking down barriers between groups; increasing organisational accountability; and promoting positive social norms (Paradies et al, 2009).

Recognising the importance of the complex interplay of the individual, social, community and organisational factors that contribute to the appropriate implementation of cultural competency, the theory of shifting cultural connectedness explored the applicability of Paradies et al's (2009) Framework to provide a cultural intervention for social work. At the individual level, the theory emphasised acknowledging personal cultural values and biases, followed by an awareness of each service user's worldview, to reduce discrimination. Understanding the meaning of the experience of mental distress, family dynamics, cultural dissonance, gender roles and associated status (izzat), feelings of shame (sharam), aging, and dying are all important elements in developing culture-specific competence. Hence, cultural competence for social workers needs to include more complex dimensions of cultural interventions (Horevitz et al., 2013).

Moreover, the theory highlights the importance of including families and emphasises the need to disentangle the associated social factors that are inherent in culture and may push migrants towards mental distress, for example family violence, pressure to study and other traditional norms. In the social context, the present study emphasises that, as a social worker, it is crucial to understand the cultural behaviour and identities that are embedded in the broader social contexts. Finally, the theory of shifting cultural connectedness identified structural barriers, such as difficulties in accessing mental health services and a lack of access to appropriate interpreters that could lead to health disparity. The present study calls for social workers to make broad social changes in mental health services to improve engagement and increase access to appropriate mental health services for culturally diverse people.

Therefore, the theory of shifting cultural connectedness has provided cultural knowledge at clinical and organisational levels to enhance social work values and ethics. However to further examine the implications of the theory of shifting cultural connectedness, the next section will illustrate the implications of the present study for additional mental health research.

8.7 Implications for mental health research

The key considerations of working with South Asian people accessing mental health services were highlighted by the theory of shifting cultural connectedness. The study, consequently, provides opportunities for further research to explore and examine the transferability of the theory to other immigrant groups from collectivist cultures. This

includes Chinese and Korean immigrants, who are a rapidly increasing dimension of New Zealand's population. The study could also be extended to focus in more depth on particular ethnicities, such as Indians, or religious groups, for example Muslims. The present findings might also be transferable to other countries with significant populations of South Asian immigrants. Alternately, the study could be expanded to understand the collective process of recovery for South Asian people from the perspective of clinicians and managers working in mental health services.

8.8 Strengths and limitations of the study

The purpose of the study was to explain the social and cultural context that shapes the beliefs, attitudes, actions, and strategies of South Asian people accessing mental health services in New Zealand. By conducting New Zealand based mental health research this study has contributed to the literature on the process of recovery. As a first grounded theory study on this topic, the study helped to identify the specific processes and strategies that have facilitated recovery from mental illness for South Asian people in this country. It has provided a starting point for understanding the challenges to mental health recovery for South Asian people. Knowledge of the recovery process of the South Asian people will enhance the cultural sensitivity of mental health practice and practitioners.

The strengths of this study are positioned in its consideration for the criteria of scientific rigour, in particular the transferability of results. Following the tenets of theoretical sampling and data saturation supported the criterion of scientific rigour. Hence, the conclusions of the study have the potential to be transferred to other health settings, collectivistic cultures, and immigrants.

The findings described in the study align with Charmaz's (2014a) four evaluative criteria for constructivist grounded theory. Credibility was demonstrated through the transparency of data collection and the analysis process. The theoretical findings were systematically developed from the data. A wide range of quotes was provided to establish the links between data, analysis, and concept development. Throughout the analysis, memo writing examined and conceptualised the patterns and processes. The significances of the findings for practice, research, and education have been addressed.

With reference to the limitations of the study, an important point to consider is that constructivist grounded theory studies do not seek to conclude, quantify, or control

people's behaviour, but rather convey one way of understanding an experience (Charmaz, 2014a). The grounded theory method provided a set of concepts that explained and explored the process of recovery for South Asian people. However, the findings cannot account for the experience of all South Asian people, as everyone has different perspectives and thus there are limits to the transferability of the findings. The process cannot be defined as a final or ultimate truth as it might change when further explored and refined by other research. Triangulating data collection through interviews with clinicians, peer support workers, and other stakeholders could have added depth to this research.

Although, the study sample was small, the theory of shifting cultural connectedness has value for understanding why clinicians trained in a 'Western' paradigm and immigrants using mental health services might struggle to find common ground in the recovery process. It still has value in helping both parties towards developing more effective support processes for recovery.

Lastly, grounded theory methods may not always use representative sampling (Charmaz, 2014a). The participants did not predominantly represent all South Asian religions and communities. The tenet of theoretical sampling guided the sample selection. However, it would be valuable to extend this research work further with other communities and clinicians, and with younger and elderly participants.

Prior to the conclusion, an important point should be noted. My personal status as the researcher and a South Asian mental health clinician and immigrant added both strengths and limitations to the study. Before starting the interviews, I became aware of some personal and clinical assumptions about the research topic, so I undertook a self-interview to be aware of how my assumptions might affect the data collection, interpretations of the data and the analysis processes. Memo writing helped me to be aware of my assumptions and remain open to other interpretations of the data.

Being a translator and researcher, translation of the interviews into English was a key challenge. Though time-consuming, to capture the precise interpretation and understand the exact meaning of the participants' experiences, some original quotes and metaphors were used to maintain the cultural meaning of the participants' voices. Furthermore, acknowledging the connection of the researcher's social worldview with language, I have illustrated my epistemological perspective in Chapter Three. Additionally, the process of translation was discussed during the research supervision sessions to reflect

on meanings that I might have ascribed to the data, and how the meanings shaped my dual perspectives with an insider and outsider point of view.

8.9 Conclusion

This final chapter has shown how the theory of shifting cultural connectedness connects, extends, and contextualises a range of theories and studies. The theory of shifting cultural connectedness has made an original, significant contribution to mental health knowledge that might be applied to immigrants from other countries and to other health settings.

Shifting cultural connectedness lends new meanings to the journey of recovery from conflict to a path towards confidence and compassion. These immigrants' struggles were grounded in grappling with conflict and distress. The meaning of their illness was embedded in their experiences of encountering difference and facing trauma. Through interpreting puzzling and confusing moments, the participants made sense of what their illness meant for their emerging selves. The meaning of their cultural connectedness shifted and changed as the conflict progressed or decreased. By changing perception and priorities, and creating continuity and balance with past selves, when the participants connected with available help and reconstructed new selves, they became well. However, when cultural values and norms tilted the balance of progress, the participants spiralled back to the world of mental illness.

I end the chapter with reflections on my research journey. The study provided a starting point to understand the process of recovery for South Asian people accessing mental health services in New Zealand. The whole process was challenging, particularly the application of grounded theory methodology, but studying the journey of people with mental distress taught me lessons about loss and grief and brought many wondrous moments. I learned and developed a new meaning for resilience. I acknowledge the participants for teaching me a new meaning of hope and not giving up. I also acknowledge my supervisors for pushing me to give my best. It was not an easy journey, but grounded theory transformed me into a researcher and I would like to explore the world of research further. By undertaking the research, the constructivist approach enhanced and added depth to my clinical practice. As Charmaz (2014a) stated, in "using grounded theory you can realize impassioned goals" (Charmaz, 2014a, p. 340).

If life's journey be endless where is its goal? The answer is, it is everywhere. We are in a palace which has no end, but which we have reached. By exploring it and extending our relationship with it we are ever making it more and more our own. (Tagore, 1994, p. 52).

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Appendices

Appendix A: Glossary of terms

Hapu is a section of a large kinship group and the primary political unit in traditional Māori society. It is consisted of a number of whānau sharing descent from a common ancestor, usually being named after the ancestor, but sometimes from an important event in the group's history.

Iwi means people or nation, and is often translated as tribe or a confederation of tribes. The word is both singular and plural in Māori.

Kaumātua (male) and **Kuia** (female) are elders in Māori society and are held in high esteem. They have a variety of roles, being the storehouses of tribal knowledge, genealogy and traditions.

Marae is the meeting place that is the focal point of Māori communities throughout New Zealand. A marae is a communal and sacred meeting ground of carved buildings which provides everything from eating, sleeping, religious and educational facilities for particular iwi (tribe) and hapū (sub tribe).

Mental distress the term used in this document to describe mental illness.

Tangata whenua literally means people of the land or more broadly the Māori people as a whole.

Tangata whai ora means a person seeking health.

Tikanga means Māori customs and protocols.

Well-being the term used in this document to describe mental health.

Whānau is often translated as family, but its meaning is more complex. It includes physical, emotional and spiritual dimensions. It is through the whānau that values, histories and traditions from the ancestors are adapted for the contemporary world.

Appendix B: Sample of templates

Literature review grid

Data base	Paper title	Sample	Methodology	Findings	Themes	Comments

Line to line coding sheet

Participant's detail:	Date of interview:	Interview:
Age:	Country:	

Raw data	Initial codes	Line no	Memos

Appendix C: Recruitment invitation

PARTICIPANTS REQUIRED

SOUTH ASIAN MIGRANTS

Did you have contact with mental health services in last five years?

Are you above 18 years?

If so, you are invited to consider taking part in my research.
My research is focussed on exploring recovery from mental illness.
This study will involve interview which will take maximum 90 minutes.
If you are interested in being part of this study, could you contact your GP or Keyworker for further information?

My name is **Kaberi Rajendra** and this study is part of my Doctoral programme at Auckland University of Technology.

Approved by the Auckland University of Technology Ethics Committee on 6/5/15.
AUTEC Reference number 15/95

Participant Information Sheet

Namaste, Salaam Alaikum, Sat Sri Akaal.

Project Title:
Recovery for South Asian people accessing mental health services in New Zealand

An Invitation:
I would like to invite you to take part in a research project exploring what happens to South Asian people accessing mental health services in New Zealand. I am conducting this research as part of my qualifications towards a PhD. I am a registered social worker from South Asia and currently work within Counties Manukau Health mental health services.

What is the purpose of this research?
The purpose of this research project is to gain a better understanding of experiences of South Asian people accessing mental health services in New Zealand. We hope the information gained from the study will help people who work in mental health and migrant services to better understand how they can improve mental health services for immigrants in New Zealand.

How was I identified and why am I being invited to participate in this research?
You probably must have seen an advertisement or given information flyer by your GP or mental health service provider. South Asian people with experience of accessing mental health services in New Zealand are being asked to participate. If you choose to participate, your contact information will be passed on to researcher. Your participation in this project is entirely voluntary (your choice). You can choose to withdraw from the study up to five weeks after interview and this will not affect your future health services in any way.

What will happen in this research?
The researcher will arrange an interview at a place and time convenient to you. Your interview will be audio taped, which will last for 45 to 90 minutes, and, with your permission, some notes may be taken during the interview process. The interview will be typed and you will receive a copy, which you are welcome to comment on. You can withdraw any information that you do not want included in the transcript. As I am fluent in Hindi and Bengali languages, you can choose to use one of those languages during the interview.

What are the discomforts and risks?
You must be aware that you will be talking about your experiences. Some of these experiences might be distressing and might cause upsetting emotions.

How will these discomforts and risks be alleviated?
You can choose not to talk about subjects that you find distressing. You can choose to stop the interview or choose to be interviewed at other time. You don't have to answer every question. In addition, if you wish, referral can be made to your mental health clinician to discuss any concerns following the interview.

What are the benefits?
There are no immediate benefits to you for taking part in this study. You will be contributing to information that could help to provide better services for immigrants.

How will my privacy be protected?
A trained transcriber, who will sign confidentiality agreement, will transcribe the interview recordings. Interview recordings and transcripts will only be available to the research team. No information identifying you as participant in the project will be included in any of the project reports or publication.

What are the costs of participating in this research?
The only cost to you taking part in this research is your time. If you choose to take part, you will take part in a 60 to 90 minutes interview with a researcher. The researcher will meet you at a place that is convenient for you. Should you incur any travel cost, this will be reimbursed to you in the form of taxi costs or petrol.

What opportunity do I have to consider this invitation?
You are requested to indicate if you would like to take part in the research within one week of receiving the information sheet.

How do I agree to participate in this research?
You could contact the researcher directly on the contact details available on the advertisement/pamphlet .The researcher will ask you to sign consent form before the beginning of the interview.

Will I receive feedback on the results of this research?
You can choose to receive a summary of findings of this research in the consent form. Once the findings are available, a copy of the findings will be sent to you at address you provide.

What do I do if I have concerns about this research?
Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor. My supervisor's name and contact details:
Barbara McKenzie Green. Ph.: 9219999 ext. 7352
Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz*, 921 9999 ext. 6038.

Whom do I contact for further information about this research?
Researcher Contact Details: **Kaberi Rajendra. Phone: 2654084; 021907602**
Project Supervisor Contact Details: **Barbara McKenzie Green; 9219999 ext. 7352.**

Approved by the Auckland University of Technology Ethics Committee on 6/5/15 AUTEC Reference number 15/95.

Appendix E: Participant profile

	Age	Gender	Education	Country of origin	Length of stay in NZ	Marital Status	No of children	Living situation	Employment	Religion	Diagnosis	Years of treatment	Extent of treatment	MH legal status	Treatment	Source of referral
1.Tanya	39	F	B Com	India	14	Married	-	Lives with family	Casual work	Hindu	Schizophrenia	4 years	Medication, HBT	Informal	Medication, respite	CMH
2.Sarah	27	F	BSc	Pakistan	12	Separated	-	Lives with family	Beneficiary	Muslim	Schizophrenia	3 years	Medication	Informal	Medication	CMH
3.Rose	18	F	1st year University	India	10	Single	-	Lives with parents	Student	-	Anxiety	2 months	Medication	Informal	Psycho-Therapy	CMH
4.Blondie	32	M	BSc	Sri Lanka	20	Single	-	Lives with parents	Beneficiary	Hindu	Schizophrenia	5 years	Medication, respite	Informal	Medication, Injections	CMH
#5.Father of Blondie																
6.Sonia	44	F	Primary	India	10	Married	2	Lives with family	Housewife	Sikh	Schizophrenia	5 years	Medication	Informal	Medication	GP
7.Suzie	49	F	Masters degree	India	16	Divorced	2	Lives with family	Self-employed	Sikh	Depression	5 years	Medication	Informal	Medication, hospital	CMH
8.Angela	51	F	Year10 (Secondary school)	India	27	Married	3	Lives with family	Housewife	Sikh	Depression	5 years	Medication	Informal	Medication, hospital	CMH
#9.Husband of Angela																

	Age	Gender	Education	Country of origin	Length of stay in NZ	Marital Status	No of children	Living situation	Employment	Religion	Diagnosis	Years of treatment	Extent of treatment	MH legal status	Treatment	Source of referral
#10.Daughter of Angela																
11.Sunny	40	F	BSc	India	12	Divorced	2	Lives alone	Beneficiary	Hindu	Depression	3 years	Medication	Informal	Medication, hospital	CMH
12.Ajay	23	M	Masters degree	India	22	Single		Lives with family	Beneficiary	Christian	Major depression	1 year	Medication	Informal	Medication, hospital, respite	CMH
13.Bob	61	M	Year 13 (Secondary school)	India	5	Married	2	Lives with family	Not working	Hindu	Brief psychotic reaction	6 months	Medication	Informal	Medication	CMH
#14.Wife of Bob																
15.Rob	26	M	B Com	India	17	Single		Lives with parents	Working	Parsi	Schizophrenia	5 years	Medication	Informal	Medication, discharged to GP care	GP
#16.Mother of Rob																GP

#Family participants
*Pseudonyms

Appendix F: Interview Questions

The interviews will be semi-structured therefore there are range of questions that will be asked of participants and follow-up questions will be adjusted by the interviewer in response to the participants' answers. The questions will be open-ended questions where the participants will be invited to discuss in detail about the topic. The questions will be framed to understand the experiences from the participants' views.

DEMOGRAPHIC PROFILE

Age **Gender** **Education** **Country of origin** **Length of stay in New Zealand**	
Marital status **No of children**	
Type of family **Employment**	
Religion	
*Diagnosis *** Years of treatment**	
* Extent of treatment ***Mental health legal status**	
*Treatment	

* This study is about recovery. Studies have shown that these factors influence the process of recovery. Using grounded theory methodology, this information will help the researcher understand what was happening to the participant during the process of recovery. It will also help with the process of constant comparison.

Few question examples:

Could you tell me what happened when you first came to New Zealand?

Could you tell me about your first contact with the mental health services?

Could you describe the events that led up to your family contacting the mental health services?

What contributed to your admission to the hospital?

What was going on in your life then?

How would you describe the person you were then?

Could you tell me about your thoughts and feelings when you learned about your illness?

Who has been the most helpful to you during this time? How was he/she been helpful?

Has any organization been helpful? How has it been helpful?

How have you grown as a person since you become unwell?

Is there something that you might not have thought about before that occurred to you during the interview?

Is there something else you think I should know to understand your recovery better?

Is there anything you would like to say about recovery?

Appendix G: Researcher Safety Plan

RESEARCHER SAFETY PLAN

- Gain as much prior knowledge and information about the address of the visit.
  i.e. Type of area, dogs.

- Gain as much knowledge of family and social circumstances
- Pre load important numbers for quick access.
- Ensure a working, charged mobile phone.
- Inform someone when and where the interview will be conducted and agree to contact that person at a certain time. If the researcher does not make contact, the contact person will attempt to contact the researcher. If no contact is made then the proper authorities will be notified.
- Once in the house or at the door if feeling unsafe then leave explaining why you are going. Arrange further visits as pairs if appropriate or offer alternative visiting arrangements i.e. at friends, family or hospital at a public place.

Appendix H: Sample of line to line coding

| Participant's detail: Sarah	Date of interview: 1/10/15	Interview: 2
Age: 29 years	Country: Pakistan	

15/10/15

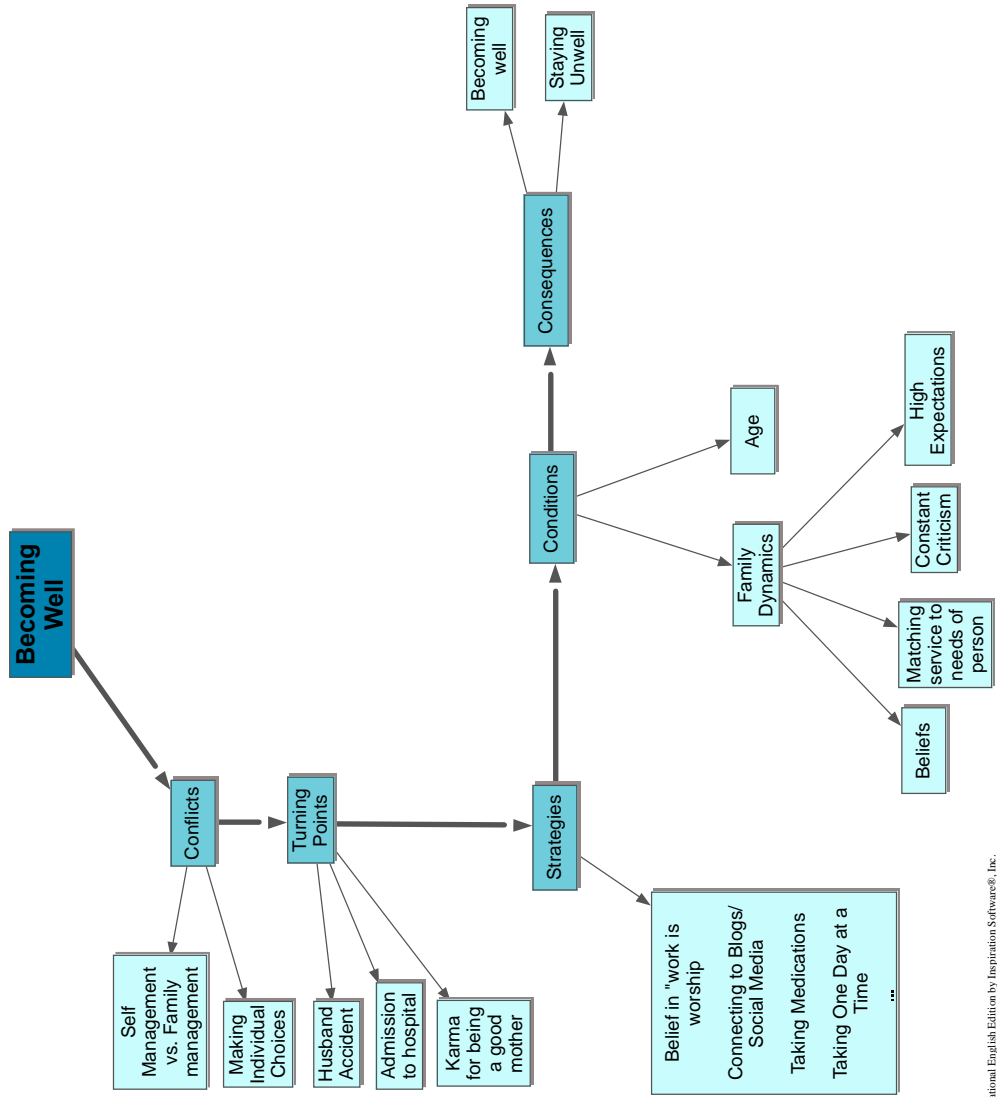| Raw data	Initial codes	Line no	Memos
The weather changed me. I was very cold, I felt very cold. Very, very cold it was a major thing for me and I know there, it was when I came here I became so sick, they had to give me lots of medic, medication from doctors so every time we went to the doctor. I think I for me I probably ate something on the plane or got stomach bug somehow, whatever the reason was but yeah for a week I was so sick and then everything started to cool down. Settle down into the space.	Becoming sick <mark>Settling into space</mark> *	2E: 42-47	NZ: Acculturation Fitting in Wearing gold
It was getting away from all the stupid people I knew from the school.	<mark>Getting away:</mark> * Pakistan Stupid people	2E: 56 89-90	Breaking away from strong rules/tradition: Arranged marriage, husband; gold
So those were the big hurdles. And in the science classes girls started laughing at me for no reason and I had no idea why there were laughing but they were just laughing because it's like a game, they're laughing at anyone new who comes to the school.	<mark>Encountering hurdles</mark>: * pace of speech no choice of subjects not understanding requirements not being able to type being negatively targeted Considering choices not to respond to targeting	2E: 74-82	Being laughed at by Pakistanis (known people) Does not fit or belong so it does not affect Education pressure on South Asians Difference in education system

* Invivo codes

Appendix I: Cluster diagram (Encountering cultural difference)
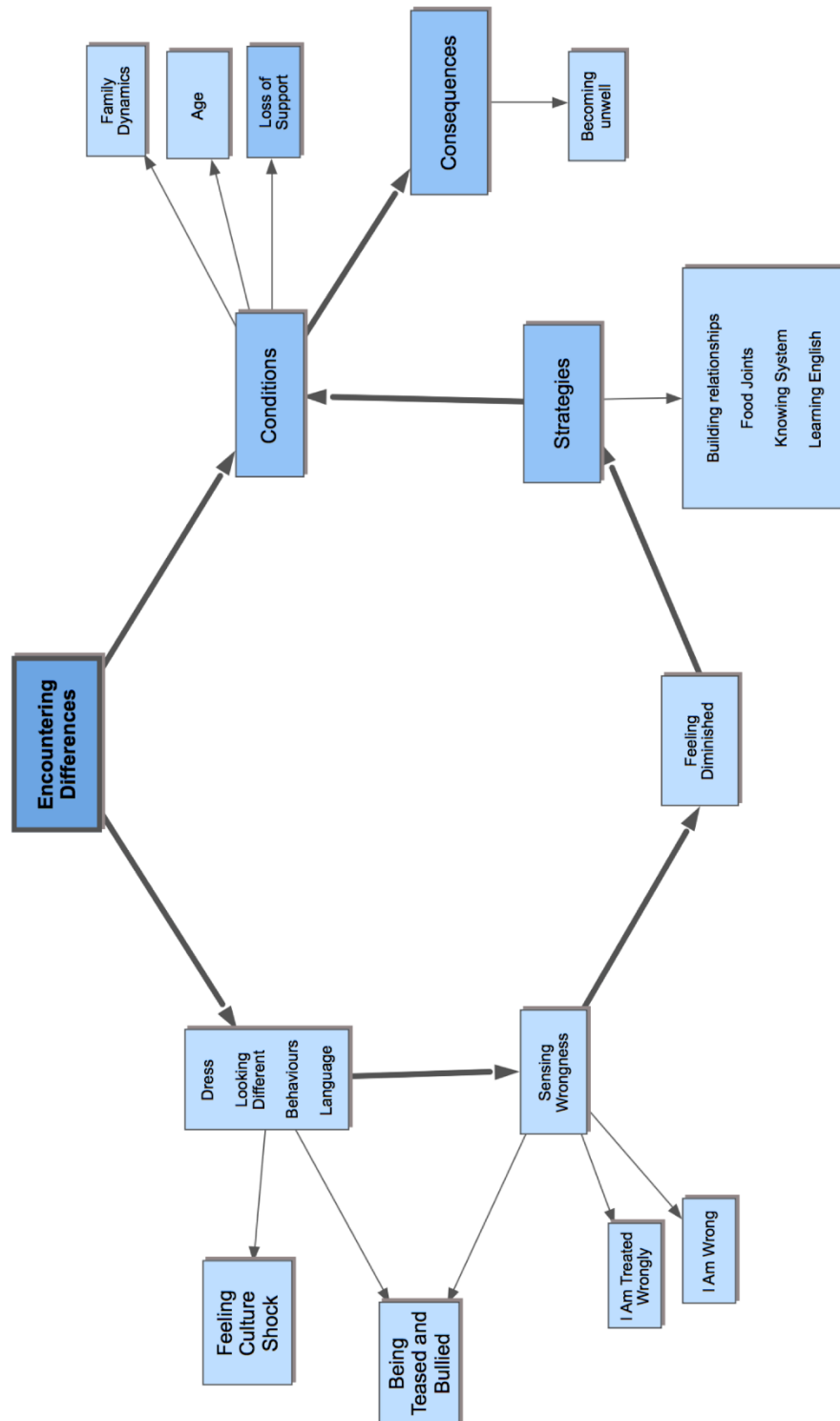
Appendix J: Cluster diagram (Experiencing trauma)
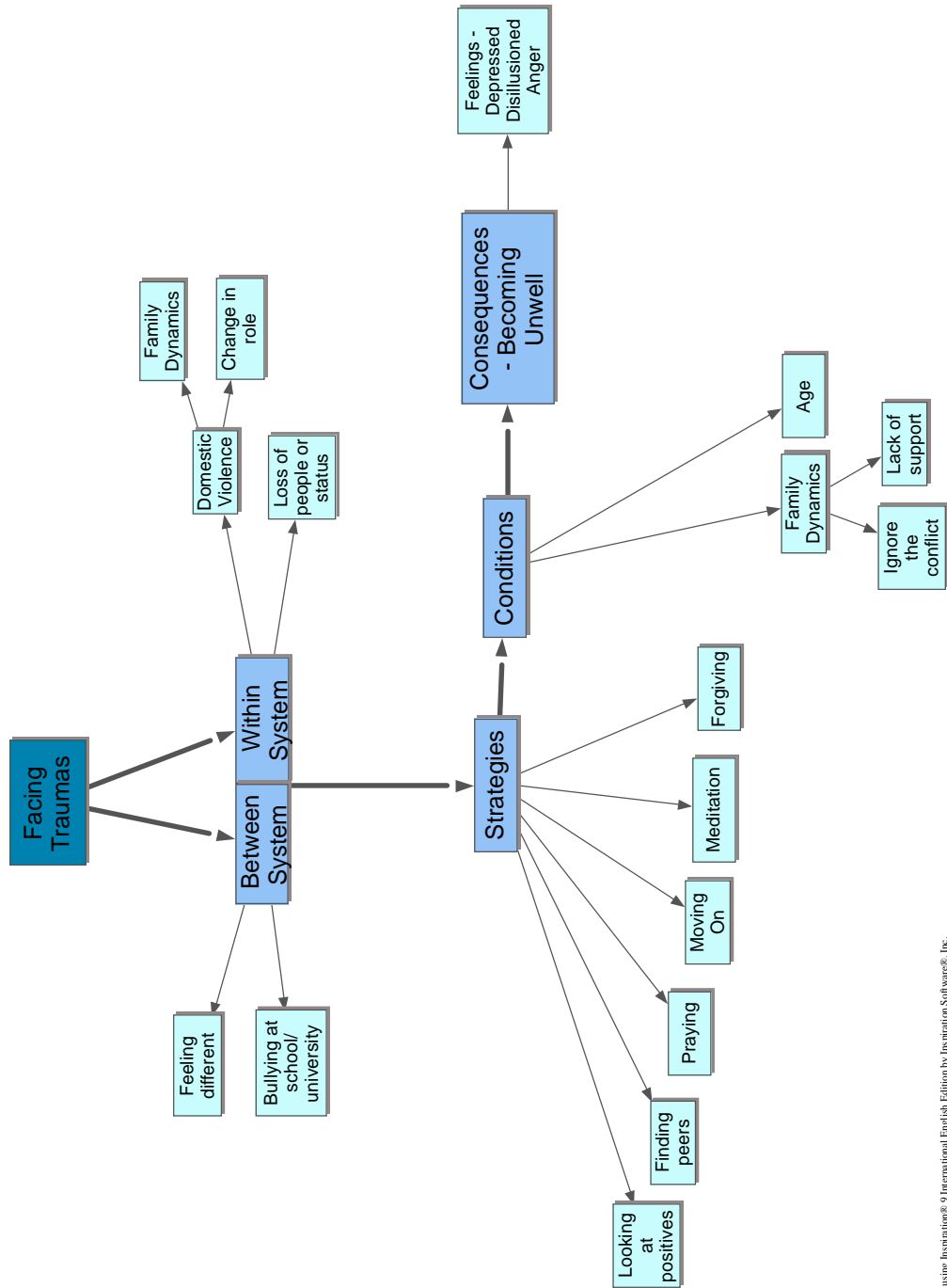
Appendix K: Cluster diagram (Becoming mentally well)

Appendix L: Sample of focussed coding

Conditions	Actions	Consequences	Strategies
Studying: To meet parent's expectation To <mark>fit in</mark>* (acculturation)	Feeling guilty for playing up or seeking independence (Fit in) Missing home (Family support)	Bullying Seek mental health help	Giving up (Internalizing stress): not recovery focused approach. Praying Accepting parent's and professional's decision and taking medication (Collectivist approach)
Medication Professionals/family not listening to the participant's world view of illness	Developing side effects	Losing job Unable to complete education. Unable to fulfil dreams Shattering of hopes Change of role Ineffective treatment	Passively accepting help (Not recovery focused) Praying (spiritual support)
Work: To become economically independent To be good citizen <mark>Work is worship</mark>*: cultural belief To <mark>fit in</mark> *	Feeling guilty for not fulfilling duty Getting pressure from boss	Losing job Seeking help Change of role Becoming dependent on family for support	Praying Taking medication passively to become well and hoping to get job
Getting married To fulfil parent's expectation	Feeling depressed Unhappy with decision	Becoming unwell Becoming victim of Family violence Divorce	Praying Seeking happiness in work, bringing up kids (fulfilling parental duties), looking after siblings children Becoming resilient
Seeking help Parents/family seeking help (Collectivist) Professionals not listening to participants voice	Feeling dissatisfied with service	Losing voice to ask for help/ seek help Losing confidence	Passive recipient of service
Parenting style High expectation Rituals/traditions	Feeling frustrated, angry Feeling guilty	Becoming unwell Alienation	Taking medication Being passive Praying

* Invivo codes

Appendix M: AUT University Ethics Committee approval

A U T E C

S E C R E T A R I A T

6 May 2015

Barbara McKenzie Green

Faculty of Health and Environmental Sciences

Dear Barbara

Re Ethics Application: **15/95 Recovery for South Asian people accessing mental health services in New Zealand.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 6 May 2018.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 6 May 2018;

- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 6 May 2018 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this. If your research is undertaken within a jurisdiction outside New Zealand, you will need to make the arrangements necessary to meet the legal and ethical requirements that apply there.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Appendix N: District Health Board locality approval

CMH Research Office
Counties Manukau Health
Clinical Support Building
Room 124, Level 1
Middlemore Hospital

4 June 2015

Dear Kaberi

Thank you for the information you supplied to the CMH Research Office regarding your research proposal:

Research Registration Number: **2090**

Ethics Reference Number: **15/95**

Research Project Title: **Recovery for South Asian people accessing mental health services in New Zealand**

I am pleased to inform you that the CMH Research Committee and Director of Hospital Services have approved this research with you as the CMH Co-ordinating Investigator.

Your study is approved until 6 May 2018 as specified on your HDEC ethics application.

Amendments:
- All amendments to your study must be submitted to the Research Office for review.
- Any substantial amendment (as defined in the *Standard Operating Procedures for HDECs*, May 2012) must also be submitted to the Ethics Committee for approval.

All external reporting requirements must be adhered to.

Please note that failure to submit amendments and external reports may result in the withdrawal of Ethical and CMH Organisational approval.

We wish you well in your project. Please inform the Research Office when you have completed your study (including when a study is terminated early) and provide us with a brief final report (1-2 pages) which we will disseminate locally.

Yours sincerely

Dr Shamshad Karatela
Research Advisor
Counties Manukau Health
Under delegated authority from CMH Research Committee and Director of Hospital Services

Appendix O: Health and Disability Ethics Committee (HDEC) approval

Health and Disability Ethics Committees
Ministry of Health
Freyberg Building
20 Aitken Street
PO Box 5013
Wellington
6011

0800 4 ETHICS
hdecs@moh.govt.nz

10 July 2015

Ms Kaberi Rajendra
Whirinaki,
P O Box 217198,
Botany Junction
Auckland 2164

Dear Ms Rajendra

Re:	**Ethics ref:**	**15/CEN/88**
	Study title:	Recovery for South Asian people accessing mental health services in New Zealand

I am pleased to advise that this application has been _approved_ by the Central Health and Disability Ethics Committee. This decision was made through the HDEC-Expedited Review pathway.

Conditions of HDEC approval

HDEC approval for this study is subject to the following conditions being met prior to the commencement of the study in New Zealand. It is your responsibility, and that of the study's sponsor, to ensure that these conditions are met. No further review by the Central Health and Disability Ethics Committee is required.

Standard conditions:

1. Before the study commences at *any* locality in New Zealand, all relevant regulatory approvals must be obtained.

2. Before the study commences at *a given* locality in New Zealand, it must be authorised by that locality in Online Forms. Locality authorisation confirms that the locality is suitable for the safe and effective conduct of the study, and that local research governance issues have been addressed.

After HDEC review

Please refer to the *Standard Operating Procedures for Health and Disability Ethics Committees* (available on www.ethics.health.govt.nz) for HDEC requirements relating to amendments and other post-approval processes.

Your **next progress report** is due by **09 July 2016.**

Participant access to ACC

The Central Health and Disability Ethics Committee is satisfied that your study is not a clinical trial that is to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled. Participants injured as a result of

Appendix P: Asian consultation support letter

Support letter for Cultural Consultation

Project title:
Recovery for South Asian people accessing mental health services in New Zealand

Project Supervisor:
Barbara McKenzie Green and Daniel Sutton

Researcher:
Kaberi Rajendra

To whom it may concern:

The Counties Manukau Health South Asian Mental Health Interagency Group (SAMHIG) provides a forum for discussion on mental health/addictions service development and promotion among South Asian working in mental health, addictions, NGO, primary health and community sectors in Counties Manukau. The SAMHIG is aware of the research study, and has agreed to provide cultural consultation during the study. Please do not feel hesitate to contact me, if you would like more information on the SAMHIG.

Yours sincerely

Kitty Ko
Asian Service Development Coordinator
SAMHIG
7 January 2015

Appendix Q: Māori consultation support letter

COUNTIES
MANUKAU
HEALTH

23 January 2015

To whomever this may concern

I am writing to approve the request for cultural supervision for Kaberi Rajendra's endeavour in furthering her academic qualification- in order to achieve her PhD

Yours Sincerely

Mahaki Albert

Senior Cultural Advisor

Counties Manukau Health

Appendix R: Transcriber confidentiality form

Confidentiality Agreement

Project title:

Recovery for South Asian people accessing mental health services in New Zealand

Project Supervisor: Barbara McKenzie Green

Researcher: Kaberi Rajendra

○   I understand that all the material I will be asked to transcribe is confidential.

○   I understand that the contents of the tapes or recordings can only be discussed with the researcher.

○   I will not keep any copies of the transcripts nor allow third parties access to them

Transcriber signature:

Transcriber Name:

Transcriber's Contact Details (if appropriate):

…………………………………………………………………………………..

Date:

Project Supervisor's Contact Details (if appropriate):

Barbara McKenzie Green 9219999 ext. 7352

Approved by the Auckland University of Technology Ethics Committee on 6/5/15. ***AUTEC Reference number:*** 15/95.

 Note: The Tran scriber should retain a copy of this form.

Appendix S: Consent Form

Consent Form

Project title:

Recovery for South Asian people accessing mental health services in New Zealand

Project Supervisor: Barbara McKenzie Green

Researcher: Kaberi Rajendra

○ I have read and understood the information provided about this research project in the Information Sheet dated 21/01/15

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes may be taken during the interviews and that the interviews will be audiotaped and transcribed.

○ I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.

○ If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.

○ I agree to take part in this research.

○ I wish to receive a copy of the report from the research (please tick one): Yes○ No○

Participants signature:

....……………………………………………

Participant's Name:

....……………………………………………

Participant's Contact Details (if appropriate):

……………………………………………………………………………………..

Date:

Approved by the Auckland University of Technology Ethics Committee on 6/5/15 AUTEC Reference number 15/95

Note: The Participant should retain a copy of this form.

Appendix T: Sample of memo

I wrote this memo after my supervision session discussing about conditions.

1.2.18

Conditions: What are the conditions when the participants are disconnecting?

Age: When they are young, they are more connected with their friends. Whereas older people maintaining their traditional ways.

Who suffers more? Both.

For older people giving up traditions painful. For younger people maintaining traditional ways at home and outside at school, university connecting with friends. What a contrast? Intergenerational conflict. There is conflict within and outside.
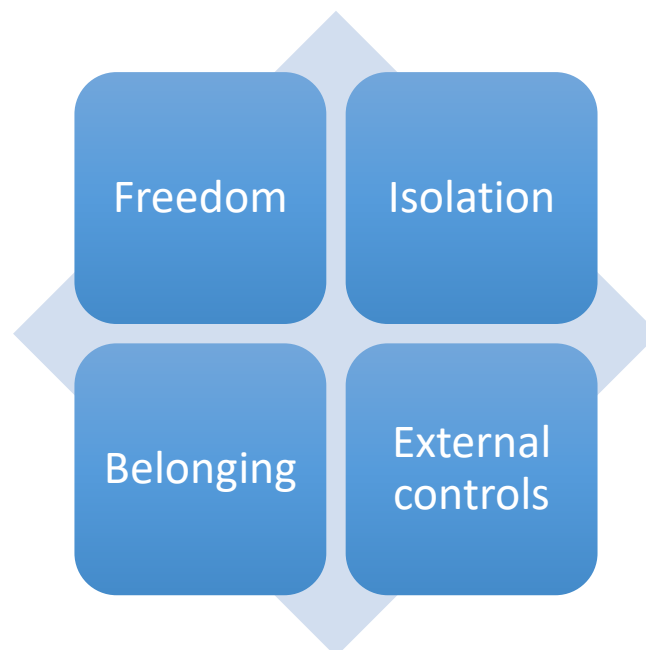
Differences: Clothing: Older prefer /wearing traditional clothes. But it is not an issue. Language: English. Not knowing English problem. Bullied due to accent.

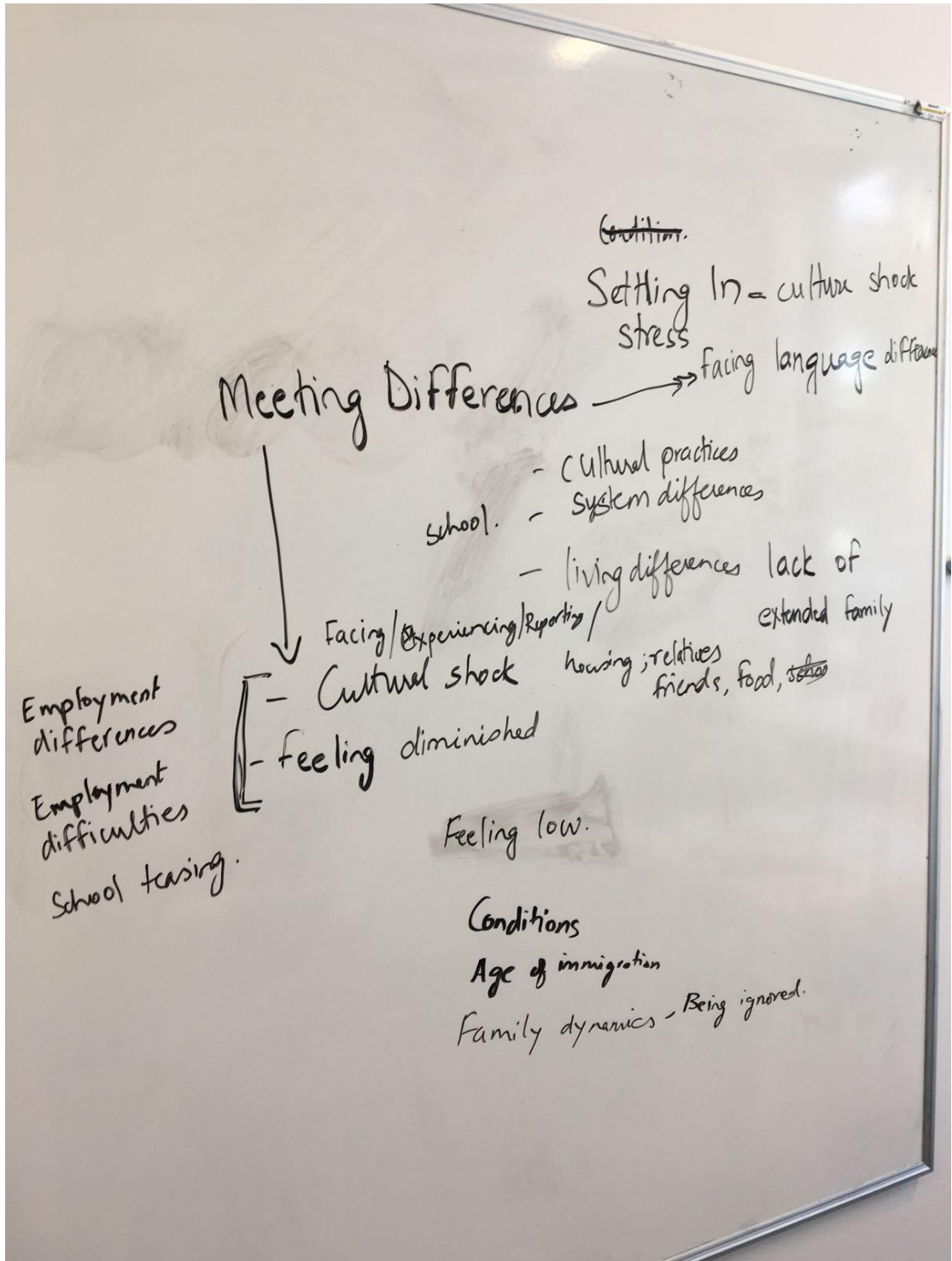Sometimes they are fitting in and other time they are taking a stand.

So under certain conditions, the participants are fitting in and when they are taking a stand. There is a dichotomy: freedom, isolation, sense of belonging, and external controls.

Are they disconnecting? No they are shifting. Trading off. Is that a condition? It is a strategy.

I need to ask about their interpretation of trading off or shifting.

Appendix U: Developing theory

Appendix V: Developing diagram

Shifting Cultural Connectedness

← Becoming Well

Working to become well

Mental Health Services

Crisis Point

Mental Distress

Making Sense

New Zealand Culture

Conflicts and Traumas

Traditional Culture

Life stages, Support, Family Dynamics.

CONDITIONS