The Experience of Depression among Black and Minority Ethnic Women in the United Kingdom: An Interpretative Phenomenological Study

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ABSTRACT

Background: Identity and health status have been linked in the extant literature, but the lived experience of depression in Black and Minority Ethnic (BME) women in the UK is an under researched phenomenon. This study therefore aimed to gain an in-depth understanding of the experience of depression in a small group of UK based BME women using Interpretative Phenomenological Analysis (IPA), affording the ability to describe, explore and provide an idiographic analysis of this lived experience.

Method: Semi-structured interviews were conducted with a purposive sample of five BME women with experience of depression. Participants provided detailed accounts of how they made sense of their experience. Interviews were audio-recorded and verbatim transcripts of the interviews were analysed using IPA. In keeping with the underpinnings of IPA the researcher's personal and epistemological reflexivity is embedded throughout to demonstrate greater transparency and demonstrate how IPA was applied in practice.

Results: The analysis produced two master themes; '*Cultural Expectations and Depression: "I just need to be me"*' and '*The Nature of Depression: Agency, Façades and Coping*'. The first theme captures how identity conflicts led to isolation for the participants, heightened stress and exacerbated or brought on depression. The experience of being a minority was considered and how this can cause stress, impacting on the ability to cope with adversity and influence perceptions of mental health. The second theme explored perceptions of the nature of depression and the stress of managing physical complaints. Participants adopted a range of coping strategies such as presenting with façades and resilience which impacted on help-seeking behaviours, diagnosis and management of their depression. Discussions around experiences of taking antidepressants served to highlight the importance of the understanding of medication for lay individuals and their implications for treatment adherence.

Conclusion: The central finding of this research is that the experience of depression for BME women in the UK is heavily influenced by identity, cultural factors, minority status and pressures of societal norms. This research expands on the extant literature on the relationships between stress, coping and health, illuminating the essence of the lived experience of depression. The recommendations of this research include the need for health practitioners to better understand variabilities in the experience of depression among BME women in the UK (considering ethnic identity and culture) and the need for them to seek to work with individuals in a co-productive way. There is a need for the development of high quality, personalised services which engage with harder to reach communities along with health promotion campaigns and health services to support enhancing the health literacy of BME women with depression.

INTRODUCTION

Qualitative research on the experience of depression in Black and Minority Ethnic (BME) women is an underrepresented area in extant literature, particularly in the United Kingdom (UK). It is this study's aim to begin to redress this. Stoppard & McMullen (2003) posit that knowledge about depression is possessed by those who experience it and yet, the voices of those with experience of depression are effectively silenced in much of the literature. It is one of the central tenets of this study that the assumption that the experience of health issues such as depression are the same among all groups is to ignore the variability of individuals.

The World Health Organization [WHO] (2009) identifies depression, particularly in women, as being a major public health concern and thus a priority within research. Other research has highlighted a need to explore the issue of depression in minority ethnic groups, in particular women in these groups (Templeton, Velleman, Persaud & Milner, 2003; Bhugra & Becker, 2005). Thus, the current study is concerned with the experience of depression in BME women, a group that it is thought experience a higher rate of depression in comparison to other groups. Although it is recognised that depression can be experienced by all individuals regardless of gender, age, ethnic and socioeconomic factors (Jackson, 2006), it is felt that the experience of depression may differ for specific groups such as ethnic minorities and minority groups in specific countries. Ethnicity can be defined as the "social group a person belongs to and either identifies with or is identified with by others, as a result of a mix of cultural and other factors including one or more of language, diet, religion, ancestry and physical features traditionally associated with race" (Bhopal, 2007 p311). The term 'minority', in modern parlance, suggests a small group of people who differ from the majority in a given society (Soanes, 2006). Within health research, the term Black and Minority Ethnic does not only refer to skin colour but to people of all groups who may experience discrimination and disadvantage, such as those of Irish origin and East European migrants (Department of Health, 2005). Although there is of course variability, those from different ethnic minority backgrounds have been found to share similar experiences which have an impact on their health and subsequently their experience of health issues such as depression (Sewell, 2009).

Individuals have unique ways of seeing the world and as such, their experiences, such as health experiences, are diverse. There are myriad studies which have explored health issues that are seen to be of particular importance among those from BME communities, such as heart disease and diabetes (Mochari-Greenberger, Miller & Mosca, 2012; Kanaya et al., 2012). However, fewer studies have explored mental health issues such as depression. Of the research that has been conducted it has been shown that women from ethnic minorities experience a range of issues which may predispose them to depression (Sewell, 2009). With this it is thought that the experience of depression in BME women may differ due to differences in the perceived causes of depression, perceptions of depressive symptomology, coping styles, help-seeking behaviours and management of depression (Ekanayake, Ahmad & McKenzie, 2012; Nadeem, Lange & Miranda, 2009; Ward & Heidrich, 2009; Edge & Mackian, 2010; Ward, 2007)., highlighting the importance of exploring individuals' lived experience of such health issues.

We actually know very little about the experience of depression in BME women (Stoppard, 2000; Templeton et al., 2003). Although there is some research which looks at depression in BME women much of this is quantitative and therefore does not serve to understand the experiences of depression in BME women within the context of their life worlds (Wahl, 2012). Any experience is subjective and this is no different for the experience of health issues such as depression. It would seem therefore that it would be beneficial to gain a better understanding of the experience of depression in BME women in the UK, an idiographic focus being useful in bringing us closer to this phenomenon, considering both the convergence and divergence of these experiences (Smith, 2004). Such exploration will help us to better understand the complex array of factors which may lead to such health inequalities and differences in health experiences. Thus, it is the focus of this research to gain an in depth understanding of the experiences of depression among a small group of BME women in the UK, getting closer to these experiences.

LITERATURE REVIEW

Reid, Flowers & Larkin (2005) argue that in using Interpretative Phenomenological Analysis (IPA) the analytic process is to be inductive rather than deductive in order to provide an 'insider's perspective', this study aims to be conducive to this spirit. Therefore, whilst consideration of the extant literature is essential to help build the argument for why this research into the experience of depression in Black and Minority Ethnic (BME) women in the United Kingdom (UK) is needed, this is not exhaustive. Therefore this section provides an overview of some of the most relevant literature and the rationale for this research, with further relevant literature explored within the analysis and discussion section. Provided within this literature review section is an exploration of background information about depression and depression in BME groups, a critical literature review of the most relevant qualitative literature exploring the experience of depression in BME women in order to frame this study and a statement of originality to justify the need for this research and explaining the rationale and purpose of the current study and the methodological approach chosen.

AN OVERVIEW OF DEPRESSION

What is Depression?

The word 'depression' is used in many different ways. Many people experience what is often called feeling low or down from time to time due to circumstances in their lives (e.g. loneliness, bereavement, relationship break-ups, loss of a job). There may be low mood with no specific cause or reason and the term 'depression' is used to describe this negative affect (Jaremka, Lindgren & Kiecolt-Glaser, 2013; Wakefield & Schmitz, 2013; Cano & O'Leary, 2000; Gallo et al., 2006). In contrast, the clinical definition of depression occurs when such experiences become severe and persistent (Butler at al., 2006).

In the UK the recommended tool for diagnosis is based on National Institute of Clinical Excellence (NICE) guidelines is the DSM-IV (NICE, 2009). Depression in the clinical sense of the word can be diagnosed when there is presence of symptoms (such as depressed mood or loss of interest accompanied by at least four additional symptoms of depression) for most of the day, every day for at least two weeks (APA, 2000). In some cases depressive symptoms can include other somatic complaints such as aches, pains or cramps that do not go away even with appropriate treatment (Kapfhammer, 2006). It has been suggested however that there is no ‘one size fits all’ in terms of diagnosing conditions such as depression and that there are “fundamental racial, ethnic and cultural differences in the experience and manifestation of depression” (Cardemil, 2006, pg.151). Diagnostic tools such as the DSM do not take in to account the complexity of such conditions and the diversity of an individual’s expressions of distress. This is particularly so when considering the Western approach of such assessment tools where lay individuals are expected to use the same language as medical professionals.

Within primary care settings depression is often described as a common problem of practice rather than a condition which has to fit specific criteria (Chew-Graham, Mullin, May, Hedley & Cole, 2002). Therefore, it could be argued that depression is not a disorder in need of psychiatric or medical attention per se, but instead an experience which people may have at some point in their lives. Narrowly focussing on the widely accepted clinical manifestations of depression does not help us to understand the process by which such experiences may occur for individuals and the impact they have on their life-world. As explained by Smith & Rhodes (2014, pg. 2) such descriptions of generic features of depression do not help us to learn “what the experience feels like for particular individuals or come to see the nuanced convergence and divergence in those experiences”.

Causes and Management of Depression

The Western biomedical view is that depression is caused by a chemical imbalance in the brain and thus requires medical intervention (antidepressants) to redress this imbalance (Clarke & Gawley, 2009). However, such an approach ignores the complexity of this experience and perhaps even serves to pathologize and decontextualize the experiences of depression in individuals, thus to some degree dismissing the impact of deep distress. An alternative viewpoint is that depression is not a biological entity which lies within the person but more a reaction to adverse life events and stresses (Hammen, 2005) or perhaps part of a normal human experience, such as 'sadness' (Horwitz & Wakefield, 2007).

Approaches to management of depression are varied between individuals. Many individuals will manage low mood or symptoms of depression without seeking any form of support (Barney, Griffiths, Jorm & Christensen, 2006), others will seek help via social support i.e. partner, friends, family, faith leader (Walsh, 2009). For those who seek support through health services the first person with whom they will discuss their symptoms will normally be a GP. Within primary care the support offered ranges from an active monitoring approach, commonly used if symptoms were brought on by a specific adverse event, antidepressants or referral to psychological therapies (e.g. cognitive behavioural therapy (CBT), guided self-help, counselling, psychotherapy and group therapy) (NICE, 2009; MIND, 2012; Department of Health, 2008; Walsh, 2009). Other treatments for depression include exercise, peer support and complementary therapies (MIND, 2012; Walsh, 2009).

DEPRESSION IN BLACK AND MINORITY ETHNIC WOMEN

Ethnic minority women have been found to have higher rates of depression than other groups (Sáez-Santiago & Bernal, 2003). Such differences may be explained by a range of factors such as; health inequalities, culturally derived differences in the perceptions and management of mental health, experiences of prejudice and discrimination associated with their minority status, issues related to migration and cultural conflict and health services failing to meet their needs (Eshun & Gurung, 2009). The diversity among and between those from ethnic minority groups in terms of, for example, religion, culture, biology and status can lead to a number of inequalities in health and thus impact on the health experiences of ethnic minority individuals. Thus, in exploring the experience of depression in BME women it is important to briefly review issues such as health inequalities, acculturation, migration and minority stress, which in regards to the experience of depression may heighten stress levels and lead to an increase in distress and depressive symptomology (Thoits, 2010). How such factors may have an impact or be seen as protective against depression should also be considered. It is important to understand such variabilities among individuals and what impact these can have on the experience of health issues such as depression.

Health Inequalities

BME groups in the UK (particularly women) have generally been found to have worse psychological health than their indigenous counterparts (Weich et al., 2004). Health inequalities among ethnic minorities in the UK have been well documented with disparities found between a range of ethnic groups in comparison to the indigenous population (Erens, Primatesta & Prior, 2001; Nazroo, 2003). Thus BME women may experience a range of health inequalities which could be seen to be related to their experience of depression. Health inequalities can be defined as differences in health status or in the division of health determinants between different individuals and groups (Kawachi, Subramanian & Almeida-Filho, 2002). Such inequalities are brought about by factors such as socioeconomic status, material deprivation, place or context, educational attainment and differences in the uptake of health services, which can have an accumulative effect on health (Kawachi et al., 2002).

It has been suggested that lower socioeconomic status in one of the main factors influencing these health inequalities- with differences in income, unemployment and area deprivation (Nazroo, 2003) all contributing to these inequalities. The WHO (2013) suggests that poverty places a higher amount of burden on women from ethnic minorities than it does men. High levels of depressive symptoms are common among ethnic minority women with a lower socioeconomic status (Kessler, 2003). Both traditional and non-traditional socioeconomic status indicators have been found to be associated with depression in BME women. In a study of ethnic minority women’s health traditional factors such as income and educational attainment were seen to be related to a higher incidence of depression among the women studied, along with more non-traditional indicators such as lack of access to public health services, material deprivation and subjective social standing (Stewart, Dean, Gregorich, Brawarsky & Haas, 2007). Thus, the relationship between socioeconomic status and depression in BME women is complex; it is not just lowered income which can impact on an individual’s psychological health, but also the stress and negative impacts on social support which come with this (Belle &

Doucet, 2003). Other research has supported this, Bromberger, Harlow, Avis, Kravitz & Cordal, (2004) explored the relationships between ethnicity, psychosocial factors, socioeconomic status and depression in middle-aged women. Those from an ethnic minority background showed a higher incidence of depressive symptoms, as well as a heightened risk for other health issues. This higher incidence of depressive symptoms was seen to be as a result of socioeconomic status, stress and related psychosocial factors (e.g. low social support). The recommendation of this research was that it is important to look at ethnicity and health and also consider how ethnicity can exert effects on other variables, highlighting that the relationships between ethnicity, health inequalities and depression are not clear cut.

Thus socioeconomic status and its indicators are not the sole explanation for these health inequalities. There are also specific disadvantages which BME women may experience which could also contribute to these health inequalities, i.e. normative social roles. Expectations such as being the perfect woman, wife or mother sometimes place women under intolerable pressure. It has been found that ethnic minority women often feel that unrealistic expectations have been placed upon them and failure to reach such ideals can lead to feelings of depression (Beauboeuf-Lafontant, 2007). Other research has found for example that Black women feel a burden to be strong, resistant, successful and the primary caregiver, which was seen to lead to heightened stress and depressive symptoms (Woods-Giscombé, 2010). Other factors which may contribute to the ethnic health inequalities among BME women and a heightened risk for depression include; underutilization of support services, reluctance in talking to a GP about psychological health, along with other treatment inequalities e.g. lesser likelihood of being referred to mental health services (Cooper et al., 2013; Maginn et al., 2004; Snowden & Yamada, 2005).

Due to the wide disparity of health experiences among ethnic minorities in comparison to the rest of the population the improvement of ethnic minority health is high on the public health agenda in the UK (Marmot, 2010), particularly in regards to the mental health of those from ethnic minority backgrounds (Department of Health, 2005). It is felt that such health inequalities can be improved by improving the social status and living conditions of such disadvantaged groups (Bécares, 2013). It is also important to recognise that conventional explanations for the health inequalities experienced by BME women do not provide the full picture (Karlsen & Nazroo, 2002). It is important to consider the everyday life experiences which can have an impact on ethnic minority individual's health such as the experience of racial harassment and discrimination (Nazroo, 2003). Regardless, it has been said that although health inequalities among ethnic minorities are well documented they are not well understood (van Dijk, Dijkshoorn, van Dijk, Cremer & Agyemang, 2013). Thus it is important that research explores this variability in more depth and seeks to understand how individual's experiences of depression can differ.

Culture, Migration and Acculturation

The term 'culture' in health research helps to define influences on individuals which determine their behaviour, attitudes and ways of life. Thus differing health experiences (including depression) among BME women could be influenced by a range of culture related variables i.e. culture itself, migration and levels of acculturation (Kleinman, 2004; Fernando, 2010). Migration has been linked to a range of health issues in BME women, including depression (Collins, Zimmerman & Howard, 2011; Breslau & Chang, 2006). Not only in those who have recently migrated but also among those born in the host country (via an intergenerational process of adjustment). On the other hand, it has been argued that migration can bolster protective factors against depression in BME women (e.g. family harmony and social support) (Kennedy, McDonald & Biddle, 2006). With this levels of acculturation (phenomenon by which the minority culture assimilates the values of majority culture) can impact on health outcomes (via behavioural choices, coping strategies and help-seeking behaviours) of various ethnic groups (Bhugra, 2003; Nguyen, 2011). Issues in the process of acculturation have been found to be negatively associated with the experience of depression (Yoon et al., 2013) and can lead to heightened levels of stress (Torres, 2010). Intergenerational acculturation can also lead to heightened levels of depression due to cultural gaps, parental conflict and family distancing (Hwang, 2006). However, there are also positive effects of acculturation on an individual's mental health e.g. higher self-esteem and satisfaction with life (Yoon et al., 2013). Regardless, health services increasingly see individuals from different cultures and ethnic backgrounds and therefore it is vital to understand their subjective health concerns and the possible influences of such culture related variables.

Minority Stress

There has been increasing interest in the interactions between social stressors experienced by those from minority groups and the impact such stressors have on an individual's health status (Hatzenbuehler, Nolen-Hoeksema, & Erickson, 2008; Thoits, 2010). Stress in general terms is experienced when an individual perceives there to be in imbalance between demands and resources to cope with stressful situations (Folkman, Lazarus, Gruen, & DeLongis, 1986). It is thought that there are specific types of stress which can be brought on by being in stressful social environments (prejudice, discrimination and stigma), which, in accordance with stress theory, can have both physical and psychological consequences and leave people at risk of health problems (Meyer, 2003). Researchers have used the term 'minority stress' to refer to the experience of stress "to which individuals from stigmatized social categories are exposed as a result of their social, often a minority, position" (Meyer, 2003, pg. 675). Minority stress can also be caused by other factors including poor social support and low socio-economic status (French & Chavez, 2010). Although much of the research on minority stress is focussed on sexuality (Meyer, 2003; Frost, Lehavot & Meyer, 2013), the literature also suggests that minority stress constitutes a unique source of risk for the social and psychological adjustment of other minority groups including ethnic minorities.

Arbona & Jimenez (2014) explored the relationship between minority stress, ethnic identity and depression among female Latinos. The results from their questionnaire study showed that higher levels of minority stress were significantly associated with a higher depression score. Past research has also supported this link, Wei et al. (2010) found that minority stress was positively associated with a higher incidence of depression in ethnic minority students. The primary concepts or experiences in regards to minority stress which have a detrimental impact on health status are the experiences of prejudice, discrimination and stigma (Meyer, 2003). Pascoe & Richman (2009) explored racial prejudice and discrimination and their impact on mental and physical health outcomes, including stress responses and health behaviours. The results from their review showed that prejudice and discrimination experienced by minority ethnic groups was related to anxiety, psychological distress and depressive symptoms and a wide variety of physical health outcomes (e.g. hypertension and diabetes). However, it has also been found that ethnic identity is related to increased wellbeing and having a strong minority ethnic identity can moderate the relationship between such ethnicity related stressors on wellbeing (French & Chavez, 2010). Regardless, it is important to consider the role of discrimination and prejudice in the development of health inequalities (Karlsen & Nazroo, 2002).

Meaning, Help-Seeking and Use of Health Services

Ethnic identity can impact on understanding of depression, presentation of symptoms, coping styles and help-seeking behaviours of BME women (Kleinman, 2004; Walsh, 2009). It has been found that, in comparison to the indigenous population, there are differences in the ways ethnic minority women conceptualise depression (Ballenger et al., 2001). For example it is common for BME women to see depression not as a diagnosable health issue but rather a reaction to life events (Sterk, Theall, & Elifson, 2006), thus conceptualising depression outside of mainstream biomedical assumptions. Perceptions of how depression or distress should be managed are affected by such conceptualisations. Stigma of mental health conditions is higher in BME groups compared to that of the indigenous population and such stigma can result in self-stigma and negative attitudes towards mental health (Corrigan, 2004; Knifton, 2012; Bathje & Pryor, 2011).

BME women have also shown differences in help-seeking behaviours. Ethnic minority women are more likely to try and treat depression via means outside of treatments provided by health professionals, such as family support, faith healers and other personal contacts (Bhui, Stansfeld, Hull, Priebe, Mole & Feder, 2003). Other research has found some ethnic minority women do not feel that health services can help and thus do not see the benefits of accessing services (Shaw, Creed, Tomenson, Riste & Cruickshank, 1999). Thus differences in views about health services and the utilization of other sources of support to some degree explain ethnic differences in help-seeking behaviours. When they do access health services those from different ethnic backgrounds may explain their symptoms differently from other groups, which may affect the treatment they receive (Cohen, Magai, Yaffee & Walcott-brown, 2005). Ethnic minority women are more likely to present with somatic complaints (e.g. fatigue, headaches, constipation or pains) (Klengel et al., 2011; Bhugra & Mastrogianni, 2004). Such somatization can lead to issues within doctor-patient communication and with diagnosis of distress and thus lead to incorrect diagnosis and individuals being less likely to be referred for appropriate treatment (Ahmed & Bhugra, 2007).

Research has also found disparities in the management of depression among BME women. BME women are less likely to support the use of drugs to cope with depression and are thus less likely to adhere to medication such as antidepressants (Nadeem, Lange and Miranda, 2008; Lecrubier, 2001). It has also found that those from ethnic minority groups are less likely to accept other forms of treatment such as psychological therapies (Fortuna, Alegria & Gao, 2010). There is considerable literature which has looked at the barriers to mental healthcare use and heightened rates of discontinuation of treatment by BME women. Issues identified include treatment not meeting expectations (Huang, Wong, Ronzio & Yu, 2007), lack of speciality mental healthcare (Miranda & Cooper, 2004), lack of ethnic matching between patient and provider which is thought to lead to better engagement (Cooper et al., 2003), mistrust of the mental health system (Whaley, 2001), and inadequate services provided to those from ethnic minority groups (Ward, 2007).

DEPRESSION IN BLACK AND MINORITY ETHNIC WOMEN: WHY RESEARCH EXPERIENCE?

Historically it has been argued that to assume the experience of mental health issues such as depression are the same among all groups is to ignore the variability of individuals (e.g. personal characteristics such as identity, motives, intentions, social standing, values and ethics) (Fabrega, 1996). Yet still the extant literature exploring depression in BME women which has been reviewed here is by and large quantitative - making generalisations to populations based on ‘representative’ samples of individuals. Therefore such methods have been unable to explore the richness and complexity of individual experiences, hence qualitative research in exploring the experience of depression among BME women has begun to draw more attention (Templeton et al., 2003).

Quantitative research exploring depression in BME women is of course vital to the field and supports the broadening of the knowledge base (such as much of the research explored in the previous section). Large scale quantitative research has provided insight into the different prevalence rates of depression among ethnic minority women and the range of psychosocial factors which correlate to this (Bromberger et al., 2004). Arbona & Jimenez's (2014) questionnaire study assessed the relationship between demographics, stress and depression symptoms using a range of scoring methods. Yet although this provides knowledge on the possible factors which may precipitate depressive symptoms among BME women it was not an aim of this research to gain a deep understanding of the experience of the women questioned. Similarly, other quantitative research has been able to gain insight into the help-seeking behavioural patterns of BME women with depression and the amount that access health services (Cooper et al., 2013). It has not however, explored the contextual reasons behind this in any great depth.

Although such quantitative research studies provide insight into prevalence rates and mechanisms which impact on the incidence of depression in specific groups, we do not learn what the experience feels like for particular individuals. Thus, there are a range of limitations to these quantitative methods. They are often positivistic, for example. and simplify human experience, they mask underlying realities, are unable to robustly explore complex issues, do not seek to explore the context of phenomenon and often the data collection methods do not allow for participant's to challenge the researcher's assumptions about the meaning and relevance of concepts explored (Ross, 2012; Willig, 2008). Thus limitations in quantitative methodology are recognised as simplifying phenomena, lacking richness and complexity and preventing the exploration of experience (Barker, Pistrang & Elliot, 2002).

Qualitative research on the other hand enables rich descriptions of phenomena and can provide insight into meanings of experiences (Barker & Pistrang, 2005), something which is lacking within the literature in this area. Smith (1996) asserts that qualitative research in the area of health is particularly useful as they afford the ability to explore individual's own frames of reference and accounts of their conditions. There is a need to pay close attention to the voices that are relatively absent within the literature and correspondingly in the development of health services. Encouragingly, in response to this gap, a small body of research has begun to address these shortfalls by employing qualitative methods to the exploration of depression in BME women in order to get closer to this experience

(Black, White & Hannum, 2007; Burr, 2002; Ekanayake, Ahmad & McKenzie, 2012; Ahmed, Stewart, Teng, Wahoush & Gagnon, 2008; Templeton, Velleman, Persaud & Milner, 2003; Wittkowski, Zumla, Glendenning & Fox, 2011; Ezeobele, Malecha, Landrum & Symes, 2010; Hussain & Cochrane, 2002; Abrams, Dorning & Curran, 2009; Ward, Mengesha & Issa, 2014 and Schreiber, Stern & Wilson, 2000). Thus it would seem important to review this extant literature to frame the present study and where this fits within it.

EXISTING QUALITATIVE LITERATURE EXPLORING THE EXPERIENCE OF DEPRESSION IN BLACK AND MINORITY ETHNIC WOMEN

There is a paucity of literature exploring the *lived* experience of depression amongst Black and Minority Ethnic (BME) women, particularly in the United Kingdom (UK). The present research aims to address this. It is therefore apposite to critically review the major themes of the most relevant extant qualitative research which has explored the subjective experience of depression among BME women in order to frame this piece of work. The gaps which the present study hopes to fill and where it fits within the wider context will also be considered. By this, it will be demonstrated that exploring the lived experience of depression in BME women in the UK using Interpretative Phenomenological Analysis is capable of making a unique contribution to the field.

The aim of this review is to summarise, compare and interpret the most relevant literature. The papers presented were chosen by conducting a search of primary research within the area which addressed the question '*What is the experience of depression for BME women?*' Following this, the most pertinent and relevant studies were chosen to be included. This is, therefore, not intended to be an exhaustive systematic review of the evidence but instead draws together existing knowledge of the topic in order to place the present study in context and explore the strengths and weaknesses of the extant qualitative literature (Baumeister & Leary, 1997; Pope et al., 2007). The studies discussed here are: Black, White & Hannum (2007); Burr(2002); Ekanayake, Ahmad & McKenzie (2012); Ahmed, Stewart, Teng, Wahoush & Gagnon (2008); Templeton, Velleman, Persaud & Milner (2003); Wittkowski, Zumla, Glendenning & Fox (2011); Ezeobele, Malecha, Landrum & Symes (2010); Hussain & Cochrane (2002); Abrams, Dorning &

Curran (2009); Ward, Mengesha & Issa (2014) and Schreiber, Stern & Wilson (2000). A number of core themes identified across the studies will be explored. These include; the meaning of depression being shaped by culture, religious beliefs and traditions, social factors and depression, the impact of social roles and expectations, the influence of racial hostility and discrimination and barriers to help-seeking. The general characteristics of the studies, such as where the study was conducted, sampling and qualitative methodology are also discussed. There were some areas of convergence across the literature as well as some considerable variability which will be discussed. This will lead to a conclusion which summarises the core themes of the qualitative literature reviewed, the strengths and limitations of the existing literature, recommendations for future research and where the present study fits within this.

The Meaning of Depression is Shaped by Culture, Religious Beliefs and Traditions

Research into this area commonly revolves around understanding the context and manifestation of depression among BME women, whereby the meaning of depression for BME women has been found to be shaped by culture, religious beliefs and tradition. Research exploring life narratives (using thematic analysis) among older African-American women in the United States found that depression is seen as a ‘cultural phenomenon’- depression being seen to be placed within a framework of meaning constructed by African-American women from cultural systems rooted in their personal and cultural history (e.g. experiences of racism and deprivation, memories of abuse and poor relationships). These women experienced a range of hardships and deprivations which were unique to this minority group and the country which they were residing in, thus gender and ethnic disparities were seen as historical antecedents. It was seen that history and location contextualised the social construction of race and being a minority, for example the experience of both racism and sexism affected income and social class leading to an increased social jeopardy of classism and risk of depression. The meaning of depression was therefore seen to be rooted in North American society and African tradition - creating a specific cultural framework for these African-American women. However, it is important to note the focus on older African-American women within their study, whereby the history of racism and oppression may have been felt much more harshly than in other generations and therefore core antecedents may differ across generations, a view which was alluded to in other research (Ekanayake et al., 2012; Hussain & Cochrane, 2002).

There seemed to be a theme among a number of studies of the power of prayer and the benefits of religious healers, which were often seen as culturally accepted coping strategies (as opposed to for example seeking professional help). Religious beliefs (the act of prayer and talking to God) and having faith that things would improve was seen to prevent or support in managing depression for some '*I ask God, please tell me what you want me to do in this life*' (Black, White & Hannum, 2007). Prayer was often seen to be a culturally sanctioned way of responding to depression and seeking guidance, whereby the act of prayer could be seen as therapeutic and supported in gaining strength and healing (Black et al., 2007; Burr, 2002; Abrams et al., 2009; Schreiber et al., 2000; Hussain & Cochrane, 2002). For African-American women a phenomenological analysis of interviews found that, consistent with the wider literature, religion was also seen as a way of building resilience. Turning to this culturally accepted coping strategy was a way of managing life's everyday hardships (including trauma). Interestingly it was felt that this could mask depression and help women to function adequately day-to-day. This masking of depression could have perhaps lessened the desire to ask for help and prevented others from recognising they were experiencing depression. Equally women would continue to experience depression despite the use of these coping strategies (Ward et al., 2014). This raises questions around whether such strategies may in fact be detrimental and prevent women getting the support they need.

Religion and faith were explored in other studies, they were not just seen as a protective factor though, and conversely research revealed they could increase risk and cause distress. Wittkowski et al. (2011) interviewed South Asian women in England about their experiences of postnatal depression using a grounded theory approach. Many of these women turned to religion. There was, however, a conflict as their religion and cultural practices did not encourage these women to be in touch with their thoughts and feelings which led to them 'internalising misery'. Thus when they did engage with these thoughts they were seen as ungrateful and experiencing '*satanic whispers*'. This suggests that connecting religion and wellbeing could be detrimental to the health status of these women, as their primary outlet was seen negatively. This is different from the experience of African-American women in the research of Black et al. (2007), which perhaps highlights some ethnic, religious and contextual (e.g. country of residence) differences. It could be suggested then that managing depression through such culturally sanctioned coping mechanisms as prayer could in fact delay or prevent treatment seeking among some minority ethnic women, and subsequently impact on levels of diagnosis. It would seem therefore that further exploration of the impact of culturally sanctioned coping strategies among BME women is required, and whether they increase or decrease depressive symptoms, which thus far has not explicitly been addressed in the literature. In a phenomenological study of Nigerian born women in the United States, analysis of interviews revealed that depression was seen to originate from evil spirits and demons, often attributed to a curse from enemies (which raises the question of whether such perceptions affected relationships with community members and what impact this had on levels of distress) (Ezeobele et al., 2010). In contrast, other research exploring the experience of depression in a diverse cross-section of South Asian women in Canada using thematic content analysis and elements of grounded theory, researchers were surprised to find that none of the women attributed their depression to spiritual, supernatural or religious causes (Ekanayake et al., 2012). This could perhaps have been due to cultural differences in the perceived origin of depression, such as these women felt depression was the result of personal, family, cultural and social circumstances, rather than religious or spiritual influences. However, it is interesting that researchers noted that this was a surprise as there may have been some assumptions being made here - a more reflexive approach to research analysis may have provided the opportunity to explore this further. Although it is recognised that BME women are not a homogenous group it seems that there are a range of similarities in their experiences in terms of cultural and societal influences. The experience of depression in BME women may, it seems then, differ depending on the country and its cultural and social milieu (as well as a range of individual/personal circumstances), and a study of the experience of depression among BME in the UK is therefore warranted.

Cultural clashes and suppression were common themes throughout a number of the studies, many women felt a cultural clash between traditional expectations of their cultures and modern culture. South Asian women in the UK felt that they were often misunderstood. A grounded theory approach to research found that the women interviewed were very aware of being what they perceived as different 'P*eople don't understand us – our world is completely different from theirs*'. There are of course differences among people from many groups, however, this difference was not just about for example clothing or food, but fundamental differences in values and ways of living. There could be benefits to this within the close community, but in wider society they could be seen as repressed, which had a negative impact (Hussain & Cochrane, 2002). In other research this cultural distance was seen as more of an issue in relation to the women's relationships with their children - highlighting the issue of generational gaps. Women with strong Asian values felt great unhappiness when they were unable to accept the practices of their children (e.g. premarital relationships) which left them feeling a lack of power. Equally younger participants felt pressure from their parents and caught between modern and traditional culture, showing consistency across generations within this group (Ekanayake et al., 2012), this issue was similar for South Asian women in the UK (Hussain & Cochrane, 2002). This finding was not unique to South Asian women however. Templeton et al. (2003) conducted interviews and focus groups with BME women from a mix of ethnic minority backgrounds with experience of postnatal depression in the United Kingdom. Their descriptive thematic analysis found that although a number of perceived causal factors were found to be specific to pregnancy and thus experienced generally by Western mothers, culture still played a significant role in the onset or exacerbation of depression for the women interviewed i.e. a Punjab woman's difficulty in bonding with her third daughter when a son was desired by the family. Cultural conflict was also found to lead to feelings of isolation and feeling restricted. The consideration of women from a range of ethnic backgrounds in this research highlights the fact there are similarities in experience among those from a range of minority ethnic backgrounds, which supports the approach of exploring the experience of women from a range of BME backgrounds within one research group in order to explore this.

Social Factors and Depression

A focus of a number of the studies was the experience of a range of social 'difficulties' which were seen to be attributed to the experience of depression. A common thread in particular was women reporting feeling socially isolated and overwhelmed. Templeton et al. (2003) explored the experience of postnatal depression and found that all the BME women interviewed had problematic lives which were affected by a multitude of social factors such as isolation and lack of extended family. This isolation was exacerbated if women were relatively new to living in the UK or if, as in other research they were forced to remain with the family and social activities were restricted (Ekanayake, 2012). However, some of this isolation was brought on by the fact that women felt that with a new baby they could not go out as much which led to frustration- so this isolation may have been due more to their current circumstances. That said isolation and feeling overwhelmed is common among many new mothers, but the additional impact of immigration status, family values and cultural pressures could have caused added burden among these minority ethnic women. This highlights a need to explore the experience of depression in general among BME women in the UK and not just postnatal depression as has been the case for much of the relevant UK literature in order to see the differences in experience. The impact of isolation and loneliness was not just an issue for South Asian mothers, Black et al. (2007) found that for the African - American women they interviewed depression was linked to diminishment of personal strength which could be caused by loneliness. Similarly, in other research this lack of personal strength was seen to be part of life, whereby depression was seen as a normal reaction to life circumstances often found in their nature to be specific to BME women (e.g. disempowerment) (Ward et al., 2014), which raises the question as to whether depression was often masked due to this perception. In a couple of studies feelings of loneliness and isolation were brought on by bereavement, an inability to build social networks or simply as a way of maintaining confidentiality and protecting the self (again such ‘protection’ may have prevented help-seeking) (Burr, 2002; Ekanayake, 2012; Hussain & Cochrane, 2002; Ezeobele, 2010).

Within a number of studies poor relationships with important others, particularly family, were seen to be contributory factors to depression. For some there was seen to be a perceived lack of strength in relationships with others which exacerbated feelings of loneliness, leading to depression (Black et al., 2007). A key focus was on the perceived negative impact of marital problems and the experience of violence. Again it is recognised that such issues are experienced by women from all backgrounds, however, a number of studies claimed that such issues were more pertinent among ethnic minority women and accepted as the norm within their communities. In one study all of the women interviewed had experience of some form of domestic abuse which was seen as a root cause of their depression (also leading to further isolation, loneliness and feelings of hopelessness), with one woman saying '*in India it is perfectly normal for your husband to beat you*' (Ekanayake, 2012). This thread of familial abuse being common place among ethnic minority women was also found among African-American women, where it was seen that significant events or traumas such as childhood sexual abuse by the hands of those they trusted were a cause of their depression due to feelings of disempowerment and oppression which have never been addressed (Ward et al., 2014). However, a limitation in terms of applying this knowledge in a more local context is that all of the studies with this focus were conducted in the US or Canada (whereby specific historical contexts were cited as a factor) which begs the question, what is the degree and nature of abuse and oppression among BME women in the UK with depression?

Culture again was seen to have an impact on relationships, particularly in regards to relationships between mothers and children. Those who were older and a mother sometimes felt a disconnection between themselves and their children, whilst younger women had to deal with the burden of cultural pressures from parents and the wider family/community (Ekanayake, 2012). Frequency of contact with family was seen to be an issue, particularly if a woman lived away from family (geographical area playing a role), therefore lacking in quality relationships. This could be exacerbated when women had difficult relationships with their husband's mother, whereby dynamics in this relationship (with the mother-in-law having power over them) could cause strain, marital problems and depressive symptoms. This was in some ways seen to be unique to South Asian women as culture dictated they move to the familial home, a practice which is less common in other groups. Such experience was seen to be a form of 'transitional culture shock' (Wittkowski, et al., 2011). However, this was not narrowed to specific cultures within this group - a strength of this research is that numbers of cultures explored was not limited demonstrating some generalisability of key themes. In other research exploring post-partum depression among low-income Latina and African-American women in the United States, a grounded theory analysis revealed that women felt that if they disclosed any form of negative emotions to family and friends they would be rejected due to a cultural focus on maintaining integrity, the strain from this burden had a negative impact on relationships (Abrams, 2009). Conversely, in other research relationships with loved ones were also seen as protective against depression and could aid the process of recovery (Ahmed et al., 2008; Hussain & Cochrane, 2002). Ahmed et al., (2008) for example, in their research using Constant Comparative Analysis to explore depression in minority ethnic new mothers in a large city in Canada found that support from family and friends helped women to manage the difficulties they faced, as well giving access to practical support. There is a gap, it seems, in looking at how issues such as domestic abuse and familial loyalties may have an impact on the experience of depression in BME women in the United Kingdom.

Socioeconomic factors played a key role in a number of ways. This was very much related to pressure and control. The experience of lifelong poverty rested heavily on older African- American women as they felt they had failed to achieve the '*better life*' they had hoped for and the burden of trying to support others led to intergenerational hardships (Black et al., 2007; Ward et al., 2014). Among South Asian women socioeconomic factors were seen as an additional burden which caused stress and lead to depression. For example women living on government support, being made to work or not having any control over the family finances. Due to a reliance on husbands the women were left feeling a lack of independence and in some cases desperation '*he takes all the money and gives me $20…I felt desperate*' (Ekanayake et al., 2012). So particularly for women in the US socioeconomic factors were seen as a contributory factor to depression, it is not clear however, if this was the case for others.

The Impact of Social Roles and Expectations

Social norms, roles and expectations were found to be a common cause for depression (often exacerbated by specific culture specific issues), in that women across a number of the studies reviewed discussed how expectations placed on them led to their depression. Ekanayake et al. (2012) found that for South Asian women household circumstances were seen to be a cause of their depression. Social norms around the 'place' of Asian women led to these women enduring a range of injustices and emotional isolation. Similarly, multiple roles and a perceived lack of support have been found to be risk factors for depression among a range of ethnic minority women, whereby particular gender specific roles seen as socially appropriate for women (such as caregiver or being domesticated) were often a trigger for depressive symptoms (Burr, 2002; Schreiber et al., 2000). The issues related to social norms and expectations placed on women and the detrimental impact they can have are not unique to BME women, however it was suggested that different discursive sites of oppression (both gendered and racialized) had an additional impact (Burr, 2002). It may be that this is not just about role expectations specifically but about finding ones place within for example family units and society in general. In two of the studies women reported a lack of help from husbands as a contributory factor and feeling that they had to do '*double shifts*' of domestic work and going out to work (Templeton et al, 2003; Burr, 2002). Across the board there were a number of negative emotions associated with these experiences and expectations including feeling overwhelmed, worry, sadness and feeling taken for granted and depression was seen to follow these (Ahmed et al, 2008; Ekanayake, et al.,2012; Wittkowski et al., 2011, Burr, 2002). Many individuals experience pressures of what can be called normative social roles e.g. women as caregivers and men as strong and thus it could be argued that many women experience such role pressures. However it has been suggested that ethnic status can exacerbate such issues (Ahmed et al., 2008). It is important not to simplify this relationship however, and often the nuanced underlying reasons for the impact of ethnic status on social roles and expectations have not been explored in any great depth. For example, adopting such roles has been found to act as a form of personalised remedy for depression among African-American women and helped women to '*get back on track*' as it made them feel wanted and needed by their family and community (Black et al., 2007), highlighting that these roles can also be protective and support in managing depression something which was not picked up so much in other research.

There was an interesting theme across a number of the studies around being strong, which was often culturally driven. Schreiber et al. (2000), using a grounded theory approach to analyse interviews, found that West-Indian Canadian women with experience of depression felt the need to be "stronger than White women"- a concept it was felt should be explored further in future research (Schreiber et al., 2000, pg. 40). Showing this strength was seen as an acceptable way to manage depression as opposed to dwelling on it. The idea of needing to show strength was similar for African-American women, for these women it was as though depression was a weakness which you had to get past *'If you don't have that strength, things like suffering might get the best of you'*

(Black et al., 2007). The concept of strength is an interesting one and something which warrants further exploration. For example the presentation of such strength may prevent health professionals and others from recognising the impact of adversity on BME women and thus leave depressive symptoms undetected.

The Influence of Racial Hostility and Discrimination

There was a significant emphasis across the studies on experiences of racism, exclusion and discrimination. Perceived racism and discrimination and the stress from this was seen by women across a number of studies as a contributory factor to depression. For South Asian women in Canada the subjective experience of racism and perceived unfair treatment were seen to cause depression and powerlessness. This was seen to be related to experiences of discrimination within the workplace, accessing health services and accessing other service provision, with one women proclaiming '*Discrimination is 100% it's everywhere*' (Ekanayake et al., 2012). Similarly, Burr conducted a discursive analysis of interviews and focus groups with South Asian women in the United Kingdom with experience of depression. The resulting analysis emphasised a discourse of racism and oppression, which led to depression. Racism was seen as "a backdrop to everyday existence" (Burr, 2002, pg. 105). What was particularly interesting within this research was that sexism was cited as an issue which was closely related to racism, as though the women experienced a double discrimination, which individuals felt made their experience of depression and its antecedents differ from White women. For both of these studies it was as though racism was accepted as something which was essentially the norm, experienced in a number of domains. The results for these studies suggest a link between societal mistrust and racism/discrimination and power imbalances at a range of levels. The extent of this, however, will inevitably be influenced by the context in which this occurs. A question to ask in response to this research is has this experience changed at all, or is racism/suppression still a backdrop to BME women's lives, particularly in the United Kingdom where the structural, societal and systematic context may differ, or are there other factors which have a more prominent impact?

In other research with African-American women racism and discrimination was seen to be a little more subtle and embedded within social contexts. Historical circumstances (e.g.

moving from the Southern United States to north eastern cities between World War I and the Great Depression), meant that aspects of life (e.g. choice of partner and jobs) were set in cultural stone which was seen to be governed by race and gender. Such experiences supported creating a cultural language around race, suffering and depression which was intertwined with individual experiences and seen to represent this cohort of women (Black et al., 2007). Thus this may have been more about socialisation and changes may therefore be evident dependent on generational status. The idea of the current context is important in regards to the experience of racism and how this relates to depression, in that this social context is constantly changing and also different depending on the ethnic group and the country they reside in. Therefore, experiences of different 'cohorts' or generations may differ greatly. For example Ekanayake et al. (2012) found that Muslim women in America who wore a hijab felt they experienced increased racism and discrimination after the 9/11 terrorist attacks because of this. Such social context would inevitably have an impact on those people who are negatively affected and in the case of those in this study can cause a great emotional burden. Perhaps such burdens were greater for Muslim women in the United Kingdom after the 7/7 attacks for example. Similarly, Schreiber (2000) found that racism experienced by Black West-Indian Canadian women further complicated the struggles they experienced in their lives such as striving to achieve in the workplace. This is interesting as it highlights that although the challenges BME women face may be similar, the context of these will differ depending on their cultural and historical context. The experience of such social factors may differ therefore for those BME women who have grown up in a different cultural and historical context such as in the United Kingdom.

Barriers to Help-Seeking

Studies highlighted many perceived barriers that impede treatment seeking among BME women. Abrams et al. (2009) found that Latina and African American women with depression experienced a range of individual, community, and provider-level barriers to help-seeking. This presented in a number of ways, from thinking about symptoms, seeking advice and rejecting formal care to adopting self-care strategies. 'Talking it out' was seen as preferable for many of the women. Others felt, however, that there were a range of attitudinal and process barriers which prevented them from accessing mental health services. Such barriers included; fear of being seen as ‘crazy’, bad experiences with mental health services (e.g. only being offered medication and professionals being ‘uncaring’), issues with cost (due to not having insurance for example), transport, language barriers and a lack of knowledge of services. Some of these issues may have been due to their low-income status however as opposed to their ethnic background (this leads to the question of whether income-status/cost is as much of an issue in countries where there is a free health service such as the National Health Service in the UK). These findings were consistent with other research with women of mixed ethnic origins in the United States and research with West-Indian Canadians which both found that stigma was a barrier to talking about depression and seeking help, as women feared that it was incurable and they would be viewed as ‘crazy’ (Ahmed et al., 2008; Schreiber, 2000; Ezeobele et al. 2010). Such barriers led women to favour self-help practices such as engaging in purposeful activities (e.g. work, socialising, volunteering), rather than accessing mental health services (Abrams et al., 2009; Ahmed et al., 2008; Schreiber, 2000; Ward et al., 2014). This is interesting as it would seem that despite efforts to change women’s perceptions of mental health services and for example talking treatments, the attitudes of many ethnic minority women is that talking treatments do not work or are not applicable to them. Such information is vital to understanding the impact of accepted social processes and attitudes on mental health help-seeking behaviours in BME women.

Burr (2002) in their research with South Asian women brought up issues around perceptions of health professionals. The women interviewed felt that GPs were not there for psychological advice but for medical advice and thus they did not go to the GP about their depression for fear of being seen as ‘*moaning*’ or feeling that a ‘*cure*’ was not available. Not surprisingly many did not access health services to support with their depression which is similar to other findings (Hussain & Cochrane, 2002). This links to other research whereby women felt that when they spoke to their health professional they did not understand and it was felt that for South Asian women there was a lack of choice in who they saw (e.g. male or female) and therefore they were left in situations in which they felt uncomfortable, thus preventing further visits. This was seen to be a form of cultural and religious insensitivity on the part of health services (Wittkowski et al., 2011; Hussain & Cochrane, 2002; Ward et al., 2014). This highlights how important it is for services to show cultural sensitivity as even when women do access health services; it has been found that some women still felt that the success of any treatment is ultimately in the hands of religion or God, as this is what they primarily put their trust in over health professionals (Hussain & Cochrane, 2002). Therefore, practitioners need to be more alert to the influence of religion on the success of medical and psychological interventions. Fitting with this another study highlighted the benefits of services being more sensitive to the needs of individuals. Black West-Indian Canadian women reported feeling more comfortable in accessing services such as counselling if the professional was the same race as them. They recognised that they could gain guidance from professionals that they were unable (or unwilling) to get from family and friends (Schreiber, 2000). It was suggested that there was a lack of representation of ethnic minority individuals within health services (a fact which from a service delivery and engagement perspective it would seem needs addressing) which acted as a barrier or prevented return to services. A suggestion within this study was there was more of a need for community collaboration, particularly in regards to researching such groups (Templeton et al., 2003), an approach which was adopted for the present study.

CONCLUSION

This review has explored the existing qualitative literature which has made a significant contribution to the understanding of the experience of depression among BME women and has been able to deduce what is known and what is not. The studies included in this review came to some key conclusions which can be arranged under the themes; the meaning of depression is shaped by culture, religious beliefs and traditions; social factors and depression; the impact of social roles and expectations; the influence of racial hostility and discrimination and barriers to help-seeking. Culture was seen to influence perceptions of depression whereby depression was seen to be a cultural and social construction, shaped by the context of minority ethnic women’s lives. Culturally sanctioned coping strategies such as prayer and religious beliefs were seen to both protect individuals from depressive symptomology and in other cases increase distress. A common thread across the studies was social isolation and poor quality relationships with loved ones which were seen as contributing to depression, as well as causing other stresses and strains. Although it was recognised that such stresses and strains are experienced by many individuals it was found that ethnic status and cultural factors meant an increased impact. Other psychosocial factors also came to the fore in a number of the studies, often highlighting the link between social roles, demands and expectations and the experience of depression. Although these normative roles and expectations play an important part for many individuals with depression (including non-BME women and men for example), for BME women these problems are grounded in culture-specific practices and additional burdens. Racism and discrimination were seen as factors that cause stress and contribute to depression and depressive symptoms among BME women and led to a backdrop of varying degrees of isolation and suppression. With this such antecedents (along with others) were seen to influence help-seeking behaviors and led women to favour self-help practices as opposed to accessing health services.

A number of strengths and limitations were identified among the studies reviewed. A strength of all of the studies reviewed was that they were able to access populations which have traditionally been hard to reach, and therefore not understood or well researched. Some studies were able to make cultural group comparisons due to researching women from a range of ethnic minority backgrounds, which is a strength as it supports in beginning to identify the nuances of these experiences (Abrams et al., 2009). The methodologies used across all these studies were qualitative in nature and thus sought to garner the subjective nature of the experience of depression. It was noted that such qualitative studies can be seen as the beginning phase to understand populations and unravel the mystery of experience. Equally as with the studies which used a grounded theory approach for example, qualitative research provided abstract formal theory and supported in raising questions for future research (Ezeobele et al., 2010; Schreiber et al., 2000). A strength of qualitative research is that it is able to provide critical context to understand experiences (e.g. processes in help-seeking behaviours). An obvious weakness of this however, as with much research, is that a researcher’s biases and presuppositions often come to the forefront in one way or another and with the qualitative methods used it was not easy to see the impact of this based on the approaches used or within what was presented. Whilst this may not have been within the scope of their study, and thus may well be omitted for this reason, it does not mean that this cannot be viewed as a potential weakness.

A number of gaps and recommendations for further research were identified across the studies. It was suggested by a number of researchers that further research exploring the experience of depression in BME women is urgently required (Templeton et al., 2003; Abrams et al., 2009), particularly those using methods which allow women to define and articulate their own experience of depression. It is significantly noted that the majority of the studies reviewed were conducted in the US or Canada and given the social and historical influences found to be related to the experience of depression among the BME women researched it would seem vital to conduct country specific research, whereby the context of BME women's lives in terms of for example history of oppression, social norms and health service accessibility may differ greatly. The benefits of researching a diverse cross-section of women from BME backgrounds was also noted as a strength, so as not to disaggregate based on a specific ethnic minority, religious group or culture. It was recognised that for studies researching women from a range of ethnic minority backgrounds in one cohort their narratives were relatively similar (Abrams et al., 2009; Ekanayake, 2012). Wittkowski et al. (2011) highlighted the importance of reflexivity and 'owning one's perspective' as a way to address some of the criticisms of qualitative research, and suggested this may benefit this area of study immensely in terms of considering how the experience of depression among BME women is researched. There were also a number of implications for practice noted. It was suggested across a number of the studies that awareness of issues specific to BME women such as culture and racism can support in tailoring services for communities so that they are more congruent for the target group. Such insights are essential for the delivery of effective, culturally sensitive care (Hussain & Cochrane, 2002; Wittkowski et al., 2011; Ward et al., 2014; Schreiber et al., 2000). Thus, it is recognised that qualitative research into the experience of depression in BME women can have implications for policy and service improvements, which suggests that it is important to work with specific populations and communities based on the context they are in - this again highlights the importance of conducting country specific research.

STATEMENT OF ORIGINALITY: WHY RESEARCH THE LIVED EXPERIENCE OF DEPRESSION IN BLACK AND MINORITY ETHNIC WOMEN IN THE UNITED KINGDOM?

Whilst existing qualitative research into the experience of depression in Black and Minority Ethnic (BME) women has provided an initial foundation of knowledge of this subject, a number of gaps and areas which warrant further exploration have been identified. Learning thus far has shown us that the experience of depression for BME women is influenced by specific cultural systems/frameworks, historic antecedents, surrounding societal pressures, social norms and the specific social context in which it is experienced. With the prevalence of literature from the US and Canada, and the study of BME women in those countries, it is likely that, owing to the contrasting social and cultural milieu (frames of reference, social and cultural contexts (historical and current)) in the UK, the lived experience of BME women in the UK is likely to be different. With this it is noted that the predominant use of other qualitative research approaches, for example descriptive thematic analysis and grounded theory within the existing literature, suggests that additional understanding may also be gained by adopting a different qualitative method. An approach that can uncover further layers of meaning and recognises the role of interpretation on the part of the researcher (Smith, 1996, 2004; Smith, Flowers & Larkin, 2009; Smith & Rhodes, 2014), to date this has not been utilised in the existing literature. Black, White and Hannum (2007) suggest that health professionals can gain a lot from ‘experts’- BME women with a *lived* experience and exploring such subjective experience is important for understanding the content and quality of depression as it is lived. Thus, this study hopes to provide a new starting point for research into the lived experience of depression amongst BME women in the UK.

Therefore, this research aims to analyse the detailed descriptions of the lived experience of depression from a small group of BME women in the UK using Interpretative Phenomenological Analysis, with the aim of providing “renewed insight into the ‘phenomenon at hand’” (Larkin, Watts & Clifton, 2006, pg. 117), informed my participants’ own relatedness and engagement with this experience. Affording a closer examination of the lived experience of depression of individuals, ‘going back to the thing itself’ and providing opportunities to truly hear the voices of those who are often seldom heard. It is hoped that this research will provide the opportunity to consider how these experiences may be different from or similar to that of other populations, considering the convergence and divergence of this experience among the individuals interviewed. The main research question was therefore: *“What is the experience of depression like for Black and Minority Ethnic women in the UK?”*

METHOD

A QUALITATIVE APPROACH

The aim of this research was to describe, explore and interpret the experience of depression in a small group of Black and Minority Ethnic (BME) women in the United Kingdom (UK). Therefore a methodology was required which was consistent with the epistemological position of the researcher and enabled engagement with and the ability to understand the personal accounts of others. Qualitative research methods have been used extensively to explore individual's accounts of their health and illness experiences (Willig, 2001; Weich et al., 2012), they offer the researcher the ability to explore in detail the rich experiences of human life focusing on discovering new knowledge through the participant's subjective experience (Crowe, 1998). It was felt that a phenomenological lens was required and therefore this research employs Interpretative Phenomenological Analysis (IPA) (Smith, Flowers & Larkin, 2009). It was thought that using IPA would uncover further layers of meaning which have not been revealed in the existing literature. IPA has its origins in phenomenology and symbolic interactionism, which state that individuals are not passive receivers of an objective reality, but that they understand and interpret their world by forming narratives that make sense to them. IPA seeks to understand the participant's view of the world by enabling them to share their experience (Smith, 1996, 2004; Smith, Flowers & Larkin, 2009). IPA is therefore committed to getting as close as possible to the personal lived experience of phenomenon. It also, however, recognises the role of interpretation on the part of the researcher (Smith & Rhodes, 2014). Thus, within this chapter it will be discussed how of the phenomenological methods available IPA was seen as the most apposite approach for the current study.

PHENOMENOLOGICAL RESEARCH

Phenomenology is a philosophical approach to the study of experience (Smith, Flowers & Larkin, 2009). The phenomenological researcher's central concern is with returning to embodied, experiential meanings, aiming for fresh, complex, rich descriptions of a phenomenon as it is lived (Finlay, 2009). Phenomenological research varies dependent on the philosophical values and methodological procedures employed (Garza, 2007; Willig, 2008). The type of phenomenological analysis chosen is dependent on the phenomenon under investigation and the scope of the inquiry. In light of this consideration was given to which phenomenological method was the most appropriate for the present study and was conducive to the researcher's epistemological position.

A number of phenomenological approaches to research exist; the primary approaches were developed by Smith (2004); Ashworth (2003); Dahlberg, Dahlberg & Nyström (2008); Finlay (2008); Giorgi (1997); Halling (2008); Todres (2007) and Van Manen (1990). The approach adopted for the current study was IPA (Smith, 2004). The longest established phenomenological psychology is that developed by Giorgi (1997) who argued that phenomenological methods should be focussed on the descriptive and encompass three steps being 1) phenomenological reduction; 2) description and 3) search for essences. Other approaches have attempted to go beyond the purely descriptive such as that developed by Van Manen (1990), who attempts to connect phenomenology and hermeneutics. This approach, however, still adheres closely to Giorgi's framework and is more focussed on the investigation of everyday practice and advocating an artistic dimension to the writing up of phenomenological research (Smith et al., 2009; Finlay, 2009).

There is a general consensus that we need phenomenological research methods which are responsive to both the phenomenon and the interconnection between researcher and the researched (Finlay, 2009). For the present study there was a desire to not only be descriptive; providing accounts of the experience of those interviewed but also to interpret or attempt to make sense of each participant's experience, which goes beyond the purely phenomenological. Such an approach adheres to the traditions of hermeneutics and idiography, and considers the researcher's own perceptions and interpretations.

It was felt that IPA fulfils this need and moves away from the more descriptive phenomenological methods (Smith et al., 2009). IPA instead maintains some level of focus on what is distinct, but also attempts to balance this against an account of what is shared. As Smith (2004) argues the idiographic analysis of a small group of cases might bring us closer to the essence of a phenomenon. IPA therefore does not eschew generalisations but rather prescribes a different way of establishing those generalisations (Harré, 1979 as cited in Smith et al., 2009). Therefore, this research aimed to not just purely describe what the experiences of depression were for these women but to also provide a detailed analysis of the divergence and convergence across the individual cases. It sought to capture the texture and richness of each particular individual examined (Smith et al., 2009). Interpretation was not seen as an additional procedure therefore but as a natural extension of the exploration into these individuals' experiences. IPA also fits with the researcher's constructionist position (Fransella, 2003), in that they are concerned with what was 'real' for these participants, focussing on their subjective view of their experiences. In terms of the idiographic focus of IPA, it is hoped that learning from these experiences in this particular way will have a more meaningful impact on the development of services, rather than learning from or being biased by outdated theories, preordained ideas from existing research or theories based on the perceptions of other groups. Therefore, of the phenomenological approaches available it became clear that IPA was the best fit for the current research.

INTERPRETATIVE PHENOMENOLOGICAL ANALYSIS

Research in Health Psychology has been truly able to gain an in-depth understanding of individual's experiences of health related phenomena, their perceptions of their health experiences and the meanings they assign to these experiences through the use of IPA (Brocki & Wearden, 2006). IPA is informed by three main areas of the philosophy of knowledge; phenomenology, hermeneutics and idiography (Smith et al., 2009), in order to consider the application of IPA in the context of this research these areas are briefly discussed below along with their relation to the current study.

IPA is consistent with the aims of this research, in that it is committed to the examination of how people make sense of major life experiences. As discussed by Smith et al. (2009) IPA is grounded in phenomenology and is built on contributions by several philosophers primarily; Husserl, Heidegger, Merleau-Ponty and Sartre. Husserl posited that phenomenology is concerned with individual's perceptions of their world and the careful examination of human experience. This should go back to the thing itself, the thing being lived experience, not the philosophical account of lived experience (Husserl, 1927 as cited in Smith et al., 2009). Thus phenomenology is concerned with exploring how people come to accurately know their *own* experience and identifying the essential qualities of that experience. For IPA participants are seen as experts in their own experience (Reid, Flowers & Larkin, 2005), who can describe this experience in their own words. Husserl posited that phenomenology requires adopting a *phenomenological attitude* which necessitates taking a reflexive stance. This attitude as a researcher means striving to be open to the 'other' and attempting to see the world freshly, in a different way (Finlay, 2009). The aim being to direct our experiencing gaze inwards towards our perception of objects. Thus not taking for granted our experience but 'bracketing' it, attending to it and reflecting on it.

Heidegger and Merleau-Ponty (as cited in Landridge, 2007 and Smith et al., 2009) developed these ideas further, providing a more interpretative and worldly position. Heidegger's work was seen as a catalyst for the emphasis on the hermeneutic and existential focus within phenomenological philosophy. Heidegger believed in a stance grounded in the lived world and questioned the possibility of knowledge outside of what he called an interpretative stance, where meaning and consciousness is of great importance. Heidegger discusses the concept of Dasein (there-being) which is the quality of 'human-being'. This term is used instead of person or subject to allow us to examine what it means to exist, how beings engage with their environment and how our world becomes meaningful. Dasein also implies a degree of reflexive awareness, to this he applied the term *intersubjectivity* to describe the shared, overlapping and relational nature of our engagement in the world. Merleau-Ponty developed these ideas in a different way from Heidegger, describing the *embodied* nature of our relationship to the world and how this is related to the primacy of our perspective on the world. Merleau-Ponty proposed that humans see themselves as different from everything else in the world. Therefore, each person's experience is personal and belongs to them so we can never entirely share it. These approaches to phenomenology are what led the researcher for the present study to IPA, as they help us to begin to understand the complexity of experience, in other words they encompass the core concerns of the current study. IPA was seen as the best fit for the current study as its central concern is getting to the essence of how people experience and make sense of phenomena (Langdridge, 2007;

Eatough & Smith, 2006). IPA recognises that access to an individual's world is dependent on the researcher's ability to conceptualise and gain an insider's perspective of the phenomenon under investigation through interpretative analysis (Brocki & Wearden, 2006).

Another major underpinning of IPA is hermeneutics or the theory of interpretation. This interpretative aspect of IPA was particularly appealing for this research, due to its interrogative and analytical nature (Smith, 2004), whereby the accounts individuals provide are thought to reflect their attempt to make sense of their experiences. The work of theorists Heidegger and Gadamar (as cited in Smith et al, 2009 and Landridge, 2007) are seen to be influential in the practice of IPA, considering the methods and purposes of interpretation. Heidegger made a case for hermeneutic phenomenology where it was proposed that our access to 'Dasein' is through our interpretation. Heidegger focussed on *phenomenon* or appearance, the perceptual aspect, where something is presenting itself and phenomenology is concerned with understanding the thing as it presents itself. His other focus was on *logos,* meaning discourse, reason and judgement, which is the analytical part. This focus on the analytical helps us to facilitate and grasp phenomenon as it shows itself. This highlights the complementary activities of IPA being the perceptual (phenomenon) and the analytical (logos).

Interpretation is conducted with the use of the researcher's own pre-conceptions, assumptions and experiences, within IPA this is seen as a cyclical process. Gadamer discusses this complex relationship between the interpreter and interpreted (Smith et al., 2009). IPA concedes that it is not possible for an individual's inner world to be accessed directly and thus interpretative activity is a necessity when exploring individual's accounts of their experiences. There is therefore a dialogue between what we bring to the text and what the text brings to us, this relates to the 'hermeneutic cycle' which is the dynamic relationship between the part and whole at a number of levels, providing a dynamic style of thinking. This provides a useful way of thinking about the 'method' for IPA with the process of analysis being iterative. This process involves a 'double hermeneutic' (Smith & Osborn, 2008) in which the researcher is making sense of the participant, who is making sense of their experience. Access is therefore dependent on the researcher's own conceptions which are required to make sense of that other personal world through a process of interpretative activity. However, there is a need to ensure that this 'fore-conception' does not become an obstacle to interpretation. Therefore the researcher must bracket these preconceptions to some extent, putting aside their own beliefs, judgements and opinions. Bracketing is a key concept within IPA as it is important that the researcher's preconceptions do not taint the research process and interpretation of the data (Ahern, 1999; Tufford & Newman, 2012). However, researchers may not always be aware of their preconceptions and so reflective practice and a cyclical approach to bracketing is required (Smith et al., 2009), which was a process used throughout this research. This then helps to return the focus on the process of engaging with the participant which is the primary concern of IPA. Thus, within IPA the interpretation of data inevitably incorporates both the participant's and the researcher's sense-making about the phenomenon (Smith & Osborn, 2008).

The final major underpinning of IPA is idiography. This is concerned with detail and the understanding of phenomenon from the perspective of *particular* people in a *particular* context. Therefore IPA uses smaller purposively selected samples to gather data, with the aim of exploring the particular in order to get closer to the general (Smith & Osborn, 2008).

PARTICIPANTS

Recruitment Strategy

It was recognised that minority groups and those with mental health issues may be difficult to recruit (due to being more impenetrable social groupings with a higher level of vulnerability), so a 'snowballing' (subset of purposive sampling) recruitment strategy was employed which uses existing networks to access populations which are harder to engage (Faugier & Sargeant, 1997; Benoit, Jansson, Millar & Phillips, 2005). Participants were recruited via local third sector organisations, which offer a beneficial way to access populations which are harder to reach due to both their local knowledge and their contact with members of these populations (Benoit, Jansson, Millar & Phillips, 2005). Organisations such as mental health charities, women's centres and BME support groups were approached for permission to advertise the research. Organisations were sent an e-mail providing details of the study (appendix 1) and the study advertisement (appendix 2) which they were asked to share among their networks and with their service users.

Initially this information was not distributed among the researcher's own organisation (a mental health charitable organisation), in order to prevent any conflict of interest. However, due to a poor response and in order to broaden the scope of the recruitment process, an e-mail was sent to all staff within the researcher's placement organisation. However, staff or service users known to the researcher could not take part in the research for ethical reasons.

Potential participants contacted the researcher by phone or e-mail (contact details were included in the study advert) and were then sent an e-mail (appendix 3) which included a simple screening question being whether they had been clinically diagnosed with depression at some point in their adult lives, to ascertain whether they met the inclusion criteria. Those who did not meet the inclusion criteria were sent an e-mail thanking them for their interest and asking if they agreed to their details being kept for future research. All eligible participants were sent a participant information sheet (appendix 4) and were given the opportunity to ask any questions. Those who expressed that they wanted to take part in the research were contacted by the researcher in order to set up an appropriate date, time and place for the interview to take place. Five participants were recruited using purposive sampling. This approach allowed the researcher to select participants who met pre-determined criteria and based on participant's experiential knowledge, meaning they represented a perspective rather than a population (Smith et al., 2009).

Inclusion and Exclusion Criteria

Smith & Osborn (2008) recommend that five to six participants is a reasonable sample size for IPA research. A smaller homogenous sample is seen as advantageous so that the research retains an idiographic focus (Smith, 2004) and provides the ability to examine convergence and divergence in some detail (Smith et al., 2009). The aim here is to have a homogenous sample that have shared expertise and experience and can therefore provide meaningful perspectives on the phenomenon of interest. In order to achieve this within the study, the following inclusion/exclusion criteria were established:

1. Diagnosis of Depression

Participants had to have a GP/ psychiatrist diagnosis (previous or current) of mild to major depressive disorder (diagnosis via the Diagnostic and Statistical Manual of Mental Disorders, American Psychiatric Association, 2000). The diagnosis needed to have been received after the individual was eighteen years old as a diagnosis prior to this age may have had implications in terms of their psychological development.

2. Female Adult

Participants were required to be female adults over the age of eighteen years old. The decision to focus on one gender was made to maintain homogeneity in this respect (Smith et al., 2009). Also it is recognised that prevalence rates of depression are much higher in women than they are in men (Nolen-Hoeksema, 2001; Kessler, 2006).

3. Black and Minority Ethnic Background

Ethnicity was one of the main focusses of this research thus women who defined themselves as coming from a BME background were included. BME populations are distinct groups with their own identity recognised by themselves and by others. For the purpose of this research BME refers to all people of minority ethnic status. It does not only refer to skin colour but to people of all groups who may experience discrimination and disadvantage, such as those of Irish origin, those of Mediterranean origin and Eastern European migrants (Department of Health, 2005).

4. English Speaking

All participants were required to be fluent in English meaning they were able and comfortable to be interviewed in English. Analysis relies so heavily on language that meaning may be lost during translation. Without proper standards of rigor data may end up not conveying the true meaning of participant’s experiences, due to incorrect translation and subsequently interpretation (Lopez, Figueroa, Connor & Maliski, 2008).

Participant Profiles

Participants of the study were five women who identified themselves as being from a BME background living in the UK. The final five participants were the only women to come forward who met the inclusion criteria. A number of other women had shown an interest in participating but did not respond to further contact. All potential participants who came forward were English speaking so it was not necessary to exclude anyone on these grounds**.** Further information on each participant is provided below:

Anita

Anita was thirty years of age at the time of the research and was born in Bosnia-Herzegovina. Anita moved to the United Kingdom as a teenager following the start of the civil war there. Anita identified her ethnicity as White other and was very clear that she viewed her identity as Bosnian although she has British citizenship. Anita had been diagnosed with depression by her GP a few years ago (identified herself as since recovering from depression) following a range of issues; primarily relationships with loved ones. Anita tried various treatments for her depression including antidepressants, counselling and self-help.

Kay

Kay was aged sixty-four at the time of the research, was born in Sri Lanka and moved to the United Kingdom in her early twenties. Kay self-identified her ethnicity as Sri Lankan. Kay was diagnosed with depression by both a psychiatrist and her GP and had once attempted to end her own life. Kay had experienced issues in the relationship with her mother-in-law which she felt was one of the main catalysts for her depression. Kay had tried various treatments for her depression including antidepressants, counselling and attending spiritual retreats. At the time of the research Kay was still on antidepressants.

Madison

Madison was forty-two years of age at the time of the research. Madison was born in Sierra Leone, West Africa and moved to the United Kingdom at the age of five after the death of her mother. Madison identified her ethnicity as Black British - African. Madison had experienced various personal issues throughout her childhood and adolescence which later resulted in depression and substance abuse. Madison was diagnosed with depression by a psychiatrist and her GP and had tried various treatments including antidepressants, counselling and a rehabilitation facility in Africa.

Nadine

Nadine was thirty-four years of age at the time of the research. Nadine was born in the United Kingdom and her parents were from Bangladesh. Nadine identified herself as Asian or Asian British - Bangladeshi. Nadine was diagnosed with depression by a psychiatrist following a suicide attempt and had tried various treatments including antidepressants, counselling, cognitive behavioural therapy and group support.

Ria

Ria was aged forty-two at the time of the research and was born in the United Kingdom. Ria's parents were born in Guyana in the Caribbean and moved to the United Kingdom in their early twenties. Ria identified herself as Black or Black British - Caribbean. Ria was diagnosed with depression by her GP following the break-up of a relationship. Ria had recently experienced a relapse with her depression from which she had not recovered at the time of the research. In the past Ria had tried various treatments including counselling, cognitive behavioural therapy and antidepressants.

DEVELOPMENT OF THE INTERVIEW SCHEDULE

A semi-structured interview schedule was developed (appendix 5). Semi-structured interviews are described by Smith (1995) and Smith & Osborn (2008) as a data collection method which works well with IPA. The aim of the interview schedule is to guide interviews rather than dictate them and foster an environment for comfortable interaction where individuals can be open and provide detailed accounts of their experience (Smith et al., 2009). The schedule was used flexibly in order to allow probing of unanticipated areas that emerged, providing participants the ability to tell their own story in their own words. It also allows the interviewer to think prior to interviews about aspects such as the wording of questions and ensuring that questions are asked in a clear and sensitive manner (Smith, 1995).

Developing the interview schedule initially involved identifying the topic areas to be explored during the interview. The interview schedule was developed drawing on existing literature, guidance from research supervisors and guidance on developing an interview schedule for IPA research (Smith et al., 2009). The interview schedule therefore covered a range of topics relevant to the research questions (see appendix 6 for a description of the development of these questions and the areas covered). Following this, the order of the topic areas to be covered needed to be considered. Topics of a more sensitive nature are seen to be better left until later in an interview in order to first help foster a safe environment and build a rapport with participants (Smith & Osborn, 2008). Following piloting (see section titled 'piloting') fourteen main questions remained along with prompt questions for each of them which allowed for further exploration of the main questions.

PROCEDURE

Interviews

Interviews were conducted in a safe environment in which participants felt comfortable and the researcher agreed was suitable e.g. a private room in a women's centre or counselling room within a mental health organisation. Interviews lasted between 60 and 150 minutes. During interviews questions were asked in such a way as to be as open ended and as non-directive as possible, fostering an open discussion. If any areas were seen to be of interest to the researcher this was explored further by asking further questions and asking the participant to expand. All interviews were audio-taped with participant's permission and later transcribed verbatim. Once the interview was complete participants were given a verbal and written debrief and thanked for their participation in the research.

ETHICAL CONSIDERATIONS

Ethical approval was received from London Metropolitan University's Research Ethics Review Panel in November 2011 (appendix 7). The ethical considerations for the project were produced in accordance with the British Psychological Societies Code of Human Research Ethics Guidelines (2010).

Informed Consent

All participants were aged over eighteen years old in order for them to provide full informed consent. All participants received a participant information sheet, had the research and the requirements of their involvement explained in full and had the opportunity to ask any questions prior to the research to ensure they were fully informed. Prior to interviews participants were verbally reminded that they could withdraw from the research without any disadvantage or having to give a reason up to the time of data analysis. Participants were required to sign an informed consent form (appendix 8) which highlighted issues such as confidentiality and withdrawal, this form was also countersigned by the researcher. Participants were also required to complete a demographic questionnaire in order to gain basic information on each participant (appendix 9).

Confidentiality

Confidentiality and its limits were clearly outlined to participants in the participant information sheet and verbally. For the purpose of the transcripts and throughout the research all participants have been assigned pseudonyms in order to maintain their anonymity. Any identifying personal information was omitted or changed within transcripts and any quotations used within the write up of the research were sufficiently anonymised. All data related to the research was handled with the strictest of confidence and stored within a locked cabinet only accessible to the researcher. It was made clear to participants that if sensitive information in the nature of intended harm to themselves or others was disclosed, then confidentiality may need to be breached in order to manage this issue appropriately.

Protection of Participants

It was understood that due to the personal and confidential nature of the research topic that a high level of researcher sensitivity was required. It was important to, as much as possible; protect participants from discomfort and harm. Every measure was taken to minimise the risk of upset. Interviewees were informed that they could stop the interview at any time and/or take a break. Furthermore, they were informed that they did not need to answer questions they did not want to or felt uncomfortable with them. Interviews were followed by a verbal debrief and participants were given the opportunity to ask any questions. Participants were also provided a debriefing sheet (appendix 10) which contained the researcher’s and the university’s details and information regarding a range of support i.e. counselling organisations if a participant felt this was required following the research.

Risk Management

Protocols were put in place in the event of someone becoming extremely distressed, presenting with a worrying mental state or imminent risk. An adapted version of London Metropolitan University’s distress protocol (appendix 11) was adopted to help participants to cope if they became distressed during interviewing; the stages outlined in the document were followed if necessary. This may have involved terminating the interview, referring the person to mental health services or calling emergency services dependent on the level of the distress. Any actions would be discussed with the interviewee if this was deemed to be appropriate. The limits of confidentiality were outlined in the participant information sheet and explained to all participants prior to interviews. The potential risk to the researcher was also addressed. Measures were taken to ensure that the researcher was safe including contacting a trusted individual (i.e. work placement supervisor) before and after interviews and ensuring that the researcher sat closest to the door.

PILOTING

The first interview was treated as a pilot of the materials and procedure. This pilot interview provided the opportunity to test aspects of the research design including the research process and ensuring questions were understandable and would sufficiently lead to open discussion. In light of this minor adjustments were made to the interview schedule including; omitting a question regarding participant’s views and knowledge on depression as this came up elsewhere and it was felt that it could not be meaningfully analysed on its own, the language used was softened particularly within the section on identity and depression and the section on depression and health was adapted to be more specific to physical health and provide a better flow of questioning. No changes were made to the procedure following the pilot interview. Due to issues with time and recruitment the pilot interview was treated as primary data. The use of pilot data is very common within qualitative research and can be seen as beneficial due to providing valuable data and helping to increase the sample within the main study when there are recruitment issues (van Teijlingen & Hundley, 2001), as was the case for the present study. As well as this, within the present research the piloting stage marks the time in which the researcher's focus became distinct and could be clearly defined.

ANALYSIS

The data was analysed following the established guidelines for IPA (Smith, 2004). This involves a number of tasks including an initial close reading of the transcripts, individual case analysis, followed by cross case analysis. The final themes were translated into a narrative account.

Individual Case Analysis

Each transcript was initially analysed individually. First, transcripts were read through several times in order to cement the researcher's familiarity with the content, often in conjunction with listening to the original recording in order to contextualise the participant's voice. This was followed by a close reading of the transcripts making notes of significant points or anything of interest in the right margin. The initial notes were often descriptive comments, which were linked closely to the text, developing then into more conceptual and interpretive noting. In addition to this, text was highlighted or underlined. This process meant that the researcher went through the transcripts several times making notes. Some sections of transcripts were deemed to be richer than others and therefore warranted more commentary.

There was then a move to a higher level of interpretation involving more critical engagement with the data and reflexivity (Smith, 2004). This involved re-reading the transcripts and using the left hand margin to note any emerging themes, at this stage, to some extent, the process of interpretation moved slightly away from what was explicitly described in the participant's text as there was also a focus on drawing from the exploratory comments.

The emerging themes were then clustered and organised in an attempt to seek and make sense of any connections between themes. Much of this work was done by hand, by cutting up the themes and using a large surface to arrange them in. Smith & Osborn (2008, pg. 70) suggest at this stage imagining a magnet “with some themes pulling others in, helping to make sense of them”. These theme clusters were then titled with the aim of creating subordinate themes. At this stage it was required to continually return to the original transcript in order to reflect and ensure that what was said by participants was not lost. Next a table of superordinate themes was produced (see appendix 12 for the table of themes for each participant), with related sub-themes- to support with the reflexive and interpretative process this table was shown to an external reviewer who was familiar with the data. An identifier was added to each instance of a theme to make it easier to find it within the data. During this process some themes were omitted if they did not fit the structure or if there was not enough rich evidence in the transcript. Themes were also grouped together with a new theme title. The final themes were determined by a range of means including; frequency of the theme within the transcript, the relevance to the research aims and the richness within the text. Within all the transcripts there were an extensive number of themes. Many were kept at this point, however, as they helped to illuminate aspects of superordinate themes. This process was repeated with each transcript from the beginning. During this process an effort was made to look for repeated patterns but also to not neglect any new issues emerging.

Cross-case Analysis

Once each transcript had been analysed, the subordinate themes were clustered to create a master table of themes. It was important to continue going back to the transcripts, particularly in regards to any new or emerging themes. The aim of this cross-case analysis was to identify any repeating patterns across the data, as well as any convergences and divergences, often moving to a more theoretical level (Smith, 2009). Once this process was complete and sufficient evidence for themes was identified among the transcripts a final table of master themes was created for the group (appendix 13), showing how themes are nested within superordinate themes and illustrating the theme for each participant. This final table was used to outline the important aspects the analysis write-up should cover and how this would be ordered.

Narrative Account

Following the cross-case analysis the final themes identified were translated into a narrative account which shows the findings from the research, this narrative was supported by verbatim excerpts from the transcripts, as well as sections showing the researcher's self-reflective process. This narrative provides an account of participants' sense-making of their experiences in their own words along with the researcher's interpretation of this sense-making, in order to make a case for what this all means. This analysis shows a deeper level of interpretation contextualising the themes within a narrative account in order to present the experiences of all the participants in the research. This narrative is also considered in light of the research question and discussed in relation to the existing theory and literature.

REFLEXIVITY

THE APPROACH TO REFLEXIVITY WITHIN THIS RESEARCH

When the researcher and the researched are of the same order, that is, both living, experiencing human beings, it is necessary for researchers to reflect on how that may impact on the scenario when gathering and analysing data (Shaw, 2010). IPA recognises that the production of an interpretative account is a function of the relationship between the researcher and the participant, constructed and shaped by their encounter (Larkin, Watts & Clifton, 2006). Within IPA, there is a desire to gain an insider's perspective, yet there is also an emphasis on critical self-awareness, in which a researcher is required to be aware of their "own subjectivity, vested interests, predilections and assumptions and to be conscious of how these might impact on the research process and findings" (Finlay, 2008, p. 17). There seems to be a paradox here as IPA puts the experiencing subject as the central focus, however, also recognises the interplay between the researcher and the researched. As opposed to trying to devalue the researcher's role, IPA adopts the stance of acknowledging and exploring this role and demonstrating a commitment to recognising the double hermeneutic. As so aptly put by Smith et al. (2009) "Without the phenomenology, there would be nothing to interpret; without the hermeneutics the phenomenology would not be seen" (pg. 37).

Thus there is a need for the IPA researcher to develop a level of self-awareness, adopting a reflexive stance and reflecting their thinking back on themselves (Finlay & Gough, 2003; Shaw, 2010). Reflexivity has been defined in a range of ways, however the most apposite definition for this research seems to be that provided by Finlay who says "Reflexivity is the process of continually reflecting upon our interpretations of both our experience and the phenomenon being studied so as to move beyond the partiality of our previous understandings and our investment in particular research outcomes" (Finlay, 2003, p. 108). Reflexivity is a form of thoughtful, conscious, self-awareness (Finlay, 2002), through which we can review our fore-understanding both within interviewing and later within interpretative activity and come to make sense of phenomenon anew (Shaw, 2010). Within IPA there are no guidelines as to how present the IPA researcher should be within research, the points where their reflexivity should be shown and the researcher's interpretative lens should be made visible. To that end, throughout the research process, I had my own 'challenge-to-competency' in regards to reflexivity (Shaw, 2010), in that I was not sure of how much of this reflexivity to lay out within the write-up of this thesis. This was something that was debated on a number of occasions and I was subsequently challenged to explicate this reflexivity and demonstrate that the process of IPA was truly followed.

Consequently, in an effort to strengthen this study's transparency and demonstrate a commitment to adhering to the concept of the double hermeneutic, the researcher's personal and epistemological reflexivity is embedded throughout the write-up of this thesis. Such reflexive awareness comes from my own musings throughout the research process, accounts from notes taken during this process, professional logs, recounting conversations (e.g. those had with research supervisors), peer review and my general reflections and thoughts at different points. Thus this reflexivity was seen as a way of being and continually monitoring and auditing the research process (Shaw, 2010). It was, however, felt that it is important that some of this reflexivity is kept personal and not laid out within this thesis write-up, so as to make my lens visible but not distract the focus away from participants. There is an element of caution here of not wanting to do this to the extent that the "analyst and the phenomenon disappear from view" (Gough, 2003 pg. 22). It is important that what is presented does not move from an exploration of the participants' lived worlds to an exploration of the researcher's own experience, or what (Shaw, 2010) called getting carried away on a tide of reflexivity. I was mindful of not privileging my own experience over that of the research participants, due to the very purpose of IPA being to give individuals voice. Regardless, it is recognised that any discoveries made are a result of the relationship between the researcher and participant, with the accounts being constructed and shaped by their encounter (Larkin et al., 2006). Therefore throughout this thesis the reader will see sections of reflexivity which it is hoped helps to elucidate elements of this reflexive process. It is recognised that within qualitative research demonstration of such analytic processes (in this case the inclusion of the analyst's preconceptions, beliefs and reflexivity) can serve to enhance the account's rhetorical power (Brocki & Wearden, 2006). It is hoped that this thesis achieves this aim.

INITIAL SELF-REFLEXIVITY

Although reflexivity is used throughout this thesis, it is important that the reader gains an initial understanding of the researcher's personal and professional position, along with the reason why this particular research topic was chosen. The founder of IPA Jonathan A. Smith argues that "reflexivity is a central feature of understanding the nature of the person in psychology" (Smith, 2003 p.176). As with any researcher I had my own motivations for conducting research on this particular topic. Here I will briefly consider how my background, assumptions, social identity, professional and personal position impacted on my decision making processes when embarking on this research.

I am a thirty year old self-identified Black British female who grew up in Hertfordshire, England. I am the third generation from a Caribbean immigrant family. A combination of my Health Psychology training, experiences working in the NHS and voluntary sector and personal values have informed my position. My view and understanding of mental health is based on the premise that mental health conditions exist on a continuum and as such anyone can be vulnerable to experiencing a mental health issue and this goes beyond labels and diagnosis. With this I feel that such conditions are influenced by a complex range of psychological, social and biological factors and thus each individual's experience is unique (with some convergence and divergence across experiences). Overtime I have become increasingly mindful of the range of factors which can have an impact on an individual's mental health both social and environmental and also the range of health inequalities which can be experienced, as highlighted by both work and personal experiences. I do not believe that health is simply about personal responsibility but also the broader social context.

I have worked in the health sector for over ten years in the NHS and voluntary sector, spending the last six years working for a mental health charity. I am currently a Trainee Health Psychologist, with a professional interest in the impact of behaviour on health, public mental health, health inequalities and social determinants of health. Whilst completing my Masters in Health Psychology I worked as a Mental Health Act Manager, in which my role was to act as an impartial individual with a positive approach to fairness and equity in ensuring service users' rights were maintained within the terms of the

Mental Health Act 1983. This role entailed a range of skills, one of the most important being a good listener. In carrying out this role I was privileged enough to be given information on many mental health patients ‘stories’. However, the accounts which were most powerful, and provided far more context than what can be written in a report, were those provided by the individuals themselves. My interest in exploring lived experiences of health issues began at this point.

The origins of the present study began from my professional experience after this time. Upon completing my Masters I started working as a mental health Community Development Worker for Black and Minority Ethnic (BME) communities, under the Delivering Race Equality (DRE) Agenda Five Year Strategy (Department of Health, 2005). The purpose of this role was to work towards addressing ethnic inequalities in the mental health system. In attempting to deliver this goal the main focus of the role was to work closely on the ground with BME communities to help develop effective community-based responses to mental health issues. This community focus linked with developments within statutory services, commissioning and procurement processes. Much of my work was focussed on supporting BME women (many of whom had depression) as per my Key Performance Indicators, due to their identified higher level of need. During my time in this role I of course formed my own views on mental health in BME populations and the issues which it was felt were significant. Although coming from what could be called a privileged position (I had never, for example, felt that I had personally experienced racism or discrimination, a key focus of the agenda) I became aware of the impact that identity and social determinants can have on an individual’s health. However, what was brought to light to me was that there was a lack of understanding of the mechanisms by which this occurred and what this experience was like for individuals. At the end of working on the DRE agenda I reflected on whether we had achieved the ambitious changes as recommended by the strategy. Had the work really made a difference to BME communities? Had individuals from these communities truly been heard? Finally, what were the next steps going to be? I had particular concerns for the women from the communities I had worked with. I felt that we had not finished what we had started and had missed a major step in not exploring individual’s personal experiences in order to get a better understanding of the issues they faced. My interest was thus sparked in gaining a close insight into BME women's experience of mental health issues and their personal perceptions of this, something which was often a struggle to do within my work role.

At the time of embarking on this research study I had many thoughts about areas of interest in terms of my own personal curiosities and the gaps I felt I could fill within the extant literature in regards to the topic of mental health in BME women. Due to being so close to this area of work I began my initial exploration by exploring the literature and having discussions with various professionals and academics about my interests, and the idea of research into the experience of depression in BME women began to come to life. At this time I had to challenge myself to start becoming a reflexive researcher and consider my own 'positionality' (Jootun, et al., 2009) and the impact this may have. Throughout the research process I have discussed my own position and beliefs with my research and work supervisors I feel this was a valid way to 'bracket' and perhaps address issues of my own bias.

I recall a conversation I had with my research supervisor during the early stages of this research. After being inspired by my initial scoping and reading I explained that I wanted to explore the experience of depression in BME women. However, I was hesitant about this and until this discussion I was not consciously aware of why. The central issue being that I did not want to put myself in the box of being a minority ethnic woman, researching 'minority ethnic issues', a similar issue I faced within my job role. I did not want to be seen as just conducting research in the paradigm of what it was perceived I 'knew'. It was not until this conversation that I realised some of the stigma I had against myself and my professional position and the fear I had of adopting what I felt at the time was a specific label or identity. I did not want to be seen as forcing the view that the experience of depression is different for 'us', particularly as I had not personally had experience of this at that time. With this, however, I was deeply aware that in working with women from BME communities that they faced some issues in ways which seemed specific to BME communities. I was growing increasingly interested in exploring these experiences further, something I felt I was unable to do within my role as a Community Development Worker. My supervisor challenged me to be reflexive during this discussion, questioned my standpoint/fears and suggested that this could be an opportunity to challenge my own perceptions, broaden those of the mainstream population and learn more about the lived experience of depression for BME women.

Through such discussions and my initial scoping it was clear that it was felt that there were some differences in this experience. It was not understood at this stage what these were however. I spoke about how through my initial reading I noticed that there were a number of qualitative studies exploring depression in BME women in other countries such as the United States of America and Canada, however very little in the United Kingdom (UK) and certainly none which explored lived experience. It was during this discussion that it became apparent that I wanted to explore the lived experience of depression in BME women in the UK and that IPA would be the most fitting analytical approach. I wanted to give voice to this underrepresented group and add to the field of research on this subject. My aim was to fill a gap within a neglected area of research and explore the experiences of a small group of UK based BME women with depression. I felt it was important to hear the stories of these women in their own words; stories which are seldom heard, providing the opportunity to see this phenomenon in its essence. With my own subjectivity, vested interests, predilections and assumptions (Finlay, 2008) as outlined within this initial reflexivity I recognised that it was important that I stayed open to the other and throughout the research process I remained reflexive over such views in order to provide a credible account of the experiences of the participants (Clancy, 2013).

ANALYSIS AND DISCUSSION

In this section the results of an Interpretative Phenomenological Analysis (IPA) of the experience of depression among five Black and Minority Ethnic (BME) women in the United Kingdom (UK) will be presented and discussed. This IPA analysis resulted in the emergence of two master themes which encapsulate the lived experiences of the participants, these themes are as follows:

1. **Cultural Expectations and Depression: "I just need to be me"**
2. **The Nature of Depression: Agency, Façades and Coping**

These master themes and their constituent subordinate themes are summarised in Table 1. Exploration of these themes will form the basis of this chapter, with each theme illustrated by verbatim extracts from the interviews. In keeping with the spirit of IPA, particularly the recognition of the double hermeneutic, the self-reflexive process is shown throughout this analysis and discussion in the form of summaries at the end of each sub-theme. The findings are also considered in light of the research question and discussed in relation to the existing literature and theory. More novel findings are also discussed with a view to developing a rich understanding of the experiences of the women interviewed.

MASTER THEMES	SUBTHEMES
1. CULTURAL EXPECTATIONS AND DEPRESSION: "I JUST NEED TO BE ME"	1.1 Cultural Identity and Health: Stress, Pressure and Depression
	1.2 Being a Minority, Being Different: "Isolated, Put Into White Man's Soup"
	1.3 Cultural Denial of Mental Health: "There's no such thing as mental health problems"
2. THE NATURE OF DEPRESSION: AGENCY, FAÇADES AND COPING	2.1 Depression Has Agency : "Once it gets going and you just allow it to carry on"
	2.2 Emotional Feelings Presenting as Physical Symptoms
	2.3 "Putting sort of a smoke screen over it"
	2.4 Antidepressants: "It's very like rose tinted

	glasses”

Table 1: Master themes and related subthemes

1. CULTURAL EXPECTATIONS AND DEPRESSION: “I JUST NEED TO BE ME”

Overview

Group membership and social identity play a key role in influencing an individual’s health and wellbeing (Haslam, Jetten, Postmes & Haslam, 2009). This theme considers the concepts of individual identity and social identity (primarily centred on culture) and their relationship to participants’ experiences of depression. Individual identity refers to an individual’s uniqueness - a person’s distinctness from others (Fernando, 2010). Social identity reflects how we define ourselves, not just as ‘I’ or ‘me’ but as ‘we’ or ‘us’ (Jetten, Haslam & Haslam, 2011). Social identity theory posits that a vulnerable identity can impact on self-concept and health (Haslam et al. 2009). The findings within this theme support in identifying some of the mechanisms through which this occurred for the BME women interviewed. There is a thread running through this theme around the struggle of finding one’s own identity both within and outside of one’s culture. The relationships between identity, health, stress and coping are considered in relation to participants’ experiences of depression. This master theme also explores participants’ discussions of the experience of being a minority and a sense of feeling ‘different’, alongside the emotional consequences of perceived prejudice and discrimination. Consideration is also given to the denial and secrecy related to mental health in some groups.

1.1 Cultural Identity and Health: Stress, Pressure and Depression

Cultural identity is an important facet of an individual’s personal identity and a large contributory factor to an individual’s wellbeing (Fernando, 2010). This theme details participants’ identity struggles and their relation to their cultural background. Consistent with the wider literature participants described the subconscious cultural pressures, cultural conflicts and cultural expectations experienced which led to isolation, pressure, stress, anger and loneliness. All of these were seen as precursors of adverse health and depression. To manage these difficulties participants described adopting a range of coping strategies, such as resilience, to protect their wellbeing.

When asked what was happening in her life before her depression began Anita explained:

> Anita: '*I think I was going through a phase where I was constantly, I was isolated from everyone and, like my friends and family mostly, because a lot of pressure in the fact that my family's views and my views are totally different. So we used to constantly clash and it was constant just you know battle between us all the time [because of] the fact that I wanted different things in life and they weren't understanding that'* (pg. 1, lines 29-34).

For Anita isolation and pressure were a precursor to depression due to the differences in hers and her family's views- what emerged was a form of cultural distance. The clash Anita speaks of here could be a form of 'intergenerational cultural conflict'- "family conflict due to the cultural dissonance that emerges between generations" (Yang, Haydon & Miller, 2013, pg. 193). Such conflict has been found to be a factor for BME women from a range of ethnic minority backgrounds, for example, South Asian women in Canada cited feeling caught between traditional and modern culture and living in restrictive environments, which was not fitting with the western society they resided in. Some being asked to quit school or chose jobs suited to them becoming a married woman. The inability to negotiate their needs with their parents put strain on these women as they compared themselves to other counterparts (e.g. non-ethnic minority women) (Ekanayake, Ahmad & McKenzie, 2012). This, it would seem, was also the case for Anita to some extent:

> Anita: '*Obviously because I'm not from an English background and I'm not English my culture's different. The fact that I wasn't, I think the fact that I wasn't up to the expectation of my culture it was a bit just kind of a let-down. I felt like I was letting my family down. I wasn't the typical, you know, Bosnian girl that you know goes and gets married and has kids. I went to university, I wanted to ya know work, I wanted to do things and it caused a lot of, a lot of clashing. So that was I think, that was the reason, the reason that me and my*

> *family had problems. Obviously having family problems, obviously brings stress and the relationship I was having and everything around me, it was there, was nothing good everywhere I turned there was nothing nice or happy'* (2, 41-52).

In accordance with behaviour and lifestyle models of health, it has been suggested that health patterns are influenced by culture and levels of acculturation (Cassado & Leung, 2001; Blomstedt, Johansson & Sundquist, 2007), as would seem to be the case for Anita here. Yoon et al. (2013) conducted a meta-analysis exploring acculturation, enculturation and mental health. The results showed that acculturation (the phenomenon by which the minority culture assimilates the values of majority culture) and enculturation (the process in which an individual chooses the aspects they retain or reject from their home culture and at the same time what they will take on from their new culture) were negatively associated with mental health particularly depression. Research exploring BME (South Asian) women in the UK's experience of culture conflict, found similarly to Anita that cultural conflict can heighten stress levels and in turn lead to depression. This conflict can cause immense tension, acculturative stress (reduction in health status among those going through the process of acculturation) and lead women to feel they cannot reach a 'higher status' in Britain, again as with other research comparing themselves to non-BME men and women (Berry, 2006; Hussain & Cochrane, 2002; Ekanayake, 2012). It is recognised however, that stress alone can be a cause of health issues such as depression, so this is not unique to BME women. It is, however, consistent with the literature that this can be exacerbated by culturally driven relationship issues, which within Muslim culture seems to be more of an issue for women rather than men (due to gender role expectations) (Dwyer, 2000). Anita appears to feel she does not fit the criteria of being a '*typical Bosnian girl*'. For Anita the pressure of not fitting this 'cultural identity' and, in contrast, wanting to assume her own identity outside of the constraints of her culture led to unhappiness. Anita conveys a sense of restriction and being 'boxed in' due to the pressure of not meeting these cultural expectations and provides a novel insight into why this conflict led to stress. Anita's discussion of restriction perhaps pertains to the level of 'tightness' among her culture. Research exploring 'tight versus loose' cultures in a number of nations has found that those coming from cultures with clear norms and higher levels of pressure (tight cultures) feel greater levels of pressure to conform. It would seem due to the level of pressure on Anita that she came from a ‘tight’ culture and perhaps was finding it difficult to balance this with the ‘looser’ culture found in the United Kingdom (Gelfand et al., 2011).

In the context of Anita’s discussion, the process by which this stress experience is related to her health status needs to be considered within a theoretical context. Perhaps the best model of such experience is that of ‘salutogenesis’ – the origin of health (Antonovsky, 1979), which focusses on the relationship between health, stress and coping and supports in providing an explanation for why some individuals fall ill under stressful conditions and others don’t. Thus helps to demonstrate the links between culture conflict, stress and depression – a novel way of using this model. Two core concepts are central to the salutogenic theory. First, *generalised resistance resources* (GRR’s) – material and psychological factors which make it easier for individuals to understand and structure their lives (e.g. money, social support, knowledge and traditions). Secondly, *sense of coherence* (SOC) which provides the ability to use these resources (identify internal and external resources to deal with stressful life events in a health promoting manner). There are a number of identified life experiences which are seen to contribute to an individual’s SOC. More recently, the concept of *emotional closeness* has been identified, which seems pertinent to Anita’s experience of cultural distance, along with BME women from a range of backgrounds in both the US and the UK (Ekanayake et al., 2012; Hussain & Cochrane, 2002). Emotional closeness refers to the extent to which a person has emotional bonds with others and feels part of their community (Sagy & Antonovsky, 2000). It would seem from Anita’s description of her relationship with her family that this emotional closeness was lacking along with some of the resources required to have a strong SOC, leading to heightened levels of stress and depression. This agrees with the literature that suggests that a weak SOC is associated with a higher level of symptoms of mental illness, poorer general health and lower quality of life (Lindstrom & Eriksson, 2007), yet expands this to recognise the impact of cultural dissonance.

A powerful message from Madison is what she perceived to be the negative impact of cultural traditions and expectations. She relates this discussion to the cultural tradition of female genital mutilation, something she herself had experienced:

> Madison: *'…I am my own person. You see in my culture you have to be a sheep, when everybody go this way one, one all man go through yea. I'm not like that, I've got my own mind. I used to say to my sister's husband [ ] I said "why is our culture like sheep right?" I said "if God wanted us to be like sheep he would have given one person one brain and then make other man follow, but he give we all one why should I WHY SHOULD I take on a ritual like circumcision that's not in the Qur'an or in the bible. [ ] Why should I adopt that, I'm educated now. [ ] You see my mother died, I was taken away from here but actually maybe it was a good thing because look at what I would have ended up like. I don't think I would have wanted that and, but what I'm saying what you don't know you don't miss do you get where I'm coming from? But for the fact that I've come out and you know, so I take that as a good thing, yea it was a good thing right. I need to overcome this depression; I need to find a way to overcome it' (23, 912-938).*

This could be seen as Madison resisting her culture. This resistance or questioning is common during the experience of enculturation (Weinreich, 2009), whereby due to the acquisition of a more western value system as adopted in the United Kingdom, Madison has begun questioning the cultural traditions of her country of origin (one which over the last two decades has drawn substantial attention in the UK) (Whitehorn, Ayonrinde & Maingay, 2002). It may be the case that Madison is experiencing a challenge to her identity here; Madison seems to present with a strong individual identity and wants to challenge her culture whilst still preserving elements of her cultural identity. It is as though culture of origin is something which cannot be rejected outright. This fits with descriptions of culture being something within the person, a psychological state rather than just the environment in which someone is immersed (D'Andrade, 1984). Such 'cultural frameworks' are often inescapable, particularly among ethnic groups with African roots due to strong cultural traditions (Black, White & Hannum, 2007). That said Madison seems to be expressing resilience here, she is using her own personal logic to defend her right to individuality and questioning cultural traditions. In regards to health, resilience is the process of preventing or reducing health disturbance following adversity and having the ability to recover from stress related health issues (Rutten et al., 2013). Therefore, it could be said that becoming resilient is meant to protect Madison from depression, as she says she was able to overcome her culture and relates this to her desire to overcome her depression. However, it would seem from the way that she speaks that it takes a huge amount of energy to maintain this position.

Similarly to Madison, Nadine also experienced difficulties in finding where she fits within her culture and society in general. When asked about the influence of her cultural identity on her experience of depression, she responded:

> Nadine: 'Y*ea I think, yea culture makes it lonely cause like as I said, I feel like I'm a modern girl and I don't probably always know where I fit in. [ ]I would feel aware that I don't fit in and that gets me more depressed that I don't have family. I think that's what it is and I said "I'm wary if I ever date it's always been different cultures". My ex was Indian, but Indian people, it's a bit more open, but I felt I could never date a Muslim because family, Asian families ask you "where are your family?" So I have got the barrier and that gets me more down and more depressed, more isolated. The fact that I haven't got a family makes me feel like lonely or depressed, like I think there's an identity with having no family and having an Asian culture and an Asian woman that brings that…' (25, 999-1013).*

Similarly to Anita, Nadine seems to be conveying 'intergenerational cultural conflict' here, a difference between what she had described earlier in the interview as '*Asian older*' and '*new generation*' (24, 980). It seems that Nadine does not fit with Asian cultural expectations and has her own unique identity; this conflict seems to be synonymous with loneliness, isolation and a worsening of her depression. Traditionally defined, loneliness occurs when there is a conflict between a person's desire to interact and forge social relationships and their actual levels of social interaction (Peplau & Perlman, 1982 as cited in Durak & Senol-Durak, 2010) which of course can be experienced by anyone no matter their background. However, additional factors which have a strong relation to loneliness include culture and family (Medora, et al., 1987, as cited in Rokach, 2007). So expanding on this view a lack of connection with one's culture (due to not meeting expectations) or family can heighten feelings of loneliness. Both loneliness and isolation have been associated with an increased risk of developing depression and are associated with higher levels of stress (Jaremka et al., 2013; Thurston & Kubzansky, 2009; Cacioppo & Hawkley, 2003). With this, Nadine's way of dealing with her depression and the stress of her symptoms was to '*sleep and isolate*' (28, 1120) herself. Such health behaviours may help to explain why loneliness can have an impact on health status (Shankar, McMunn, Banks & Steptoe, 2011). It could therefore be suggested, that conflicts in cultural identity can lead to stress, leading to loneliness and isolation which in turn can impact on the experience of depression and subsequently health status in some BME women- this is consistent with pathways which have been found between these factors (Allgower, Wardle & Steptoe, 2001). Conversely, other research exploring such expectations in BME women has not found these to be related to isolation, and instead isolation was brought on by external factors e.g. loss or due to having just had a child, factors experienced also be non-BME women (Hussain & Cochrane, 2002; Ekanayake, 2012). .

Nadine elaborated on this cultural conflict and loneliness further and explained that in her view there is a subconscious pressure associated with her culture which she seemed to feel prevents her from assuming her own identity. She seems to be trying to find meaning for why she finds it difficult to be herself, despite having a strong desire to do so:

> *Nadine: Yea it's like a subconscious pressure, cause like I said to my psychotherapist even though I'm out of it, it still winds me up if I go to some place. Like I said here it's good but like I said, I've been to some places where girls say "are you married now?" [ ]They assume you have kids or they assume you live with your family so again there's an assumption. If you make an assumption it's really hard, whereas here it's a bit better but they are, cause I'm surprised some people have different relationships or they've left home so you have to be in the right place. But yea most other places it's an assumption. Do you celebrate this and that? You just think, you know, I need to get away from it cause it makes me angry because I just need to be me basically' (10, 387-397).*

In the above extract Nadine discusses how this subconscious cultural pressure and assumptions which others make about her identity and lifestyle leads to her feeling angry. Other research has found that anger is an emotion which is lived *through* the body

(Eatough & Smith, 2006). It is therefore not too much of stretch to surmise that poorly managed anger can have an impact on health, such as was the case for Nadine. Nadine's experience of anger is consistent with the literature, which has found that suppressed anger (particularly focussing on lower social status and feelings of entrapment) can lead to increased depressive symptoms (Allan & Gilbert, 2002). Anger has been found to be related to various health conditions (e.g. coronary heart disease and depression) and it is for this reason it is an emotion of particular interest to health professionals, with an increasing interest in the experience of anger in those from specific groups including ethnic minority women due to the additional specific stress causing burdens they may face (Kubzansky, Cole, Kawachi, Vokonas & Sparrow, 2006; Rude, Chrisman, Burton Denmark & Maestas, 2012). Bagdasarov & Edmondson (2013) investigated the role of cultural framework and anger expression in Russian immigrant women in the United States and their relationship to these women's physical and psychological health status. The results showed that anger expression and anger suppression were both predictors of mental health status. These unique findings in light of what has been unveiled here warrant further exploration within future research.

Cultural pressure can present itself in a number of guises. Gupta, Johnstone & Gleeson (2007) explored the experiences of cultural conflict among second-generation South Asian women living in the UK. Two themes were of particular relevance to Nadine's experience (she was also second-generation); 'community policing' and 'pressures and stressors'. It was found that participants often felt subjected to scrutiny from their community and felt pressure to conform, leading to frustration and heightened levels of stress. With this other research has found that these women also feel pressure from wider society in England to instil and integrate the values of the country (Hussain & Cochrane, 2002), alluding to a 'double pressure', as Nadine also seems to be experiencing here. Therefore, BME women seem to face pressure both from their cultural community and society as a whole, perhaps making their experience distinct from non-ethnic minority women. The salutogenic model of health is useful again here as it could be said that this pressure and the lack of emotional closeness with her community had a negative impact on Nadine's health status (Sagy & Antonovsky, 2000). Nadine seems to be providing context as to why culture in her view makes the experience of depression lonely. There is, it would appear, a reactionary process of feeling pressure, anger and a subsequent exacerbation of depression symptoms- demonstrating the relationships between these concepts. Nadine at this point uses a very powerful phrase '*I just need to be me*'. It is as though Nadine is struggling to assume her own identity outside of the constraints of her culture and wider society expectations, this adds to the existing literature as it posits a more nuanced argument that the cultural conflicts experienced are perhaps down to individuals trying to find their own identity, outside of any preconceived cultural frameworks.

The impact of identity conflict and its relationship to health outcomes has been considered in the literature. A strong sense of self has been found to have a positive impact on an individual's mental wellbeing and their ability to cope with life's stressors (Mann, Hosman, Schaalma & de Vries, 2004). However, if an individual has issues in their identity and feels misunderstood by others, as seems to be the case for Nadine and others, this can lead to adverse mental health outcomes such as depression (Jack, 1999). Jung & Hecht (2008) explored such identity gaps in male and female Korean immigrants in America and their relationship to situation variables (intercultural communication competence, middleperson status and perception of racial hierarchy) and depression. They found that such identity gaps put people at elevated risk for depression. This fits with Nadine's experience as it would seem that trying to suppress her real self (personal-enacted identity gap) and feeling pressure to meet other's ideals (personal-relational identity gap) led to pressure and increased depressive symptomology.

Self- Reflective Process

"Identities are the very accounts and stories people tell themselves and others" (Smith, 2003, pg. 178) - thus the self is reflexively understood and people are revealing their identities through the accounts they provide. This was very much the case in the exploration of this theme and influenced the self-reflective and interpretative processes. I could emphasise with the identity struggles of the participants and the 'gem' which Nadine provides 'I just need to be me'. This statement I felt encapsulates what this theme was about- it is an extract which offers powerful illumination of the topic under investigation (Smith, 2011). The accounts provided drew me to reflect on identity as a

concept and my own and led me to question if, for example, we all go through times where we do not know exactly who we are and where we fit?

I have felt challenged, in the past over my own cultural identity, with some in my own cultural circles seeming to perceive me as not being 'Black enough' or fitting the stereotype of a 'typical' Black woman – my own enculturation issue. Anita seemed to be going through a similar experience when she said she was not viewed as a 'typical Bosnian girl', which meant I could empathise with her. I noted that it is easy to see people in particular lights based on specific characteristics and it is important that our perceptions are not clouded by these assumptions. In exploring the findings and developing this theme something I needed to reflect on was my own assumptions and perceived prior knowledge of particular groups, for example Muslim women. Due to working with women from Muslim communities I was aware of some of the culture related issues which can be faced and had some of my own judgements of these. I therefore needed to take the time to move past these judgements and confront any prejudices or assumptions I may have had, in order to provide an open and honest interpretation of the data.

The development of this theme also prompted me to reflect on the need to take an actively reflexive approach to interviewing- something I feel in hindsight I did not do enough, so in some ways had to do after the fact during the interpretative process. It is therefore important to note that Anita (my pilot interview) was someone with whom I had had a prior relationship. This brought to light the interesting dynamics between researcher and participant. I knew, for example, that the reason she became a mental health support worker was driven by her own lived experience and a desire to help other Muslim women who faced similar cultural issues to herself. Therefore I was aware of some of her 'context' so had to consider boundaries and not allowing my prior knowledge to unduly influence me. I had a lack of knowledge about her cultural background, however, particularly the Bosnian war. This at times acted as a barrier in our exchange and later in the analytic process- bringing to light power dynamics between the researcher and the researched. Again, reflection was required here. However, in some ways this ignorance helped with my analysis and subsequent interpretations as there were no preconceptions around this. This presents an interesting reflection, that a certain unfamiliarity with the participant's social *and cultural milieu can allow the researcher to 'hear' their stories more easily without preconceived notions or prior impressions.*

1.2 Being a Minority, Being Different: "Isolated, put into 'White Man's Soup'"

The experience of being a minority and the impact this had on the onset and management of depression was a feature common to most of the participants- whereby the concept of 'difference' was an emerging theme. Participants discussed experiencing frustration and anger caused by the experience of perceived prejudice and discrimination. For some it seemed that a heightening of stress and other adverse health consequences were a result of internalising these emotions. Similarly, the pressure participants felt under to be 'better' than those around them (both people within their ethnic group and outside of it) contributed to stress and depressive symptomology. Identity conflicts were seen by some participants as responsible for loneliness and isolation. In contrast others felt that having a strong identity could be a protective factor against the possible adverse effects of being a minority.

Madison provided rich accounts regarding the experience of being a minority and how this related to her depression. Madison provided her perception of her depression, saying:

> Madison: *'My depression is internal and I think it's psychological where I hate myself. I hate myself for all the horrible things that I've done. I hate myself for, I've just felt used all my life, yea and I hate being a victim, but I don't wanna be a victim if you get where I'm coming from. So I'm kind of angry, you know' (18, 722-726).*

Madison then went on to discuss the impact of this anger and attempts to seek meaning for this anger and the internalisation of depression, she said:

> Madison: '*I'm really angry, I'm kind of aggressive with people sometimes, you know and within the workforce in the sense that I feel that coming up I felt, I went to school, I did, I got the O Levels, I got a good degree. [ ] So why can't I*

> *progress like other people? I see other people progressing why can't I? [ ] So I look at it and it, the work place I say "oh maybe my colour or whatever" and then I, I start to understand the workplace like ok ok White man, Black man, how people behave and you know all the rest of it. I realise that ok there is a little bit of racism that goes on and for me I think I just come down on it, like I can't take it do you get where I'm coming from. Because of that the people can't deal with me, because I am what you see is what you get kind of thing, do you get me? I'm very assertive, I have to be do you get me? Don't take the f*cking piss with me [ ] because of that I feel that that's hindered me*' (18-19, 728-741).

By the way that Madison talks here she appears to still be holding this anger. Such unresolved anger is linked to a range of health issues including high blood pressure, anxiety and depression (Schum, Jorgensen, Verhaeghen, Sauro & Thibodeau, 2003; Deschênes, Dugas, Fracalanza & Koerner, 2012; Busch, 2009). Historically it was a centrally held belief of psychiatry that depression was a form of internalised anger or anger towards the self (Freud, 1917 as cited in Luutonen, 2007), which may explain Madison's view of depression being '*internal*', as she is internalising her emotions. It is as though, in Madison's view, her ethnicity prevented her from progressing in her career. Madison seems to speak of an ethnic division within the workplace of '*White man, Black man*', leading to perceived racism and lack of progression- an issue which has been raised by BME women in other research (Ekanayake, 2012). Madison wants to be seen for who she is (the suggestion being not just being seen for her skin colour). Assertiveness and taking a stand against workplace racism has been seen as a necessity for Black women in Canada, as there was a sense that without this they would be taken advantage of (Schreiber, Stern & Wilson, 2000). Similarly, it seems that this is what Madison was trying to prevent but it failed as it '*hindered*' her.

There is a suggestion by Madison here that due to her ethnic identity she has to be better and more assertive. This fits with her later saying '*I know I'm a Black woman. I have to be better. I have to do everything perfect, because when I don't you're ready to flag it up*' (36, 1463-1465). Madison seems to be alluding to a feeling of having to strive for perfection so that she is not negatively judged by others. Although such pressures are experienced by many, this is a feeling which has been found to be particularly common among BME women from a range of backgrounds (Abrams, Dorning & Curran, 2009; Ekanayake, 2012; Schreiber, 2000), again highlighting another nuanced difference in the experience of BME women. What is perhaps noteworthy here is Madison's phrase '*you're ready to flag it up*'- this raises the question of who 'you' is and there can be several interpretations of this phrase. It may be in this context that 'you' is those Madison feels she is different from, those who Madison describes earlier as '*White man'*. However, equally this could be me the researcher - Madison seeing me as another professional who may judge her perhaps. However, going back to the data it can be seen that Madison used 'you' many times within her interview when talking about White people; this seemed to be her way of separating herself from those she felt she was different from.

This idea of Black women feeling they need to present differently has been considered in research which explored Black women's views on stress, strength and health. Woods-Giscombé (2010) developed 'Superwoman Schema' based on African American women's descriptions of their perceptions of their roles. The superwoman role was seen to be based on a number of characteristics including; strength, emotion suppression, resistance to vulnerability, determination to succeed and feeling a sense of obligation to help others - all of which were seen to be related to heightened stress. A number of contextual factors contributed to the Superwoman role including; a history of racial and gender stereotyping and oppression, lessons from females of previous generations, personal history of disappointment and mistreatment. Interestingly, an element of this was not accepting help from their often Black male partners, so it could be suggested that these men face a lower burden as the females are the ones taking the load. Along with this there were seen to be both benefits (e.g. preservation of self and survival) and liabilities (e.g. stress-related health behaviours and embodiment of stress) to the Superwoman role. It was concluded that in adopting this role the health of these women was adversely affected, as health was not made a priority. This idea of adopting a specific role has been alluded to in other research with South Asian women, however, was more centred on social norms around their 'place' and specific gender roles. So was seen to be more of an issue for those women experiencing postnatal depression (Ekanayake, 2012; Burr, 2002; Schreiber, 2010). This highlights the importance of first the present study exploring depression rather than postnatal depression (as there seem to be differences in experience) and considering such roles in understanding stress and health among particular groups of BME women, in particular the idea of a specific BME woman 'schema' is a novel area to explore.

Madison went on to describe how the attitude she has adopted in response to this adversity has hindered her and led to frustration:

> Madison: *'So that frustration, I worked for IKEA for four years, I worked for Conran restaurants one of the top restaurant companies [ ]but these people just wouldn't bloody accept me. I was the only Black person there anyway but they just won't accept me. Why, what's you, what's your, you know, why don't you like me, what's your problem? So that frustration and things like, ok, come train this person. I trained that person, that person would get promoted, I don't understand now. I'm thinking, hhmm, do you understand? So that's harbouring and then what made it worse, I came, you know, I worked in the West End for years and then married and then I came, the reason why I moved up this area, a car lost control and crashed into my flat in London so I lost the place and then to cut a long story short I ended up here. Here now, totally isolated, put into White man's soup now, right' (19, 743-756).*

Madison here seems to be questioning, trying to seek a reason for why she was not accepted in the work environment. She continues the previous rhetoric of racial difference and explains she was the '*only Black person*', so suggests that she was not accepted for this reason. Along similar lines, Ekanayake (2012) claimed that the South Asian Canadian women they interviewed felt that racism complicated existing struggles in life such as striving for achievement, showing similarities across BME groups (struggles which it was pointed out our experienced by their non-BME counterparts). The soup Madison talks of here perhaps tells the reader that she feels she is in an environment where she feels 'different'. This provides an explanation for what the experience of being an ethnic minority feels like for Madison, she felt different, surrounded by those who were unlike herself. This difference led to her feeling isolated. When asked how this experience is related to her depression, Madison responded:

> Madison: ‘*Yea, it’s all inside here*’ (19, 763).

This would seem to, once again, pertain to the idea of Madison’s depression being ‘*internal*’ and ‘*psychological*’, part of this is the internalisation of her anger, frustration and feeling hindered due to as she says being ‘*totally isolated, put into White man’s soup*’. This could be a form of ‘minority stress’- the experience of stress in negative or undesirable situations in which an individual’s identification with a social group, which is different from the majority and often stigmatised and the target of discrimination and / or prejudice, is a salient aspect of the person–situation interaction. Although focussed on other minority groups (e.g. Lesbian, Gay, Bi-sexual and Transgender (LGBT) individuals) it was suggested that such individual’s experience heightened levels of stress and thus are at risk for health problems (Meyer, 2003). It could be suggested that the application of this concept to BME groups may help to explain the links between racism, discrimination and poor health. It would seem that, for Madison, heightened emotions and stress generated from feeling discriminated against led to internalisation of emotions and subsequently depression. Banks, Kohn-Wood & Spencer (2006) found that perceived everyday discrimination experienced by African American women was related to both anxiety and a higher incidence of depressive symptoms. This was seen to be related to how they appraised such discrimination (rumination) and if they possessed existing risk factors (lower self-concept). In the case of Madison it would seem that such rumination and issues in her own identity (lowered self-concept) may have led to or at least exacerbated her depressive symptoms. The theme of everyday discrimination is consistent across the literature and often is seen as a backdrop to BME women’s everyday lives. The degree to which this has an impact however, has been found to be dependent on the cultural context and time e.g. this has been said to increase after specific events such as 9/11 (Ekanayake et al., 2012; Burr, 2002; Black et al., 2007). However, conversely for Madison it seems that an accumulation of smaller events had a substantial impact on her.

Similarly to Madison, Nadine discussed the experience of living in a ‘*White world*’:

> Nadine: ‘*…The fact that I haven’t got a family makes me feel like lonely or depressed. Like I think there’s an identity with having no family and having an*

> *Asian culture and an Asian woman that brings that, having to be an independent person, although I mix, I still feel lonely. Because like I said, it takes an effort and a certain part to give to fit in, otherwise people just stick to their own…and, like I said, I don't have an own to stick to. So I'm happy in mixing but I have friends from different cultures and it's been better for me. [ ] but like I said it's not an easy thing that I get naturally because I never lived in a completely White world, with [a] White mind. I had to have an Asian world...' (25, 1013-1019).*

Nadine describes the difficulty of having numerous identities, which do not seem to meet Asian cultural expectations or the expectations of the wider society. Nadine describes a sense of feeling lonely, despite not being alone, a state often described in the experience of depression (Nickel et al., 2006). Lacking a sense of group identification and community can result in depression and loneliness (Jetten et al., 2011), a common experience. Yet Nadine uses a very revealing phrase, which perhaps gives context to her difficulties saying '*I never lived in a completely White world, with [a] White mind*', the suggestion being that she was different and therefore did not fit in. This sense of alienation led to loneliness, depression and a heightened awareness of the perceived gaps in her identity. Such gaps in identity have been said to have an adverse impact on health status, due to their often negative psychological consequences, leading to pressure in attempting to meet group ideals leading to depressive symptomology (Jung & Hecht, 2008).

Anita's experience differed from others as in her view she did not feel that her identity had an impact on her experience of depression:

> Anita: '*I'm European, I'm a Muslim girl, I'm a female. To be honest I see myself, I see myself as being Bosnian, I don't have any kind of problems with that, I never did have any problems with that. I've never experienced any kind of racism or anything like that, so it didn't, I don't think it has any kind of effect on me, [I'm] quite content in the way that I feel in regards to my identity. I don't think it had any kind of effect on the way that, what I was going through and the way that I was feeling… I never I think I never once lost my, you know, sense of identity or who I was*' (15, 606-614).

It would seem that in Anita’s view having a strong identity prevents the possible adverse effects of group membership on health. Schmitt & Branscombe (2002) presented the rejection-identification model of social identity which proposes that identification with a specific group is able to counteract the negative effects of discrimination on health. Other research has extended this and proposed that such shared identification with a stigmatised group provides a basis for giving and benefiting from social support which can bolster an individual’s coping resources and ability to resist discrimination and prejudice (Iyer, Jetten, Tsivrikos, Postmes, & Haslam, 2009). This may explain Anita’s desire to use her group identification (in this case her cultural group) in the future to support others who are facing a similar set of circumstances surrounding depression, she said ‘*I think I’m more determined to get those people out of that frame of thoughts, to help them to think more positive and help them to think, oh you are what you are it doesn’t matter what anyone else says, you shouldn’t be a certain kind of person to fit into the society*’ (22, 881-885), the suggestion being that peer support among those who have a similar group identity can protect against adverse health outcomes.

Self- Reflective Process

This theme is one which required some significant re-reflection on the findings and emergent themes, which led to an alternative interpretation of the data in places. Thus, what follows is a commentary of this reflective process spanning from my original interpretations to the development of the interpretations which are provided here. I was initially hesitant to portray some of this emergent theme and this goes back to my fear of being a minority ethnic researcher, researching ‘minority ethnic issues’. However, this is something which I needed to reflect on and move past so that I was not suppressing experiences of the participants and silencing their voice due to my own conflict. Also it was important that I did not go the other way and begin to see things in the data which were not there - this process took some balancing and a great deal of self-awareness and bracketing. Being from a BME background myself, I had some empathy with the concept of being ‘different’, similar to the account of the participants. I could not empathise with the idea of being put into ‘White man’s soup’, however, as I do not feel I have ever experienced racism or discrimination in the way described by some of the participants.

This left me feeling in a privileged position at times. Reflection enabled me to attend to my own prejudices and judgements - questioning their origin. This entailed a process of working dynamically (sometimes seeking perspectives from others) to construct and then on occasions reconstruct my interpretations.

When talking to Madison for example I initially judged her in a more forthright fashion until I reflected on where this judgement came from. My lack of feeling being put into 'White man's soup' meant that I perceived Madison at times to be aggressive and overly sensitive and that she had perhaps at times judged situations incorrectly - she provoked very strong emotional reactions in me. I was conscious that I had made a number of judgements of Madison which I needed to be mindful of during my interpretation of her account. This in turn meant that I found it difficult to empathise with the situations described and elucidated by her. I even found myself becoming annoyed by the stance she was taking on occasions, caused by my lack of conception of what she had experienced. For example when Madison spoke of not progressing in work I initially interpreted that this was her own doing and nothing to do with her ethnicity. Through a process of assessing my claims, attending to my biases and going back to the data and reviewing her narrative I was able to move past these judgements.

Equally there were elements of their accounts which resonated with me, for example Madison's view of needing to be 'perfect' and 'better' as she is a Black women. This for me is not so much about external influences as it was for her, but pressures I impose on myself, regardless I empathised with how she felt. However, on re-reflecting on what Madison said about this I can see that her statement 'you're ready to flag it up' could be interpreted in a number of ways. Based on her previous rhetoric I felt that this 'you' was the 'White man' she spoke of but this could be a number of different people, even myself as the researcher. However, through a process of revisiting the data I could see that she uses 'you' in this way on many occasions throughout her interview. Similarly on returning to the data I re-interpreted the statement 'isolated, put into White man's soup' and provided an alternative interpretation in light of reviewing the entire dataset. On reflection having taken a step back from this I can see that perhaps what Madison was talking about was a sense of feeling 'different'- the minority. I perhaps initially interpreted this as being in trouble as this is how I judged Madison (aggressive) and perhaps this *influenced my perception of this statement. Equally I re-reflected on Nadine's discussion on 'White world, White mind'- again an emergent theme of difference came to the fore. I could see that Nadine was actively building her identity in our discussion and questioning where she 'fits' – this was not just about culture (although elements were) but about where she also fits in wider society. This led to an overall change in interpretation of this theme, where there was an additional focus on being different, bringing a new element to the existing discussion.*

1.3 Cultural Denial of Mental Health: "There's no such thing as mental health problems"

There is a marked perception, given voice to here, that there is a variance in how different cultures view mental health. Participants discussed a perceived denial and secrecy around mental health issues within their own cultures and, with this, how their culture and background influenced their approach to coping with adversity.

When asked how she feels society views mental health Anita's response captured how, in her view, there is a cultural difference in the perception of mental health:

> *Anita: '…I think culture wise, different cultures see it very differently. A matter of she's mad or he's mad or they belong in a mad house they see it like that which comments like that don't really help people who are feeling, you know, in that kind of frame of mind and the majority of the Bosnian community have suffered some kind of mental health problems; whether it be a mild one or, you know, because of the events that they've suffered in regards to the war' (18, 712-725).*

Anita here attends to the fact that she feels different cultures see mental health in different ways and such socially constructed views have an impact on those who have a mental health condition. The suggestion being that mental health is viewed differently in her culture compared to other groups. Anita relates mental health issues to the experience of war, the conflict in Bosnia to which Anita refers would undoubtedly lead to a plethora of mental health issues in any community. Carballo, Smajkic, Zeric, Dzidowska, Gebre-Medhin & Van Halem (2004) explored the psychological health consequences of loss of place and sense of belonging among displaced and non-displaced individuals from Bosnia and Herzegovina. Among their sample some expressed that this loss was related to feeling a sense of powerlessness and having a lack of control over their own lives, in some cases leading to a higher degree of psychological distress and depression, highlighting the impact of war on health status. Literature therefore supports Anita's assertion that being in the midst of such conflict can lead to mental health issues. This sheds further light on the influence of historical circumstances and specific events which BME (men and women) have faced, such as war and displacement, which have been found to have an impact long after the event (Black et al., 2007)

When asked specifically how she thinks her own culture/the Bosnian community views depression Anita responded:

> Anita: *'They don't talk about it, "there there's no such thing as mental health problems", "you don't have a mental health problem". [ ] I think the mental health problem that they would see as a problem is someone who's gone to a mental health institute or has been admitted. That's the kind of problem and to them that's someone who's already mad or crazy and that's how they see it but otherwise there's no such thing as, you know, mild depression or feeling down or, you know, being sad and stuff like that. It doesn't exist ((laughing))' (18, 727-733).*

The denial of mental health problems which Anita feels is prevalent in her own culture marries with research that links denial and secrecy to how people approach and talk about mental health and the language they use. Research exploring Nigerian women in America's views of depression found that this denial and secrecy was driven by a lack of language around depression, which led women to deny this even applied to them. Subsequently it was not spoken about as words like 'depression' (which were adopted in the US) were seen to be belittling (Ezeobele, Malecha, Landrum & Symes, 2010), which is consistent with Anita's account. This links to Anita's point that the only time mental health issues would be recognised in her culture is if someone '*has been admitted*' or they are '*already mad*'. Put simply, it seems to be Anita's view that '*mild*' mental health issues are seen to be nonexistent within her culture. Although it is recognised that denial and secrecy around mental health is common in many groups, it seems that culture and language had an additional impact.

After a discussion about the treatment of mental health in Sierra Leone (where Madison is from), the researcher asked Madison her opinion of how perceptions of mental health in her home country differ from that in the UK. Similarly, to Anita's account she cited a lack of understanding, responding:

> *Madison: 'Definitely no understanding' (31, 1227).*

Here, Madison alludes to a lack of understanding of mental health issues among those from her home country. Such lack of understanding can filter to those BME women who then move to a host country such as the UK, leading to an inability to recognise what is wrong when symptoms of depression appear and a lack of understanding of what they have been 'labelled' with by a health professional (Templeton, Velleman, Persaud & Milner, 2003). This was the case for Madison who went on to talk about her search for meaning of her depression and a desire to increase her understanding '*I can tell you that I have depression because I've studied it…what I've been diagnosed with and what my doctor and my psychiatrist has said is, it's you know, it's depression'* (31, 1227-1237). This perhaps highlights how seeing depression in a different social context can provide the opportunity to change or alter perceptions – so an opportunity for BME individual to change their knowledge/awareness of conditions such as depression.

In contrast to others Nadine highlighted a shift in her culture in terms of how problems are dealt with and recognition that adversity can lead to mental health issues:

> Nadine: *'Yea that you're supposed to be a certain way, like I said, I did like the centre at first cause there were some quite stuffy Asian older women, like I said, the new generation understand problems, like I said, I'm getting more comfortable with Asian girls than I've ever been because underneath it it's not hidden and there are more issues…' (24, 978-982).*

Nadine makes a distinction here between old and new generation Asians and their views on dealing with problems. Suggesting that there has been a cultural shift, perhaps a sort of cultural diffusion (Bodziany, 2008) which has led to a difference in levels of acculturation (Ying & Han, 2007), or in perhaps levels of 'openness' within her culture. Thus, there seems to have been a change in cultural context over time. Nadine is seemingly seeking meaning and understanding for a shift in her own levels of comfort in opening up about issues. Nadine suggests that there has been a change in the level of rigidity of boundaries associated with her culture (Asian communities) which has meant they are now more open about health issues such as depression. Conversely, however contextualising this view, it is not clear whether this applies to Asian men and how open they may be about such issues (Burr & Chapman, 2004). Nadine goes on to provide an explanation for why her culture has become more open:

> Nadine: *'…now we talk about it and then we deal with it, we support rather than go mad and crazy' (25, 991-994).*

It would seem from what Nadine says here that in her view her culture has become far more open towards discussing issues. It is as though being more open is used as a coping strategy in order to manage issues and prevent subsequent adverse health consequences. Coping in regards to health management is focussed on an individual's ability to manage a perceived discrepancy between demands and resources in managing an event perceived as stressful (Lazarus & Folkman, 1984). Aldwin (2004) discussed the relationships between culture, stress and coping and posits that culture can impact on the choice of coping strategies used in any given situation and thus can impact on an individual's appraisal of stressful events. It would seem that according to Nadine her culture are now more likely to adopt an emotion-focussed coping strategy (talking about the problem) as opposed to an avoidance coping strategy (hiding the problem) (Lazarus & Folkman, 1988). This fits with the assertion of Antonovsky (1979) that when such coping strategies are routinized, internalized and institutionalized, culture can be one avenue which provides this. Current literature seems to validate the view that if the context around such routinized strategies shifts (to take on a more 'western' approach), this can lead to BME women being more likely to 'talk it out' with someone they trust in the community (suggesting that there is more of an openness in non-BME groups) (Abrams et al., 2009), which seems to be the case for Nadine here.

Self-Reflective Process

As already mentioned, being a BME woman myself allowed me a unique insight into the experiences of the participants which sometimes had positive results for my analysis but always meant I had to carefully reflect on how my own experiences and biases may have influenced my interpretations. My own preconceptions of the perceptions of mental health conditions among BME communities stems from both a professional and a personal grounding. In terms of my professional knowledge I work and have always worked within mental health services in the UK. Over the last two decades we have seen significant changes in mental health services in the UK including the removal of traditional institutions. This along with other changes has led to far less stigma of mental health issues in the UK and far more openness in talking about conditions. This means that my own conception of mental health stigma has been influenced by this social, historical and cultural context. So although my professional life allows me to see the negative impact of stigma on individuals with mental health conditions, there have been substantial beneficial changes and attitudes are changing.

I have found it interesting to reflect that although in my professional life there is a noted divergence between my own experience and that of participants, there seemed to be more of a convergence when my personal background was considered. Mental health conditions have long had a stigma attached to them in Black Caribbean communities, this is primarily due to a lack of understanding and fear of such conditions. However, during the time of my research, a member of my local community committed suicide. There was a discernible change of attitude that took place as people started to talk more about mental health conditions and began to recognise that anyone can experience a mental health condition. I therefore had a new perspective which needed to be attended to in the reflexive process. This almost certainly led me to begin to have a better understanding of and openness towards Nadine's experience for example, and her discussion of the shift that was starting to happen in Asian communities towards mental health and openness in talking about problems.

A major element of re-reflection that I have undertaken is around the use of the language that both the participants and I have used here. I have reflected on the centrality of language and its impact on the researcher and the participant. In my original analysis, for example, I wrote in relation to Anita's experience that stigma had 'worsen[ed] the suffering of those with mental health issues'. I would not use this type of language usually and it occurred to me that maybe I used the words as Anita had used 'suffered'. I found it interesting to reflect that the language of the participant can impact on the researcher in this way and this in fact prompted me to re-reflect on my interpretation of the data and I could see that in fact what Anita was talking about here was the experience of conflict having an impact on mental health. Anita was not then talking explicitly about stigma per se, but was making a point about how mental health is discussed in Bosnian communities compared to other communities. I can now see that to some extent I was trying to use concepts which made sense to me within my own frame of reference, instead of fully focusing on the words of Anita.

Theme Summary

This theme's primary focus was identity and health. All of the participants discussed their own unique struggle with identity, whether from a cultural or a personal perspective and the impact this had on their health. The collision of the concept of culture and trying to hold onto one's own identity was seemingly one of the main causes of their depression or at least contributed to aggravating their experience. There were a range of reported factors which impacted on their levels of stress and subsequently their experience of depression which seem to be specific to BME groups, including (but not exclusively), enculturation, acculturative stress, intergenerational conflict and identity gaps, which were seen to lead to feelings of stress, anger, isolation and loneliness. There was a consideration of the relationship between health, stress and coping (salutogenesis), in particular the impact of a lack emotional closeness on health status (Sagy & Antonovsky, 2000). There was also a discussion on the coping strategies used by participants in view of their cultural framework and the relationship between resilience and health. The coping strategies adopted seemingly had an impact on appraisal and response to stressors and thus the impact of stressors on their health and experience of depression for the participants.

Participants discussed their experience of being an ethnic minority and some of the pressures associated with this. It would seem that the perceived experience of prejudice and discrimination led to heightened emotions and ‘minority stress’ (Meyer, 2003). Some participants felt pressured to meet identity ideals, whether due to expectations from their own culture or wider society – highlighting a ‘double pressure’ experienced by BME women. This led to participants feeling ‘different’ and internalising or carrying the emotions associated with this, leading to increased stress and subsequently adverse physical and psychological health consequences. That said it was also noted how having a strong identity could protect against some of these adverse consequences. Finally, participants discussed how views on mental health differed among different cultures. For some it was portrayed as though, within their culture, there is a denial and secrecy of mental health issues which to some degree had an impact on their perceptions of such issues, response to their own depressive symptomology and approach to coping with stressors. Although not pertinent to all participants it was seen that more recently there has been a shift in the perceived appropriate coping strategies used to manage stressors. It seems, from the accounts of the participants, that identity, culture and health are intrinsically linked. Identity is thus a key determinant of health issues such as depression in BME women and there are a number of mechanisms through which this relationship is formed.

2. THE NATURE OF DEPRESSION: AGENCY, FAÇADES AND COPING

Overview

This theme considers perceptions of the nature of depression, focusing on what it felt like to be depressed for the participants. Depression was perceived to have agency, a sense of momentum and drive. There was a discernible sense among the participants of a loss of control, to which they described their reactions. Participants described the mixed emotions experienced during bouts of depression and how these led to heightened levels of stress which, in turn, often led to a range of physical symptoms. There was discussion around the medicalisation of depression, whereby participants discussed their own perceptions of the nature and causes of depression as well as those of health professionals. The disparities in these perceptions were seen to be a contributory factor to breakdowns in communication with health professionals and misdiagnosis. The difficulties around the stress of managing somatic complaints and the impact on their health status were a recurring theme of discussion. Participants reported presenting with a façade in order to hide or mask depression. Such façades were seemingly a form of (often culturally sanctioned) coping - a way to show resilience and present as strong in the face of adversity (ill health). However, these coping strategies were seen to have both positive and negative effects on health status. Participants also discussed their experience of taking antidepressants and how often these did not meet their expectations. It would seem that the often negative experiences of taking antidepressants impacted on the levels of adherence participants gave to their antidepressants, thus impacting on their health status and recovery.

2.1 Depression Has Agency: “Once it gets going and you just allow it to carry on”

A loss of sense of agency (control/capacity to act) is common in the experience of depression among all individuals (Shepherd, Boardman & Burns, 2010). The loss of control described by participants in this study seemed to lead to a sense of agency-related impairment (lack of capacity to act), passivity and in some cases physical exhaustion. Participants captured the complexity of the experience of depression alluding to the mixed emotions often associated with the condition. The prolonged stress associated with this loss of agency and the mixed emotions associated with depression was described by some participants as being a strain on their physical health.

This idea of depression having agency was alluded to by Anita when she first discusses her experience of depression:

> Anita: *'…it just makes you feel like you're alone, you don't have anyone, you've got no-one to talk to, no-one understands you. Sometimes it gets to a point where you don't wanna be here anymore, to be honest and I didn't know anything about why I was feeling like that, what it was, or what the symptoms were of depression…' (1, 9-13)*

Depression led Anita to feel alone, as though depression left Anita feeling in an incapacitated state, unable to interact with the world around her or connect with others in her world. This is synonymous with the fact that women with depression often come to feel removed, detached and alienated from others and feel that they lack other's understanding (Scattolon, 2003; Rice, Grealy, Javaid & Millan Serrano, 2011).

At the time of her depression Anita described feeling a loss of control:

> Anita: '…*things weren't good and it just, you just felt that it all spirals out of control and you just you don't know how to bring it all together. I think that was the, they were the main factors that affected me and then once it gets going and you just allow it to carry on it just gets worse and worse*' (1, 35-38)

Anita describes a gradual loss of control, a continual spiral. Depression has been described as a downward spiral - self-perpetuating damaging cycles which are triggered by negative emotions. An example of this spiral is provided by Garland, Frederickson, Kring, Johnson, Meyer & Penn (2010) who explain how sadness stemming from loss tends to co-occur with rumination on that loss coupled with behavioural withdrawal and fatigue and these components can interact dynamically to produce subsequent sad feelings, leading to further rumination, withdrawal and fatigue. This description of emotional spiralling illuminates Anita's description of how things began to spiral out of control. Such emotional spirals have been linked to an individual’s health experience, whereby rumination and prolonged negative emotions can have a significant impact on health (Brosschot, Gerin, & Thayer, 2006).

Anita goes on to explain more about this spiral and alludes to depression’s agency. She explains ‘*once it gets going and you allow it to carry on*’, as though this spiral or, in this case, depressions antecedents have their own momentum. Rather than intervene in this spiral it would seem that Anita allowed this momentum to continue, which could be seen as a passive reaction or, as has been found among other BME women, internalising misery due to a lack of engagement with thoughts and feelings (Wittkowski, Zumla, Glendenning & Fox, 2011). On the other hand, other phenomenological research posits that passivity can actually be seen as an active response to the experience of depression in women (BME and non-BME) rather than a lack of agency, a form of protecting oneself from what cannot be endured nor escaped by turning away from the world. However, such a response to depression was found to lead to some women experiencing other health issues such as anxiety, insomnia, feelings of sickness, fatigue and sleep deprivation (Røseth, Binder & Malt, 2013). Such was the experience for Anita who explained ‘*I had a lot of anxiety and a lot of anxiety and stress, I used to feel sick*’ (3, 103-104).

Ria provided some particularly rich descriptions of what depression felt like for her:

> Ria: *‘…all I can describe, an awful black hole a few days went by and I just felt this awful black hole just literally, almost like a tornado, just trying to take me over and whirl, whirl, whirling, whirling around and if I’d thought I had depression bits and pieces prior, this was nothing compared to what I actually went through and it was just an awful, awful experience…’ (2, 64-69)*

Ria describes depression as ‘*an awful black hole*’. The term ‘black hole’ would seem to connote disappearing, vanishing, or a void. This hole suggests a sense of stillness and being in darkness. This idea of depression being like a pit or a hole is one of the most common metaphors used in depression (Emslie, Ridge, Ziebland & Hunt, 2006). Such metaphors help individuals to better express their experience of themselves and their world (Lakoff & Johnson, 1980). According to Jackson (1986) there are three main types of metaphors used by those with experience of depression; (1) ‘being in the state of darkness’; (2) ‘being weighted down and (3) ‘being slowed down’. This explanation fits with the metaphors provided by the women interviewed, as well as by Ria. These images would seem to echo the assertion of Steen (2007, pg.19) that the term ‘depression’ itself is a metaphor: the Latin *deprimere* meaning ‘to press down’ and this more literal sense is found in the meaning ‘ground that has sunk into a hollow’, an image that would seem to sit alongside that of Ria’s ‘*black hole*’ recollection. However, in contrast Ria then describes depression as a tornado, an image suggesting continual movement rather than statis, a type of chaos. These contrasting visual and dramatic descriptions of depression perhaps pertain to the often mixed emotions experienced in depression. Although depression is a collection of psychological and physical symptoms, a profound change in mood and emotions is its most characteristic feature (Rottenberg, 2005).

Later in her interview when asked to elaborate a bit more about this ‘*awful black hole*’ Ria explained:

> Ria: ‘*you literally feel like you’re about to die… your head’s about to explode you’re in a… I mean you’re in a… I felt like I was on ariverbank, swimming and it’s just like someone’s pulling me under under under like an undercurrent and your head just starts spinning… it just starts spinning and you just feel like you’re not gonna make it… something is pulling you under and keeping you under. That’s what it, that’s what it feels like’ (5, 186-194).*

Ria here describes a dark horrific scene. Ria describes a feeling of being pulled under, head spinning, feeling like she is not going to make it and seemingly being in imminent danger of drowning. This water based analogy captures the central features of what depression feels like to her. Drowning itself is can be quick and silent. It is, however, often preceded by visible distress and panic. A river can be shallow but fast flowing and would have the ability to sweep you away violently and at great speed. This drowning or battling with external elements could be both mentally and physically exhausting. Essentially, it would seem from her description here that for Ria, depression feels like a complete loss of control and being unable to seek help. Although such loss of control is felt by many people with depression, it has been found that for other Black women this loss of control has been highlighted as not only a result of depression but as a precursor to depression. Whereby, due to their cultural schema and desire for control, when this control is lost it was seen to cause psychological distress (Edge & Rogers, 2005).

Self-Reflective Process

I naturally gravitated towards the narratives of participants in this theme as it was emerging and saw a number of 'gems' in these accounts (Smith, 2011). This led me initially down a path of being emotionally drawn in, relating to these accounts in a different way and thus being creative and abstract in my interpretation - slowly moving further and further away from their narratives. Considering Ria's 'black hole' recollection as in example, throughout the analysis process this statement begun to hold increasing meaning for me and stirred a range of emotions. During the process of conducting this research I had my own lived experience of depression. I therefore begun to find it difficult to not get drawn into their narratives too deeply and to ensure I heard what they were telling me. It was undoubtedly due to this, to some extent, that my first interpretations were far more abstract, for this reason I also needed to go back to the literature and reflect on the use of IPA and remind myself of its central tenets. Some of the narratives had quite a powerful impact on me brought up moments of realisation perhaps and in the initial stages of interpretation I did not recognise that I needed to take a step back. My own experience of depression meant that I, as a researcher, moved from the position of an 'outsider' to the position of an 'insider' to some extent. I found it difficult at this time to separate out myself and my emotional responses and thus took a step back from the research process in order to attend to and partially bracket my own emotions and newly developed preconceptions.

This later led me to re-analyse some of the data from a distance. In some ways I needed to construct, deconstruct and then reconstruct the participant's accounts in order to disentangle my own standpoint and view their accounts afresh. It was when I became less of an 'insider'; through a process of self-reflection, that I was able to better ground my analysis in the words of the participants. This process supported in better understanding their life-world. This entailed a process of staying close to the data and also using peer-review, which supported in challenging some of my assumptions and connectedness to the *data. The result of this was that I picked up on some elements that I had not previously e.g. this loss of agency/control and thus the emergent theme developed into the interpretation which is presented here.*

Further to this, I have since conducted a further process of re-reflection and recognised that there were elements within this theme that perhaps I explored based on my own conceptions and thus this has been re-analysed and altered interpretations given having now gone back to the data. When the participants described depression as 'it' for example, I saw this as participants detaching themselves from their depression. However, in re-visiting the data I can see that there could be quite different interpretations of the use of the word 'it, e.g. it could have been life or just a word used instead of depression. However, due to my own experience I may have interpreted it in this way due to my own 'self-imposed detachment'. Similarly, I described Ria's account as a 'dark horrific scene' and although this is my interpretation the element of horror perhaps came from my own perceptions, even if they did seem to fit what she was saying. On reflection this perhaps also related to or started with my rapport with Ria.

My perception of Ria was quite dark in that her emotions seemed to emanate from her, and her interview was quite emotionally draining. On reflection I should have attended to these emotions sooner as they clearly had an impact on my interpretations. This was something I needed to move beyond in order to see this gem afresh. Another point to make here is the benefits of not just the use of distance and time to let emotive responses subside, but the use of seeking other perspectives (Shaw, 2010) can be useful in developing our interpretations. For example the core thread of this theme 'loss of capacity to act' (agency) was to some extent co-constructed with peer reviewers, a process which supported in developing my interpretation.

2.2 Emotional Feelings Presenting as Physical Symptoms

This theme is focussed on symptom presentation and captures descriptions of the nature and manifestation of depression as experienced by the participants. They reported many physical symptoms of depression including; stomach problems, tiredness, nausea and vomiting, lack of appetite and sleeping problems. The experience of physical symptoms impacted on their help-seeking behaviours, as well as the diagnosis and management of their depression. Participants made comparisons between managing the psychological and physical symptoms of depression and discussed the complexity of managing a condition with such a disparate mix of symptomology.

The diagnosis of depression is ‘polythetic’ in that it requires multiple criteria which include physical symptoms as well as emotional (Sadler, 2005). This relationship is complex however and often physical symptoms of depression are attributed to other conditions. Such was the experience for Anita. Anita had particularly negative experiences of physical complaints, going to her doctor on several occasions with symptoms such as stomach pain, nausea and an inability to sleep, for which she was initially given a ‘medical’ diagnosis. When asked if she ever spoke to her doctor prior to receiving her depression diagnosis about why *she* felt was getting these physical symptoms Anita responded:

> Anita: ‘*I use to have problems with my stomach so much that they sent me twice, yea twice, for gastroscopies to find out what was wrong with me. There was absolutely nothing wrong with me internally and they use to just give me, pump me full of drugs this and antibiotics this and antibiotics that “oh this is gonna help you, this is gonna help you”. But nothing helped and I think I used to say this to my doctor, “this is how I feel when I get upset or angry”. I still get that feeling, it’s like a thumping feeling in your stomach and it makes you feel sick straight away, but it never really registered I think it was just “oh let me test your stomach you’ve got, you know, irritable bowel syndrome that’s all it is” blah blah blah but what’s causing it he never, he never looked into that’ (7-8, 285-295)*

Anita seems to be making distinctions between internal and external. Anita describes the physical (external) manifestations of depression as though they were a reaction to her emotional feelings (internal). She alludes to the type of relationship she had with health professionals elusively describing them as ‘*they*’ (*she uses this phrasing on a number of occasions throughout her interviews and sounded very dismissive*), as though dehumanising them. There seemed to be some confusion or gap in communication with her doctor - her doctor taking a medical stance, whilst Anita was trying to get across that this was an emotional issue. Despite long standing suggestions that GP consultations should be a ‘meeting between experts’ where there needs to be some consensus (Tuckett, Boulton, Olsen & Williams, 1985), this does not seem to have been the case for Anita. The complexity of the relationship between patient and GP may help to explain why in Anita’s case it took some time for her to receive a diagnosis of depression. Although such complexities can occur within any doctor-patient interaction, research has posited that such complexities are exacerbated for women from a range ethnic minority groups. A range of contextual issues such as perceptions of depression, perceptions of the role of GPs, fear of being seen as ‘moaning’ and feeling uncomfortable or misunderstood were seen to have an impact on this relationship. Such issues were seen as deriving from cultural or religious viewpoints (Burr, 2002; Wittkowski et al., 2011; Hussain & Cochrane, 2002; Ward, Mengesha & Issa, 2014). For example, in research exploring the experience of depression in South Asian women in the UK it was reported that often they felt unable to talk to a doctor about ‘psychological’ issues as they did not see them as legitimate. It is not that they did not want to tell their doctor; just communicating this was seen as a difficulty (Burr, 2002).

Research supports this division and suggests that GPs tend to adopt a more medical model of depression much like Anita’s GP. Although focussed on a general population, Ogden et al. (1999) explored the beliefs around depression among GPs and patients, considering aspects such as; symptoms, causes and treatment. It was found that there was a lack of agreement between GPs and patients on the nature and labelling of depression. Often if a patient presented with only physical symptoms, then a diagnosis of depression would be seen as unacceptable by a GP due to them adopting a more medical perspective. Such an attitude may explain why Anita was sent for physical tests before other avenues were explored. This fits with research which posits that most individuals with depression are assessed and treated in primary care settings and often present with somatic symptoms. This has been found to lead to unnecessary tests to attempt to get a diagnosis and has therefore led, in some cases, to incorrect treatment (Thomas & Brantley, 2004). It would seem from Anita’s account that her GP was unsure about the issue she was facing and thus tried a range of treatment options. Anita seems frustrated that they never looked into the 'cause'- seemingly this cause was psychological and her GP missed these signs.

Anita goes on to describe how she gets '*a thumping feeling*' in her stomach, as though when she experiences strong emotions such as anger her body evokes an internal physical attack on itself leading to a physical reaction or sensation. Danielsson & Johansson (2005) conducted a gender analysis of expressions of depression and found the most common 'bodily expressions' of depression for women were focused on the stomach, with mention of stomach pain and something being within the stomach. This type of illness narrative brings to mind the mixed physical and psychological manifestations of depression. Anita's descriptions could also have been a form of somatization. Within health research the term 'somatization' has been used to describe medically unexplained symptoms of various domains (Klengel et al., 2011) and has been found to be particularly common in those with depression. Typical complaints cited in the literature include fatigue, weakness, tiredness, headaches, constipation, pains or heart complaints (Vaccarino, Sills, Evans & Kalali, 2008). Such presentation will inevitably affect assessment and diagnosis of depressive disorders as was the case for Anita. Such somatization or the expression of somatic complaints is common in those with depression from all backgrounds, but is particularly common among ethnic minorities (Klengel et al., 2011; Bhugra & Mastrogianni, 2004). Ezeobele et al. (2014) in their research exploring the experience of depression among Nigerian born women in America found that somatic complaints were seen as more acceptable and emotional complaints were seen as an embarrassment. This fits with Anita's experience when she recognised that what she was experiencing may be depression *'I felt embarrassed, I was like oh god I fit into that, I related to it and I felt a little bit embarrassed and I just put my head down'* (9, 335-337).

Kay had a similar experience to Anita, when asked about her experience of depression she explained:

> Kay: '*I feel always the life, the struggle I was always feeling tired and nobody could explain why the tiredness. So when I, when I went to the GP he did the thyroxin and then it was low so I started taking thyroxin and the tiredness and you don't know which one is which' (3-4, 118-121)*

Kay here depicts depression as both a psychological and physical demand, which by others has been described as “the black struggle” (1990, pg.83). Kay’s description is consistent with other phenomenological research which focussed on the experience of depression in older women. This research found that the struggle of everyday life was a common theme among these women, whereby even the simplest of tasks took on momentous proportions (Allan & Dixon, 2009). Such descriptions of depression highlight the feelings of constraint associated with depression and in Kay’s case, the impact of this struggle on the body. Similarly to Anita, Kay’s somatic symptoms were seen by a health professional to have a solely physical cause. Kay herself seemed to be finding it hard to distinguish between the physical feeling of tiredness which, according to her diagnosis, had a physical cause and what she describes as ‘*life the struggle*’. Thus it could be that Kay was finding it difficult to distinguish between depression and her physical condition. There was a perception that both her physical and emotional strength was affected, which for other BME older women has been found to be down to life struggles grounded in their personal and communal history (Black et al., 2007).

Nadine’s experience of physical symptoms was quite different from other participants. Nadine focuses on the fact that after being diagnosed she experienced a range of physical health issues:

> *Nadine: ‘…depression, it causes a lot of stress but I had like bladder and thrush and all those women stuff and they said it’s all linked because every time I got stressed I got all those things on and off. It’s horrible, you know, to deal with that side of things, it’s embarrassing, you know, to deal with all that privately and you’re trying to get on with life, so I think I’ve had to learn not to get stressed because then all those physical stuff come in and, yea, I got migraines and I lost appetite so it’s not easy having all those things’ (27, 1095-1101).*

Nadine here makes a link between depression, stress and the onset of physical symptoms. From a health professional’s point of view it may be felt that an individual has recovered from depression if they are no longer showing signs of emotional distress. However, as was the case for Nadine, beyond managing the emotional symptoms of depression, an individual may have to manage a range of physical complaints, which may continue beyond abated emotional symptoms (Trividi, 2004). Another way to look at Nadine's description of managing the physical symptoms of depression is that she may have been experiencing physical health issues which she would have to deal with anyway. Her depression, however, made this more difficult. Research supports the notion that depression can aggravate physical illness in women and their perception of these physical conditions (Melville, Delaney, Newton & Katon, 2005). Conversely, for other BME women such physical health problems can be seen as beneficial in the experience of depression as due to 'physical' illness being a valid reason to access healthcare (in comparison to psychological health) they would be more likely to get help and support (Hussain & Cochrane, 2002).

In Nadine's case however, it seems the stress she experienced exacerbated the physical symptoms of depression, which are what she found most difficult to manage:

> Nadine: *'It didn't help, it got me more frustrated and angry because I think if I don't have the physical problems I can just concentrate on mental and I can just hide away and you can sleep it off. But when you've got physical you have to go to the doctor, get your tablets, you have to go to the toilet, all those horrible physical things and when you're depressed you don't wanna do any physical action but you have to take action when you get physical problems' (28, 1105-1111).*

Nadine here seems to be alluding to her desire to distance herself from the lived experience of depression. However, due to experiencing physical symptoms for which she had to get professional healthcare, she was forced to face her depression. It is as though for Nadine the physical nature of depression forced her into action, which led to frustration and anger- similar to Anita's experience above. Perhaps the opposite outcome to what has been found for other BME women (Hussain & Cochrane, 2002). Nadine goes on to reiterate her frustration around having to deal with her physical symptoms:

> Nadine: *'Yea, but it got me more frustrated because I felt more weak and powerless because then you can't, because then I can't even go out, but I can't just sit at home because I'm in pain as well' (28, 1124-1126).*

Nadine suggests a feeling of lacking energy and control due to the nature of this experience which left her incapacitated and lacking energy/power. That said other research has highlighted that just the experience of pain and physical health issues along with the experience of depression can lead to feelings of powerlessness (Miller, 2000; Turner et al., 2004).

However, not all participants' discussion of the physical representations of depression were focussed on somatisation/ physical complaints. Madison used a powerful metaphor about emesis to describe what depression feels like for her:

> *Madison: '…all these thoughts are going round and round and round and round in my head, I need to vomit…' (19, 766-768).*

This desire to vomit could represent Madison's desire to let go and rid herself of the negative thoughts going round in a loop in her head, a means to violently take these thoughts away from her internal being, perhaps highlighting the burden they are having on her body. Charteris-Black (2012) conducted a research study where they looked at the use of metaphors in depression and proposed a 'containment' model for depression. This model proposes that the negative feelings of depression are contained within the self, leading to a desire to rid the self or the 'container' of these negative emotions. Unlike the descriptions of others this is not directly somatisation, it does help, however, to illuminate the meaning of this theme. For the participants depression could manifest itself in a number of physical reactions whether these were actual existing physical symptoms or descriptions which convey the way it feels to be depressed.

Self-Reflective Process

The connection between the physical and psychological is of particular interest to me as a Trainee Health Psychologist. I had my own preconceived ideas about the ways in which *depression manifests. The connections between physical and psychological seemed obvious to me as I have a very holistic approach to health. Thus I needed to separate this out and explore what was different or the same about the experience for the women interviewed.*

Relationships with health professionals were an underlying theme within this sub-theme. I have a professional interest around the area of doctor-patient communication in that I feel there can be a lot of improvements made on the side of health professionals in order to improve these exchanges and 'patient' outcomes. I therefore needed to be conscious of not seeing things in the data that were not there. I needed to move beyond my investment in particular research outcomes, as influenced by my own experiences and the existing literature. An example of bias around my interests in this coming into my analysis is when exploring Anita's account of visiting her GP. I have since re-reflected on my initial interpretation here; where I previously assumed that Anita's doctor felt uncomfortable in broaching the subject of depression, but it could well have been a lack of understanding or just missing the signs. As a professional in the field I also felt frustrated by the experiences participants had had, and extremely disappointed as well. On reflection this initially came through in my interpretation. I questioned whether I was taking this interpretation too far due to this bias. This came through in my discussion with Anita and the analysis later. However, I reflected that I was picking up on her frustrations and disappointments at feeling let down by a health professional and seeing these reflected in my own emotions and thus these rightly, I feel, influenced my interpretations.

Having gone back to the data and re-reflected on the findings I also came to a different interpretation of the essence of this theme. I reflected back on a conversation with a reviewer whereby the concept of the 'embodied nature of depression' came to the fore. On reflection I feel that perhaps I was unduly influenced by this reviewer to include the concept of 'embodiment' – one which on reflection I did not fully understand and do not feel fits my interpretation of the accounts given and the central tenet of this theme. This was evident in my use of the term (or lack thereof) in the development and write-up. Thus this concept has been omitted and the theme now more truly reflects my interpretations of the meaning-making of the participants. Something I reflected on during this process was how the nature of experience is constructed – this is very much an interactional *process and the introduction of new voices/interpretations can substantially alter the narrative- a process which requires careful attention and, from an IPA researcher's perspective, reflexivity.*

2.3 "Putting sort of a smoke screen over it"

This theme is focussed on descriptions of reactions to depression and how some participants dealt with their experience. Instead of acknowledging depression participants made attempts to present themselves differently externally from how they felt internally. Such façades served to hide their true feelings and protect them from the implications of what could be called negative events in their lives, or the experience of depression itself. However, some participants found this façade difficult to maintain which led to stress and diminished health status. There was a significant focus on the relationship between coping, stress and depression whereby participants discussed the range of coping strategies used in order to manage their depression including; perfectionism and developing resilience. Such coping strategies often had an impact on their health status, help-seeking behaviours and relationships with health professionals.

Ria spoke about how she tried to take the focus away from her depression by keeping herself busy:

> Ria: *'Initially, when I did the counselling I wasn't that bad because when I talked things out with the counsellor I was thinking, "why am I even here, I'm absolutely fine… I don't need to have… I don't need to be counselled" …walked away feeling... thinking things were ok and I think part of it as well and I am aware that I do this a lot as well, is just keeping myself busy so I don't have to think about or worry or focus about my mental health, actually it's sort of like almost like putting sort of a smoke screen over it' (10-11, 405-412).*

Ria here seems to be denying her depression or at least the extent of her need for support. She explains that for her keeping busy was like '*putting sort of a smoke screen over it*', giving her something to hide behind, using a distraction technique. A smoke screen conveys the idea of attempting to disguise and distort something, rather than covering it completely, it is an attempt to hide what is really going on. Therefore, there is an element of Ria using keeping herself busy to hide from her depression, giving herself a different focus or trying to disguise what was really happening in her life.

Keeping busy to deal with stressors and health issues is a common coping strategy. Yet for BME women such an approach can be seen as a means to 'get back on track' and back to a place of strength (Black et al., 2007). The approach used by Ria seems to fit with the escape - avoidance and self-control strategies of coping (Folkman & Lazarus, 1988), whereby she uses keeping busy as a way to avoid her depression and attempts to modulate her feelings. This is not an issue faced by just BME women of course, Scattolon & Stoppard (1999) explored women's experiences of depression, a number of women from the study asserted that they adopted coping strategies such as keeping busy and keeping up with demands and responsibilities in order to cope with the symptoms of distress associated with depression. It can be argued that trying to keep up with one's demands serves to take the focus away from the distress associated with depression. This type of coping has been found to have an impact on women's help-seeking behaviours e.g. not seeking professional help and instead adopting strategies which made sense to them in the context of their social worlds; it would seem that this was the case for Ria.

Nadine described this disguise in quite a different way:

> Nadine: *'…I showed as more the joker, the perfect, tried to make friends but I lived that lie. [ ] the more you live that fake lie the more it comes and it and I wasn't progressing. Everything was going wrong at work with people and I wasn't progressing by living in the denial, because underneath I had a weakness I think of not being strong and it all just went downhill'* (16, 629-634).

Nadine describes presenting herself differently to the outside world from how she felt internally. Externally Nadine tried to present with perfection and humour, in contrast internally she felt she had a weakness of not being able to show strength. The idea of trying to present herself with a '*perfect life*' or façade was brought up by Nadine on a number of occasions throughout her interview where she made comments such as '*I* *wanna be perfect I think it's like a survival thing*' (14, 568-569), as though perfectionism can protect against depression which adds further knowledge to the idea of BME women wanting to show integrity (Abrams et al., 2009).

An increasing body of research has looked at the link between perfectionism and health in a range of groups, often considering the stress pathway whereby personality traits may affect the exposure and reactivity to stress (Segerstrom & Smith, 2006). Perfectionism is characterised by a tendency to set and strive towards excessively high standards and to make overly-critical self-evaluations (Frost, Marten, Lahart & Rosenblate, 1990). In Nadine's case this stress was associated with the feeling of things not progressing in her life. For BME women in a range of contexts this feeling of not progressing or reaching particular standards has been found to have a wide range of impacts; including feeling a burden due to trying to achieve a better life but feeling this hasn't been attained and seeing attaining certain standards as a survival mechanism required due to the impact of perceived oppression (Black et al., 2007; Hussain & Cochrane, 2002). The idea of viewing reaching particular standards as a survival mechanism was brought to light in research exploring South Asian women's experiences of depression. It was found that second generation women felt they needed to reach appropriate standards both within their community and the host community, which led to living in continual conflict (Hussain & Cochrane, 2002). Fry & Debats (2009) found there to be a range of long-term consequences of perfectionism (and fear of rejection) on health including; higher mortality rates and heightened risk for psychological distress, specifically depression (Fry & Debats, 20009; Flett, Besser & Hewitt, 2014). However, conversely fitting with what perhaps was the expectation for Nadine, perfectionism has also been found to act as a health protective factor. Whereby traits such as conscientiousness have been found to be health 'enabling' and self-orientated perfectionism being linked to positive health behaviours and a reduced risk of mortality (Fry & Debats, 2009; Fry & Debats, 2011).

Connor & Davidson (2003) posit that features such as; hardiness, adaptability to change, thinking of yourself as a strong person, working to attain goals and humour in the face of stress are essential characteristics of resilience in response to psychological health issues. It would seem that Nadine tried to adopt such characteristics in order to stay resilient against the adversity of depression. It could be argued that this was an 'external resilience', however, a survival mechanism but not something she truly believed she possessed, she saw herself as weak. Alternatively, this could be a social role which Nadine adopted. Research exploring minority ethnic women's responses to adversity and psychological distress found that often the women studied tended to try and normalise distress and present themselves as strong women in order to maintain better wellbeing. Showing such strength was seen as a way to cope with depression - a culturally accepted coping mechanism (Edge & Rogers, 2005; Black et al., 2007). Nadine presented differently to others from whom she really felt she was- she adopted a different identity, again leading to heightened levels of stress, diminished health status and subsequently depression.

Nadine asserted that this perceived need to present herself differently was also situation specific:

> Nadine: *'…Asian culture, you know, they are still hard but with talking more about vulnerabilities and as I said men are more, but like I said the career woman thing as I was just saying we had to be strong and I was in a male like logistics industry. We had to be strong and we can't show weakness… …' (14, 557-568).*

There seems to be an identity element to Nadine trying to hide her depression. Nadine here seems to be drawing from her experience from a number of identities/cultures; her Asian cultural background and her gender – again alluding to 'double pressure' faced by BME women (culture and gender influences) . Nadine seemingly describes an apparent shift in openness in Asian culture in terms of talking about issues. Asian cultures have traditionally been seen as private and there is a higher level of stigma about mental health issues, which has an impact on help-seeking behaviours and can lead to reluctance in seeing a GP (Loya, Reddy & Hinshaw, 2010), this has also been found among other ethnic minority groups (Wittkowski et al., 2011; Hussain & Cochrane, 2002; Ward et al., 2014; Schreiber, 2000). For example, Amri & Bemak (2012) presented case studies which explored health help-seeking behaviours among Muslims. They suggested that there was a social stigma and cultural mistrust of western health services and with this came a stigma of mental health problems and help-seeking. Such attitudes resulted in many living with untreated mental health issues (along with other health issues). They recognised that such stigma is obviously present in all cultures but suggested that more needs to be done to remove the barriers (language, health illiteracy, lack of culturally sensitive services etc.) faced by specific minority communities in accessing health services, due to the range of health inequalities they face.

However, fitting with Nadine's discussion other research highlights that this pattern may be changing. Hussain & Cochrane (2003) explored the coping strategies of Asian women living in the UK with depression. Among one of the most common coping strategies found in this group was talking. Although this talking was reportedly primarily to be with health professionals and within Asian support groups, a number of participants also spoke about the benefits of talking to family and friends and those within religious settings. On the other hand this research also found that when talking to non-professionals the focus was primarily on topics other than depression to take the focus away from it, which echoes Nadine's sentiment.

Presenting as a joker and the denial of depression was something which also occurred for Anita, she explained:

> Anita: *'I, we used to joke about it cause one second I'd be crying and the next second I'd be laughing. It was really weird, I'd be sitting there with, you know, my cousins or someone and I would be like "ooh I'm so depressed" like joking. I never ever, it never crossed my mind I thought, you know, for real it might be something, it might be something going or happening or going on until my GP suggested that I look it up. Then when I researched it, obviously it did match up to the way that I was behaving, the way that I was feeling and everything that was that I was experiencing at that time…' (3, 83-91).*

There is a suggestion by Anita here of a need for legitimisation or validation of her symptoms. It is not until her GP suggests that this could be an explanation for her marked changes in mood that depression suddenly became something '*real*' and, in contrast to her previous descriptions, tangible and definable. This suggests that, in terms of legitimisation of her symptoms, the health professional had the power. In response, Anita had to re-conceptualise her ideas about her symptoms to fit with the GP's medical diagnosis (Rogers, May & Oliver, 2001). It is not until this point that Anita moved to owning her depression and is able to identify it in herself. The idea of GPs being able to provide legitimisation is interesting as conversely in other research exploring the experience of South Asian women it was felt by those interviewed that GPs were not there for psychological advice, but for medical advice only and a visit to the GP should be for physical issues only (Burr, 2002). If this is the case it is easy to see why BME women are less likely to seek help from a health professional and therefore depression more often than not remains uncovered (Hussain & Cochrane, 2002).

Self-Reflective Process

This theme brought to light the very nature of experience, in that one is never able to fully access an individual's experience, it is only accessible in so much as the person presents this experience and tells their story. Thus, people can present their lifeworld in a plethora of ways. Similarly, they can present themselves and who they are in different ways.

I, like some of the participants in this study, sometimes find myself the victim of a desire to reach standards of perfectionism. This idea of attempting to attain perfection is not unique to me, the BME women in this study or indeed women in general, but society as a whole feels these pressures. Any researcher, therefore, would find it difficult to completely distance themselves from this notion. I was, at times, hesitant in my interpretation of their accounts. For example I initially saw the smoke screen Ria spoke of when she said 'almost like putting a smoke screen over it' as a cover blanketing her experience. I was encouraged to take this interpretation further and really find the meaning in the words she was using. It was at this point I begun to see this statement as a 'gem'. This process of peer review helped me to move pass my hesitation during the interpretative process. When engaging in the process of interpretation it is not only about what we as researchers bring to the data, but about what it brings to us. What was interesting from this in terms of my self-reflective process was that I found myself questioning my own experience in light of that of the participants. When Ria used this phrase, I did not initially explore it to its fullest extent. I reflected, later, that this might have been due to me putting up my own smoke screen. I therefore considered that maybe I was feeling the *same emotions as the participants to some extent. I began to recognise that we were looking through a more similar lens and thus after some separation of this I was able to look their narratives in a new way.*

2.4 Antidepressants: "It's very like rose tinted glasses"

Despite antidepressants being the most common form of treatment for depression (Montagne, 2011) most of those interviewed had negative experiences of taking them, which for many helped to shape their opinions of this medication and its use leading to lower levels of adherence. Within health 'adherence' refers to the extent to which an individual's behaviour is in line with the agreed recommendations provided by their health professional (Horne, 2006). It is believed that adherence is essential to an individual's recovery from conditions and is therefore linked to health outcomes (DiMatteo, Giodani, Lepper & Croghan, 2002). Adherence can be influenced by a range of factors including patient attitude, individual characteristics and patient education/health literacy (Chakraborty, Avasthi, Kumar, & Grover, 2009; Pampallona, Bollini, Tibaldi, Kupelnick, & Munizza, 2002; Yeh, Sung, Yorker, Sun, & Kuo, 2008). Due to the negative experiences of participants in taking antidepressants a number felt that medication did not make them feel any better and instead exacerbated their symptoms of depression or masked their symptoms without actually supporting in managing their condition.

Anita described how when she first started taking antidepressants they made her feel worse:

> Anita: '*…the first three weeks felt like they were horrid. I was, I felt worse than I did when I wasn't on them and it was after three weeks I started to feel a little bit better, but it wasn't better in a sense that "oh you're happy" it was just you didn't, you didn't have the feeling of feeling sad to be honest, it was you just felt numb*' (3, 107-112).

It is this experience of symptoms appearing to worsen before they get better which is the reason for a significant decrease in adherence to antidepressants during the first three months of treatment (Lin et al., 1995). Anita suggests that her expectation following beginning to take antidepressants was a feeling of '*happiness*', so a marked difference from the emotions that she felt previously. In contrast Anita describes how taking antidepressants led to a feeling numb, seemingly leaving her lacking the ability to feel any emotion, either positive or negative. This fits with research which has found that antidepressants can induce a number of changes including apathy, indifference and reduced motivation (Barnhart, Makela & Latocha, 2004; Reinblatt & Riddle, 2006; Wongpakaran, Reekum, Wongpakaran & Clarke, 2007).

Read, Cartwright & Gibson (2014) explored the experiences and beliefs about antidepressants in a large sample of individuals who had taken the medication. Participants reported a range of adverse effects ranging from not feeling like themselves and reduction in positive feelings. One of the most prominently reported adverse effects however was feeling emotionally numb. As side effects such as emotional numbness are common in the experience of taking antidepressants in order to improve adherence it is important that health professionals educate patients on antidepressants and how such medication works. They should also make patients aware of what to expect from taking them (increasing their health literacy) and have discussions with their patients about how long it is expected they will be on antidepressants (Brown, Battista, Sereika, Bruehlman, Dunbar-Jacob & Thase, 2007). The importance of this type of communication has been highlighted in research specifically with BME women. Latina and African American women cited communication as a barrier (along with other individual and unique community barriers) to accessing health services. Due to this breakdown they were left adopting self-help strategies instead (e.g. religion and focussing on physical health), ones which were accepted with their communities (Abrams et al, 2009). This communication with her health professional was lacking for Anita who explained '*I was never explained any of this, I had to go through it all on my own, [ ] the GP didn't really help much at all*' (4, 125-127), which led to her taking her own initiative when it came to the time when she wanted to stop taking her antidepressants. However, unlike other research with BME women where religion was often used to cope (Black et al. 2007; Burr, 2002; Abrams, 2009; Schreiber, 2000; Hussain & Cochrane, 2002) there did not seem to be a pattern of turning to religion as a self-help strategy (by Anita or any other participants), which perhaps might be due to the wider social context in the UK, it may be that generally this is not as much of culturally accepted coping mechanism or it is just not spoken about.

The expectation of happiness following taking antidepressants was shared by Ria:

> Ria: '…*I just thought I took, I could just take these happy pills and everything would be fine, I'd get back on track*…' (10, 380-382).

The phrase '*happy pills*' is a common metaphor used in relation to antidepressants (Herzberg, 2010). Such metaphors for drugs and drug experiences are an important way in which individuals assign meaning to their experiences and thus give insight into their understanding of how these drugs work and affect their lives (Montagne, 2011). Ria's experience of taking antidepressants was similar to Anita's as she discusses how antidepressants did not rid her of her depression symptoms but instead prevented her from seeing reality:

> Ria: *'…the antidepressants, it kind of mellows you out and you're living in, like, rose tinted glasses. You're not seeing the reality of the other side if you know what I mean, so to someone from outside looking in it looks like you don't care, but you do care. You're well aware, you do care, you know, you know and you want to get better but, you just sometimes, you just don't know how and I find it very very draining, very draining, very tiring. It's almost like my head's a washing machine, it's a constant washing machine of thoughts, negative thoughts which in the end just drain you and bring you down…' (7, 247-255).*

Ria conveys antidepressants as a substance which alters her reality, she explains '*you're living in, like, rose tinted glasses*'. Ria could only see the pleasant or positive things around her. Perhaps, for Ria, being on antidepressants acted as a form of disguise, altering her perception and the way she experienced emotions, maybe even protecting her in some way from the unpleasant. However, it is important to recognise the impact that such emotional blunting and altered perceptions can have on an individual's health experience and their decision making about antidepressant adherence. Price, Cole & Goodwin (2009) explored patients' experiences of such emotional blunting/detachment and found that individuals experienced significant emotional change which they attributed to their antidepressant use (rather than their depression). A common theme was disconnection from reality. This emotional blunting was seen to have an impact on the functioning and decision-making about antidepressant adherence, with a proportion being non-adherent due to the emotional side-effects. This suggests a need for a better understanding of the phenomenon of emotional blunting and its impact on adherence and recovery.

Ria goes on to describe these rose tinted glasses as though they alter the perception of her lifeworld, whereby others have a different perception of this world to her own, as though on the outside of this world. Ria describes an acute awareness whereby the desire to get better becomes physically draining, leading to a '*washing machine of thoughts*'. The awareness Ria describes pertains to a type of conscious awareness, as though she was aware of the reality but the rose tinted glasses distorted this - she only saw the pleasant things. She conveys thoughts which are constantly spinning around in her head and the very consuming nature of depression.

Madison also had a similar experience to Anita in that antidepressants made her feel worse and she therefore no longer takes them, she explained:

> *Madison: '…I know the drugs don't work. The seri and what the setra and what not it doesn't work for me because it makes me go madder, if you know what I mean. I can't explain to you, it makes me go a little bit more loop than I was, you know and I don't want that I've got enough chemicals going in I don't want another lot right, so this is psychological…' (29-30, 1183-1189).*

Madison's view is that medication did not work for her. Madison makes a link between antidepressants and the severity of her condition. She explains that she feels she has '*enough chemicals*', which is one of the reasons she does not want to use antidepressants. This is perhaps related to the fact that for most of her life Madison has used substances such as alcohol and marijuana to deal with her depression, such use of drugs used to 'treat' depression is common and many lay individuals believe that such substances are more beneficial than that which would be provided by a health professionals (Aselton, 2012). It would be interesting to explore whether this is more of a factor in cultures where the use of particular substances are seen as more of a cultural and religious tradition.

Madison makes an interesting distinction between ‘*physical*’ and ‘*psychological* ’- a distinction which is a common narrative among BME women (Burr, 2002). Madison describes her depression as ‘*psychological*’. This perhaps provides some context as to Madison’s view on how such medication works. If she saw depression as something which had a physical cause she may agree that medication would be the more appropriate form of treatment. Traditionally, treatment of depression has adhered to this split of the mind and the body, whereby depression is often seen as a ‘chemical imbalance’ in the brain and therefore antidepressants are prescribed as a treatment to correct this imbalance (Leventhal & Antonuccio, 2009). However, it is now recognised that there are a range of causes and treatments of depression other than medication and thus there is now more emphasis on what Madison calls the ‘*psychological*’. This approach provides more emphasis on an individual’s social context and on treatment such as therapy, peer support, relaxation and exercise in order to improve mood (Lampe, Berk & Coulston, 2013).

Nadine’s account of taking antidepressants was quite different from the others. She does not explicitly explain what it was like to be on antidepressants, she explained, however, that:

> *Nadine: ‘…I think I took antidepressants all that time on and off, but I kept trying to go off them because the doctors gave the impression that, well, [they] wanted me to go off them. They said “you’ll have this happy life if you get your friends, get your social life, then it will work” but it doesn’t always work like that, your mood, if you’re still low even with all that it’s not gonna sustain…*’ (14, 547-552).

Unlike other participants whose expectation was that antidepressants would lead to a happier life, Nadine was given the impression by her doctor that she would have a happier life if she came off her antidepressants. This perhaps highlights the differences in how health professionals conceptualise depression. The doctors treating the other participants wanted them to be on antidepressants to treat their depression; however Nadine’s felt that instead she needed to focus bolstering the social aspects of her life. Clinician’s attitudes to depression are important to consider as they will shape the way they assess and respond to people with such issues, their willingness to adopt new approaches and treatment decisions (Dowrick, Gask, Perry, Dixon & Usherwood, 2000), this is particularly key for individuals from BME background where there are other complexities such as a desire to see a clinician who has a better understanding of their cultural context (Wittkowski et al., 2011; Hussain & Cochrane, 2002; Ward, 2014). Nadine’s perception was quite different to her doctor’s however, as she felt that even with those things she may not be able to sustain this happy life suggesting that there is a certain level of effort required to sustain this type of lifestyle which she was not confident she was willing or able to give.

Self-Reflective Process

There was a dichotomy here between my professional role as a Trainee Health Psychologist and my own personal lived experience of depression, in terms of my pre-conceptions around antidepressant use. Relating this theme to the wider health literature and theory means that there was a common thread throughout of the concept of ‘adherence’, as this is a term so commonly used in the literature about antidepressant use (a very medicalised approach). On a professional note I am aware that adherence is very common terminology used in relation to medication taking behaviour. However, when reflecting on the use of this term, I was drawn back to the participant data and I chose to explore this further as medication-taking behaviour was a common emergent theme. This process of questioning was supportive of my interpretative activity. On a personal level I have always considered the concept of ‘adherence’ to be potentially unhelpful to individuals with depression as it could lead to an imbalance between them and health professionals. As put by Steiner and Earnest (2000) many terms used in relation to medication-taking behaviour are often problematic because they often “exaggerate the physician’s control over the process of taking medications” (pg. 927) and can assign blame to the patient. I have always believed that, if individuals have more control in the management of their health and the approaches taken towards it, especially in the case of depression, (which is so often medicalised) this will be positive in terms of health *outcomes and prevents a sense of 'them' and 'us'. I therefore had to establish a rational distance from these conflicting views (my fore-understandings) when interpreting the accounts of participant's, in order to better make sense of their meaning making. Of course it was not possible to completely escape this subjectivity.*

What was interesting as a researcher and a professional was that I felt in a privileged position because I potentially understood more about how antidepressants work than the participants did. Therefore it was important to be aware of such power dynamics. The participants were given to the same sense society often has surrounding the use of antidepressants, that they are 'happy pills'. I however had a different conception, when embarking on the research at least. On further reflection, it occurs to me that I did 'adhere' to taking medication myself during my own personal experience of depression, and this made me change my ideas towards their use. Whilst I had always been in favour of medical and psychological treatments working together, I found it difficult to deny that antidepressants alone had been of great help to me. By examining my own position, I was reminded that accounts of experience are both diverse and sometimes contradictory, due to a myriad of influences, as was often the case for participants. This also allowed me to identify more strongly with the participants and the disadvantaged position they were often left in. It is important, I feel, to be aware of such points of identification between participant and researcher, attend to this, and then to some degree use this to develop depth in the analysis.

The statement 'rose tinted glasses' to me was another gem and helped to bring together this theme. I initially had a number of interpretations of this statement. I needed to take away any pre-conceptions of this phrase to some extent however in order to interpret it in the context of Ria's social world. Again a process of reviewing the data allowed me to enquire in an open and interested manner.

Theme Summary

This master theme captures the descriptions of what depression felt like for the participants –and how they felt it presented itself (be that physical, psychological or emotional). Depression seemed to have agency for the participants - which often led to a loss of control. The descriptions of what depression felt like for participants chimed with the emotional changes characteristic of depression, whereby depression has an impact on individuals’ active engagement with the world (Slaby, Paskaleva & Stephan). Participants discussed the psychological and physical effects of depression, primarily focusing on stress and the difficulty in managing physical complaints. Somatic symptoms were a cause of stress for participants, which seemed to have an impact on their health status. Such somatisation seemed to be related to help-seeking behaviours, diagnosis and management of depression, whereby differences in perception of the nature and causes of depression were often seen to have an impact on doctor-patient communication.

Participants presented with a range of façades in order to hide or disguise the negative aspects of their experience. The idea of presenting with a façade in response to the experience of depression is a common occurrence in lay representations of the condition (Bengs, Johansson, Danielsson, Lehti & Hammarström, 2008). Participants used a range of coping strategies, rooted in their seeming desire to show resilience. These coping strategies had an impact on help-seeking behaviours, health status and relationships with health professionals. There was a common theme of discussion around difference in the perceptions of depression amongst lay individuals (individual participants) and health professionals and the complexity of managing these differences. It would seem that understanding of lay representations serves to gain a deeper understanding of the experience of depression, particularly those from BME groups who are often absent in the literature. Finally, participants’ discussions of their experience of taking antidepressants served to further highlight the nature of depression. For those interviewed the use of antidepressants led to a number of physical and psychological side-effects. Participants used a range of metaphors to describe their experience of taking antidepressants, which again served to give an insight into lay understanding of how medication works and their attitudes towards the efficacy of such treatment. These, often negative, attitudes towards this type of treatment often affected levels of adherence to their medication and the experience of depression itself often leading to a worsening of depressive symptomology.

CONCLUSION AND RECOMMENDATIONS

The purpose of this study was to analyse the detailed descriptions of the lived experience of depression from a small group of Black and Minority Ethnic (BME) women in the United Kingdom (UK) using Interpretative Phenomenological Analysis (IPA) with a view to answering the question *'What is the experience of depression like for Black and Minority Ethnic women in the UK?'*. The central finding of this research is that the experience of depression for BME women in the UK is heavily influenced by identity, cultural factors, minority status and pressures of societal norms. Alongside this, the emergent themes included '*Cultural Expectations and Depression: "I just need to be me"*' and '*The Nature of Depression: Agency, Façades and Coping*' which elucidate the personal stories of the five women interviewed. It is important to note that the accounts of participants in this study do not necessarily speak for all BME women in the UK. They do, however, provide a rich and meaningful insight into these women's experiences of depression and have afforded the ability to make tentative claims about how the experience of depression among BME women in the UK holds both similarities and differences to those of other groups.

The women interviewed had complex life experiences which were intertwined with their experience of depression. The resulting analysis shows that the women interviewed viewed depression as the consequence of an often complex array of personal, cultural and social circumstances and stressors which they faced. Cultural (and individual) identity was experienced as complex and contextual in nature. Consistent with the literature exploring the experience of depression in BME women many of the participants faced a range of cultural conflicts, perceived discriminations and pressures which were seen to have an impact of their wellbeing and emerged as antecedents of depression (Hussain & Cochrane, 2002; Ekanayake et al., 2012; Templeton et al., 2003). Culture had a significant impact on all the participants, but they also seemed to feel a more individualised 'double pressure', in relation to cultural expectations they felt, both from that prevalent in their backgrounds and those from wider society in the UK- a finding which seems to be unique to the present study. It would seem that although comparisons can be made with the experience of non-BME individuals (for example, in terms of striving for achieving a higher status) the BME women interviewed experienced additional pressures alongside this. Others maintained that having a strong identity and identification with a cultural group could be protective against depression and other adverse health outcomes, building on the existing literature which alludes to the relationship between strength and wellbeing among BME women, and suggested this is an area which warrants further exploration. This is a sentiment which the current research concurs with (Schreiber et al., 2000; Black et al., 2007). Many of the issues were not specific to BME women and thus there were found to be similarities with other groups (e.g. non-BME women and men and BME men), but such issues were often culture specific and experienced through the prism of cultural norms, expectations and histories. However, what would seem to be different for the women interviewed is the societal and systematic context in which they occurred, which it could be said is specific to the context in the UK.

For some of the women interviewed adverse circumstances experienced led to increased stress and undermined both their psychological and physical health status. The findings of this research help to expand on the extant literature on the relationships between stress, coping and health, particularly building on the model of salutogenesis (Antonovsky, 1979), and adds cultural dissonance as an element which has an additional impact on this relationship. A deeper understanding of the coping skills adopted in response to adversity by those interviewed was afforded here, with a particular focus on showing strength, perfectionism and resilience. It was brought to light that different coping skills are seen to exacerbate or attenuate the psychological consequences of adversity. There were a number of culturally sanctioned coping mechanisms fitting with existing literature (Bodziany, 2008), but a novel element this research found was that this was often to do with the ‘current’ context in the UK and attitudinal shifts in BME communities in the UK had an impact. In the context of the existing literature around the experiences of depression for BME women, this study highlights the importance of being a minority in terms of its implications for health status. This research has extended knowledge on ‘minority stress’ to BME populations and broadening understanding of the relationships between racism, discrimination and poor health (Meyer, 2003). Depression was found to manifest itself in a range of psychological and physical health consequences, which were seen to impact on help-seeking behaviours, management (and perceptions) of symptoms and doctor-patient communication. With this expanded knowledge depth was given to BME women’s perceptions of medical treatments for depression (primarily antidepressants), their lack of health literacy in regards to these medications and the implications the use of such medications had on their experience of depression.

The findings of this research have implications for practice and service provision. One recommendation drawn from this research is that health practitioners should seek to understand the variability of the experience of depression among BME women, considering the many impacts of an individual's ethnic identity and culture on their experience of depression. A further recommendation is that health practitioners must seek to understand conceptions and explanations of depression on an individual basis and work with them in a co-productive way (Slay & Stephens, 2013), building open and trusting relationships in order to provide effective person-centred support and treatment. With this both statutory and third-sector services need to work towards providing high quality and personalised services which understand the importance of engaging with communities which are harder to reach. Finally, this study recommends that that health promotion campaigns and health services need to support in enhancing the health literacy of BME women with depression, so that they can fully understand the positives and negatives of taking medication such as antidepressants and feel they have sufficient knowledge to navigate the ever changing arena of health services and communicate with health professionals about their individual needs.

While this research contributes to the extant literature exploring the experience of depression among BME women, there is still much more to explore. Further phenomenological research into the experience of depression among BME women is needed in order to acknowledge the lived experience of individuals, especially a further exploration of the relationships between identity and health and stress, as well as that between coping and health status.

STRENGTHS AND LIMITATIONS OF THE RESEARCH

From a critical standpoint any research has both strengths and limitations which need to be recognised. IPA was deemed to be an appropriate method of analysis for this research due to the desire to explore the complexity of this personal health issue and understand it on a deeper level. Thus a key strength of this research was the fact that the analysis used afforded the production of rich, detailed accounts of participants' experiences -

remaining conducive to the research aims. Care was taken throughout the analysis process to ensure rigour within the study, in capturing participant's experiences and fostering a high level of interpretative engagement with their accounts. To support with this endeavour elements of the researchers self-reflexive process are shown throughout this thesis in order to demonstrate that the process of IPA was truly followed and the commitment to recognising the double hermeneutic (Smith et al., 2009).

IPA is an idiographic approach which does not aim to seek definitive answers or develop theory, thus it was not an aim of this research to generalise the findings to all BME women with experience of depression. However, the transferability of the findings should be borne in mind. IPA is an interrogative approach (Smith, 2004), which aims to broaden and develop the existing knowledge base, resonating with personal experiences and thus hopes to illuminate the broader context (Smith & Osborn, 2008). Thus it is recognised that whilst other BME women in the UK may have similar experiences the findings presented within this research provide an in-depth insight into the experience of those women interviewed and therefore the transferability of the findings must be considered within context (Smith & Osborn, 2003). The findings for this research were tentatively linked to that of the extant literature and while there were some areas of resonance, the current study also developed some new and emergent findings which warrant further exploration (discussed in the section '*Recommendations for Future Research*').

A challenge for this research was the recruitment of participants (although the scope of the advertising was widened to counteract this). Whilst, to some extent, this was anticipated due to the sensitive and complex nature of the research, it does point to the need to raise awareness of mental health issues so that this becomes part of a common health experience allowing individuals to feel more able to speak openly about their own experiences. Doing so may help individuals to feel more comfortable in coming forward and talking about their experiences for research purposes and feel that their stories are valued and serve an important purpose. Also in terms of recruitment there may have been some selection bias in that those who took part in the research volunteered to do so (self-selection bias). It may have been that in advertising the research the organisations/professionals involved in this process (by disseminating the study advert) may have primarily approached those who they felt would be more interested in taking part in the research and feel comfortable in talking about their experiences, it is also the case that all those who were interviewed were accessing some form of mental health support/service. Something to consider for the future is perhaps trying to capture the voices of those who have not accessed mental health services, whose experiences may have been quite different. Therefore only the experiences of those who chose to participate are heard and others may have had different experiences. However, with the idiographic focus of IPA this was not seen to be an issue.

In regards to the sample itself IPA warrants a purposive, smaller sample whereby the group is broadly homogenous (Smith & Osborn, 2003). With this it would seem important to at least mention the small sample size for this research and highlight why this should be seen as a strength. Although for other qualitative research this could be seen as a limitation, this is not the case within IPA research which challenges the traditional relationship between the number of participants and the value of the research (Reid et al., 2005). IPA's focus is on the detailed exploration of individual experiences and thus a detailed analysis of a small number of cases is preferable (Smith et al., 2009), as the exploration of a large data set may result in loss of meaning (Smith & Osborn, 2003). As Smith (2004) argues the use of IPA with smaller samples is a key area of development within health research, whereby "the very detail of the individual brings us closer to significant aspects of a shared humanity" (pg.43). In regards to homogeneity this was present in the sample of women interviewed by virtue of the fact that they were all women from ethnic minority backgrounds with experience of depression. Thus, Smith et al. (2009) are not contradicted by this use of IPA. There were some variants in the sample used however, such as the range of ethnic minority backgrounds that these women originated from and perhaps having a group more homogenous in this respect would have strengthened the research, as has been found in other research with BME women (Ezeobele, 2010). However, as Smith & Osborn (2008) argue, pragmatics dictate that to some extent one's sample is partly defined by who is prepared to be included in it.

There are a number of criticisms of qualitative research and the methods used including issues with rigour, researcher bias and subjectivity (Silverman, 2000). However, a number of approaches were used to counteract such issues in this research including an emphasis on quality control and reflexivity. As a novice IPA researcher, every effort was made to ensure quality by attempting to gain an in depth understanding of IPA through training, reading and supervision. Peer review was also undertaken in order to ensure rigour, whereby the researcher's supervisors provided feedback throughout the analysis process, which also supported with validation of interpretations and ensured credibility of the final account (Brocki & Wearden, 2006). With this the researchers self-reflexive process was presented throughout the analysis section in order to demonstrate the concept of the double hermeneutic and justify the smaller sample. That said, although every effort was taken to remain transparent throughout the research process, the analysis section shows the researcher's interpretation of individuals' experience and is not "concrete 'findings' corresponding to 'reality'" (Yardley, 2008, pg. 249). The themes have been selected on the grounds of their importance to the participants who took part in the research and their relevance to the research questions. It is recognised that this is a subjective interpretation and that other researchers may have focussed on other aspects of the participants' accounts.

Within the field of IPA research there has been debate about the usefulness of participants commenting on the analysis (Brocki & Wearden, 2006). Initially for this research it was desired for participants to have the opportunity to comment on the data analysis and the researcher's interpretations, to ensure these made sense to them and perhaps enrich the interpretation of their accounts. However, unfortunately this was not possible due to time constraints. This should not necessarily be seen as a weakness however, as it has been argued that such participant feedback is inappropriate (Smith, 2004), particularly if the participants are unable to relate to the analysis process (Yardley, 2008). In any case, the approach of this research was to recognise the 'double hermeneutic' of IPA, whereby the researcher is trying to make sense of the participant, trying to make sense of their experience (Smith et al., 2009), and thus a lack of feedback from participants was not seen as detrimental to the quality of the study. Indeed this smaller qualitative study with an idiographic focus has provided valuable insights into the experience of depression for the BME women interviewed.

IMPLICATIONS FOR PRACTICE

This research has highlighted some, potentially key, implications for practice which can have a meaningful impact of mental health service development in the UK. This research brought to light the difficulty and complexity of the experience of depression among BME women and the variability of this individual experience. This experience was embedded in so many aspects of their lives that it is vital to consider the implications of their cases within practice and the many influences of an individual's identity, the intricacies of illness experience and social and cultural context. On a practical level a better understanding of how identity is linked to health will help to provide the ability to look at how to better target health promotion, implement person-centred interventions and promote more effective management of health conditions such as depression.

A further implication to consider in light of the findings of the present study is that of the need to develop appropriate support and health interventions better suited to the needs of BME women with depression in the UK. It is important to develop culturally sensitive interventions which account for the myriad needs of those from such communities. That said it is important that service developers and providers do not make assumptions about the needs of BME women and that they are treated on a case by case basis, with knowledge of the potential needs of various groups informing their practice. Despite drives to be inclusive, mental health services are still underutilised by those from BME communities. It is important that in trying to encourage the utilisation of services by such communities the correct approach is taken. For example, the Delivering Race Equality in Mental Health agenda (Department of Health, 2005) seems to place the blame of underutilisation of mental health services on communities' under engagement primarily, rather than focussing on what professionals individually and service providers can do to counteract this underutilisation as has been suggested in other research (Hussain & Cochrane, 2002; Ward, 2014).

It is known that there is a need to tackle the health inequalities experienced by those from ethnic minority communities and part of this needs to come from health professionals (NICE, 2011). Although there have been great strides towards this in mental health (Department of Health, 2005), it would seem that more needs to be done. This research highlights that there is still a gap and thus a need to consider such health inequalities as those alluded to by some of the participants, low social support and difficulties in utilising health services being particularly pertinent. Other research has supported this need and suggested issues such as disillusionment with doctors, perceived exclusion from services and concerns about the cultural competence of services needs to be addressed (Cooper et al., 2013) and the current study concurs with this sentiment.

This research perhaps also highlights some inequalities in health literacy, which is the capacity to obtain and understand basic health information and use this information to make informed decisions about one's health (Selden, Zorn, Ratzan & Parker, 2000). If an individual lacks health literacy this can have a negative impact on their management of health issues (e.g. medication-taking behaviour), such was the case for some of the women interviewed. As highlighted in this research and supported by other research, such difficulties in health literacy among ethnic minority women with depression can lead to a failure of individuals recognising symptoms of depression, lack of knowledge of treatment options and difficulties in utilising health services and making choices based on treatment recommendations (Coffman & Norton, 2010). Thus it would seem that the health literacy of BME women with depression needs to be considered in the presentation of health information to these women (which also needs to be available in a wide range of formats) and within doctor-patient communication, particularly as highlighted by this research when communicating about medication.

This research also highlights the need for preventative interventions to support individuals in dealing with issues before they escalate. Also, there is a clear need to focus on the use of interventions which concentrate on improving the sense of self and self-perception (in relation to identity struggles for example) i.e. Cognitive Behavioural Therapy. There is perhaps even a need to look at support such as family therapy to support an individual with issues they may be having in their relationships with others e.g. due to cultural conflict (Yang, Haydon & Miller, 2013). Ultimately, given some of the issues raised in this research, in terms of intervention it is important to consider the strong position of public health in supporting the diverse needs of BME women in the UK. However, if this approach is going to work more work needs to be done on educating frontline health professionals (particularly GPs) on the management of conditions such as depression, particularly in regards to the presentation of somatic complaints and the use of antidepressant medication.

With this it would seem that there is a need to consider the ways in which the existence of services is communicated to BME women. Effective communication across the health care continuum is seen as key due to its impact on knowledge of services, health outcomes and an individual's satisfaction with health services (Wanzer, Booth-Butterfield & Gruber, 2004). There is therefore a need to look at the range of ways in which the existence of health services (preventative services included) and treatment/support options are communicated to BME women with depression. As brought to light in the current study the women interviewed accessed a range of support. A key concern, however, was finding the right support for them and understanding the health information with which they were provided so they can make informed choices. Thus there is a need to consider things such as targeted health promotion campaigns and policies, the use of social development approaches (particularly considering the influence of culture), community participation, advocacy and empowerment in terms of supporting the needs of BME women with depression, ensuring that their health communication needs are met right throughout care pathways.

The implications of stigma, denial and lack of understanding of mental health issues amongst some cultures came to light in this research. Therefore, there is a need for services and professionals to champion awareness raising of mental health issues and the acceptance of such issues among BME communities. It is important for health professionals to be aware of the importance of building trust, really listening to an individual in order to ascertain their needs and working to build relationships with individuals. With this is felt that this research highlights the need for BME women to discuss their personal experiences of depression and discuss their sense making of these experiences, something which all commented was a positive experience. Lastly, encouraging consistent sources of support for these women through family, friends and the community is vital, particularly as brought to light in this research exploring the benefits of peer support. Voluntary services can also play a key role in the engagement of individuals and given the consistent changes in statutory services should be supported in providing both short and long-term support for individuals and help to maintain services and community health interventions.

RECOMMENDATIONS FOR FUTURE RESEARCH

Qualitative research using the approach of IPA to explore the experience of depression in BME women in the UK is still in its infancy. However, the present study opens the door to explore this area further and build upon some of the findings within this research. It is important that those with experience of depression are given the opportunity to talk about this issue themselves and reflect upon their experience and what it means to them. The relationship between identity and health status was a key area within this research and thus it would seem important to first and foremost explore further the lived experience of depression among BME women and the impact of for example minority stress, perceived racism and discrimination, identity conflicts, ‘double pressures’ (due to expectations related to both culture and gender) and stress on depressive symptomology. With this studies perhaps need to explore the stress *process* among BME women and the impact of management of stress in specific situations, particularly stress associated with minority status. Research into better understanding of risk-related and health-seeking behaviours in relation to the experience of depression in BME women is warranted. Considering the risk and protective factors involved in stress management and the impact this can have on stress related health outcomes and health status in general. With this research is needed to explore specifically some of the protective factors which can support preventing such stress or distress from resulting in emotional wellbeing issues. In regards to coping it is important for research to look at gaining a deeper understanding of the coping skills adopted by BME women in response to adversity and how these exacerbate or attenuate the psychological consequences of such adversity.

Different recruitment strategies could be used in order to target different populations, for this research participants were recruited through voluntary sector services. A broader recruitment strategy may have yielded a different population with a different range of experiences. Particular areas of focus moving forward could include exploring the experience of a more homogenous sample (for example Black-African women, given the significant impact of cultural traditions) or research considering the experience of specific groups e.g. younger or older BME women as this was a factor in terms of levels of acculturation and acculturative/minority stress and their relationships to health status.

Research is also required to evaluate the effectiveness of primary care health services and their ability to meet the needs of BME women. The research aims would need to match the aims of the service evaluated whether it is GP services, low level psychological services as provided via the Improving Access to Psychological Therapies Framework or other community based services. With this perhaps research exploring health professionals' perceptions of the recognition and management of depression in BME women and a closer look at care for depression across a range of primary care settings needs to be explored. Pertinent to the current study the implications of the medicalisation of emotional distress was highlighted, for which it is suggested that research explores this in more depth and the impact this can have on for example doctor-patient relationships. Better partnerships need to be forged between communities and community/health organisations in order to produce collaborative research, whereby there is a two-way exchange of knowledge and the ability for local research to influence policy and practice. Policy and practice which recognises the variability of health experience among individuals. Fields such as Health Psychology should, therefore, be central to the development and dissemination of such research.

Overall, there are many areas of further exploration in this area of research and this section has only highlighted a few. It will be interesting to see, however, how the research within this area develops and the implications this has on the experience of individuals and the practices of healthcare services.

CLOSING THOUGHTS

In exploring the experience of depression in BME women through IPA scope was given to explore rich accounts of their experiences. The current research shows some consistency with the broader extant literature exploring the experience of depression in BME women. Most importantly however the present study was able to highlight new areas of interest and provided further detail to that which is already known. The present study indicates that an individual's identity and health are intrinsically linked. For those interviewed depression was heavily influenced by identity, cultural factors, minority status and pressures of societal norms. This research highlights the implications of significant life events, consequences of feeling different from community and networks, the impact of emotions such as anger and loneliness, the myriad of depressive symptomology (particularly the difference in perceptions of such symptoms) and the importance of sharing experiences. Of particular interest within the field of Health Psychology is the implication of this for perceptions of mental health, coping strategies used in response to stress and adversity, help-seeking behaviours, diagnosis and management of depression among BME women in the UK. Further research exploring the facets of this experience brought to light in this research is justified. Fundamentally, research should tell the reader something interesting, important or useful (Smith, et al., 2009). Hopefully the present study has achieved this.

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APPENDICES

E-MAIL TO ORGANISATIONS

Hi All,

I hope you are well. As you may be aware I am currently completing my Doctorate in Health Psychology. As part of this doctorate I am conducting research looking at 'The Experience of Depression in Black and Minority Ethnic Women'.

I am hoping that you will all agree to advertise this research to anyone you feel meets the research criteria and among your contacts (non-statutory only).

In order to see if there are any women from a Black and Minority Ethnic background with experience of depression who would be interested in participating in my research project. This study, through hearing individual’s stories aims to gain an in depth understanding of the experience of depression and management of health in black and minority ethnic women.

All who agree to participate will be asked to take part in a semi-structured confidential and anonymous discussion. This study has been reviewed and approved by the London Metropolitan University Research Ethics Review Panel. Any support with this valuable piece of research would be very much appreciated.

I hope you will agree to advertise this project among your networks. If you have any questions please let me know. Thank you for your time and I look forward to hearing from you.

Kind regards,

Sabrina Robinson

Trainee Health Psychologist

VOLUNTEERS NEEDED

Research Exploring the Experience of Depression in Black and Minority Ethnic Women

Have you ever had experience of depression?

Are you a female from a Black and Minority Ethnic background?

Would you be willing to talk about your experiences?

My name is Sabrina Robinson and I am a Trainee Health Psychologist completing the Professional Doctorate in Health Psychology at London Metropolitan University. As part of completing this doctorate I am conducting research looking at '*The Experience of Depression and Management of Health in Black and Minority Ethnic Women*' and I am looking to recruit women to take part in this study.

This project aims to gain an understanding of this experience from an individual perspective. It is hoped that the results for the study will be shared and will help those offering support to women like you make sense of and gain a more in-depth understanding of the experiences, perspectives and needs of Black and Minority Ethnic women with depression and how they feel this experience is related to the management of their general health. Thus potentially helping to facilitate changes in the services and support available to this group helping to improve their mental health and wellbeing.

If you are interested in confidentially sharing your story or would like further information about this research, please contact the researcher using the details below. Thank you.

Sabrina Robinson
Trainee Health Psychologist
E-mail: sabrina.robinson@hotmail.co.uk
Tel: 07545 120 622

Initial E-mail to Potential Participants

Dear XXX

Thank you for allowing me to contact you today and for expressing an interest in participating in my research. To explain a bit further, I am currently running a number of studies relating to health issues within Black and Minority Ethnic women and am looking for people with a range of experiences. For my current study I am looking for women who have been clinically diagnosed with depression at some point in their lives - it doesn't matter whether this is a current diagnosis or something that happened a long time ago, whether it is on-going or was a brief episode - all of these experiences are of interest to us.

If this applies to you please read through the attached participant information sheet which describes what will be involved if you agree to take part.

Thank you for contacting me, your time and input is extremely valuable. Thank you.

Kind regards,

Sabrina

APPENDIX 4

London Metropolitan University
School of Psychology
Faculty of Life Sciences

The Experience of Depression in Black and Minority Ethnic Women

Participant Information Sheet

Background Information

You have been invited to take part in a research study looking at '*The Experience of Depression and Management of Health in Black and Minority Ethnic Women*'. Please find below further information about the research, please take the time to read through this information to help you come to a decision as to whether you would like to participate in this research.

About the Researchers

My name is Sabrina Robinson and I am a Trainee Health Psychologist. I am carrying out this research as part of completing the Professional Doctorate in Health Psychology at London Metropolitan University. This research is supervised by Dr Joanna Semlyen (Academic Supervisor) and Dr Esther Murray (Second Supervisor) of London Metropolitan University.

Why is this research being conducted?

This study aims to gain an in depth understanding of the experience of depression and management of health in black and minority ethnic women. It aims to get an understanding of what it is like to experience this disorder, gain an understanding on your thoughts and feelings in relation to this, how this ties with management of your general health and how you feel this experience is related to your identity. Not much is known about what this experience is like from an individual perspective which is what this research hopes to explore. It is hoped that this study, which aims to gain a deep understanding of this experience hearing the stories of black and minority ethnic women themselves, will enhance healthcare professionals understanding, and thus facilitate changes in the services and support available to this group helping to improve their mental health and wellbeing.

Why am I appropriate to take part?

This research aims to gain an understanding of the experience of depression in black and minority ethnic women. It is hoped that between four and six women will agree to take part and share their experiences.

Do I have to take part?

No. You are under no obligation to take part, participation is entirely voluntary. If you do agree to take part you will be asked to sign an informed consent form in order to confirm your consent to taking part in the research, a copy of this will be provided to you and I will keep a copy for my records. Even if you do decide to take part; you can still change your mind in the two weeks after the interview (up to the point where the data from the interview becomes part of the analysis) without any disadvantage or having to give a reason.

If I choose to participate what will be involved?

If you agree to participate please contact me using the details provided below. You will then have the chance to find out more about the research and ask any questions you may have, after which you can take some more time to think about it if you wish, or we can arrange a suitable date, time and place to meet.

During this meeting we will first do a brief going back through information on the study and you may ask any further questions you have. If you are still happy to go ahead then I will ask you to sign an informed consent form to say that you agree to participate. I will then conduct a one-to-one audiotaped interview with you which will last around 1 ½ hours. During this time we will discuss a bit about you, your views and knowledge of depression, your experience of depression and managing or seeking help for your depression, what you feel your identity is and how it is related to your experience of depression and lastly we will discuss your experience of managing your general health in relation to your depression.

After the interview you will be debriefed and have the opportunity to ask any questions or raise any concerns you may have, you will also be provided with a debriefing sheet for you to keep.

What will happen to this information?

The recording of the interview will be typed out and made into a transcript, so that the information can be looked at in detail. The aim of this is to uncover common themes that are important in understanding the experiences we have discussed. Both the recordings and the transcripts will be made anonymous and kept locked in secure storage only accessible to the researcher.

Anonymised sections of the transcripts may be reviewed by my supervisors, and may also be looked at by representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research project. As part of the doctoral programme, I will write up a report of the research. This report will include anonymous extracts of all interviews conducted to illustrate themes which have been discussed.

These extracts will not include any information that could identify participants; any identifying aspects will be changed. There is the potential that the research findings may be submitted for publication in an academic journal and/or presented at conferences in the future, but again this would not include any information that could identify participants.

The written transcripts of interviews will be kept in a secure locked location for a maximum of five years after this time they will be destroyed. Please note that you have the right to request a summary of the research findings to be sent to you once the study is complete.

Are there any possible disadvantages or risks to taking part in this research?

You will be asked to discuss your experience of depression, talk about yourself and your background and how you feel about your experiences. This is a sensitive topic and you may potentially find this upsetting. However, every measure will be taken to minimise this risk of upset. If at any point during the interview you feel uncomfortable or there are any questions you do not want to answer please let me know and we will move on. If required you will be given the option to take a break or we can stop the interview altogether.

Following the interview you will be given the opportunity to discuss any issues or concerns you may have regarding what we have discussed and ask any questions you may have. If needed I will be able to give you information on a range of support if you need someone to talk to following the research. You will also be provided an information sheet with details of various sources of support.

What are the potential benefits of taking part?

There is no guarantee that there will be any benefits to you in taking part in this research. However, you may find it beneficial being given the opportunity to talk openly and honestly about your experiences and what they mean to you. Also it is hoped that the findings from this research will help improve understanding of the experience of depression in black and minority ethnic women and therefore improve the support and care offered in the future to those who go through similar experiences.

What will happen if I no longer want to take part in the research?

If you decide you want to withdraw from the study, you can still change your mind in the two weeks after the interview (up to the point where the data from the interview becomes part of the analysis) without any disadvantage or having to give a reason. Please let me know by contacting me on the details given at the end of this information sheet. If you have completed the interview you will be asked what you would like to happen to the data. It can either be included in the study, or destroyed. Either option is perfectly acceptable.

What if there is a problem?

If you have a concern about any aspect of this study, you can contact me and I will do my best to answer your questions. Alternatively if you have any concerns or complaints you can contact my research supervisor Dr Joanna Semylen (please see contact details below).

Will my taking part in this research be kept confidential?

All information which is collected about you during the course of the research will be kept strictly confidential. Any information about you will be kept in a secure locked location only accessible to the researcher.

Confidentiality will only be breached in exceptional circumstances if you disclose any information which suggests that either you or someone else is at risk of harm. If this is the case then professionally I am obliged to breach confidentiality and inform someone. If I have any concerns I will do my best to discuss this with you first.

Who has reviewed the study?

This study has been reviewed and approved by the London Metropolitan University Research Ethics Review Panel.

Contacts for Further Information:

If you have any questions or queries, please do not hesitate to contact us using the details below.

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Interview Schedule

Many people experience depression at some point in their lives, however, the experience of depression can be different for each individual. An individual's identity whether it's their sex, age, ethnic identity or culture may have an impact on their experiences. Also some people find that their experience of depression can impact on their health generally.

I would like to have a discussion with you about your experience of depression and would like you to be as open and honest as you feel comfortable with. If at any point during our discussion there is something you do not want to talk about then please let me know and we will move on. Please note that I am not a clinician and this interview is intended to be reflective rather than therapeutic. As mentioned in your briefing please remember that anything we discuss will remain anonymous. There are no right or wrong answers, so please feel free to say whatever you want; everything you say will be valuable information for this research.

1. First, can we start by you telling me a bit about yourself?

    a. Age, background, where you grew up etc.

Experience of Depression

I would now like to move on to discussing your experience of depression.

2. What was life like before you first experienced depression?

    a. At what point did you realise you might be depressed?

3. I would like to know about your experience of depression. Could you please tell me about this?

    a. What impact did/does depression have on different aspects of your life i.e. home, family, work etc.?

Depression and Help Seeking Behaviours

4. How did you initially try to manage your depression?

    a. How much do you think the depression itself contributed to your way of dealing with your problem?
    b. How much do you think your emotions and the way you were feeling affected your motivation to seek help?

5. When were you diagnosed with depression and how did this diagnosis occur?

    a. Who diagnosed you?
    b. What did they say?

6. Please could you describe some of the treatment options you were offered/sought to help you with your depression?

    a. What was appealing about these options?
    b. What did you think they would involve?
    c. What did you find most helpful?
    d. Were there any barriers to getting the help/support you wanted?

7. How did you feel telling your family and friends about how you were feeling?
    a. Why/how long did it take to tell them?
    b. What were their reactions?

Identity and Depression

It has been really helpful to get an insight into your personal experience of depression and I appreciate that it can be difficult to put some of these things into words. What I'd like to do now is to look at things from a slightly different angle and talk a bit about how your depression might have affected how you see yourself or how you think others see you.

8. Could you please tell me how you see yourself, what you consider to be your identity?

9. Some people find that they experience some prejudice or discrimination in relation to their identity. What is your experience of this?

10. As has been mentioned some people find that how they see themselves can influence their experience of depression. What is your experience of this?

11. How do you feel that society views depression and mental health?

    a. How does this affect you?
    b. What reactions have you personally experienced?

Depression and Health

Depression can have an impact on many aspects of an individual’s life including their physical health and wellbeing. What I would like to do now is discuss your experience of depression in relation to your health, more specifically your physical health, health behaviours and general quality of life.

12. How do you view your general physical health?

13. Do you think your depression has had an effect on your general health?

    a. Do you think depression has had an effect specifically on your health behaviours e.g. eating habit, physical activity levels, sleeping patterns etc.? How?
    b. What were your health behaviours like before you experienced depression?

14. Taking all things into consideration, how would you rate your general quality of life before your depression? (this can be described as your general satisfaction (or dissatisfaction) with your sense of wellbeing)

    a. How did this change when you were experiencing depression?
    b. How would you rate your general quality of life now?

At the end of the interview participants will be given the opportunity to process our conversation and communicate how they felt about the experience. They will also be given the opportunity to ask any questions they may have. They will then be given a verbal and written debriefing.

Development of the Interview Schedule

1. Participant History

A gentle opener was used to start the interview. Therefore, the interviews commenced with the question '*First, can we start by you telling me a bit about yourself?*' This was seen to be an appropriate topic to start with in order to help participants feel more comfortable with the interview process. It also provided the opportunity to gain some history on each participant. In actual fact in answering this question most participants began to talk about their experience of depression as a natural lead on from this line of enquiry. Topics of a more sensitive nature are seen to be better left until later in an interview in order to first help foster a safe environment and build a rapport with participants (Smith & Osborn, 2008).

2. Experience of Depression

The next section of the interview was centred on discussion of participant's experience of depression in terms of what life was like before and how it changed. Participants were first asked what life was like before they experienced depression and at what point did they realise they may be depressed, in order to gain an insight into what was happening in their lives when they first experienced depression. In answering this question participants began to open up about what they felt were the reasons for their depression and the life events which preceded this experience. Participants were then asked '*I would like to know about your experience of depression. Could you please tell me about this?*' This was to get participants to discuss what depression was like for them and the meaning they assigned to this experience. In answering this questioning participants discussed what depression felt like for them and the impact this experience had on them personally. Participants were also asked to consider what impact depression had on different aspects of their lives such as home, family and work in order to get an understanding of the scope and impact of this experience for each participant.

3. Depression and Help-seeking Behaviours

The aim of this section was to gain an insight into how participants managed their depression, including what support they sought or were offered. First, participants were asked '*How did you initially try to manage your depression?*' Participants discussed whether they tried to manage the depression themselves or whether they sought external support. Participants were asked when they were diagnosed with depression and how this diagnosis occurred such as whether they were diagnosed by their GP or a psychiatrist. Participants talked in some depth about receiving a diagnosis of depression and what impact it had on them. Participants were then asked about their experience of treatment with the question '*Please could you describe some of the treatment options you* *were offered/sought to help you with your depression?*' Participants discussed the range of treatments they experienced, what they liked and didn't like about them, what they found the least and most beneficial and whether they felt there were any barriers to accessing support. Lastly, within this section participants were asked '*How did you feel telling your family and friends about how you were feeling?*' The aim of this question was to gain an understanding of how participants felt telling those close to them about their depression, the reactions they received and whether the felt supported.

4. Identity and Depression

This section focussed on participant's identity and how they felt their identity may have had an impact on their depression. Participants were first asked '*Could you please tell me how you see yourself, what you consider to be your identity?*' This question aimed to get participants discussing what they believed their identity to be. Prior to interviews commencing it was explained to participants that identity could refer to their sex, age, gender, ethnic identity or culture. For those interviewed ethnic and cultural identity were a primary concern. However, in answering this question other identities arose for example their different roles i.e. mother, wife etc., and their perceived place in society. For most their identity was strongly related to their depression. Participants were asked whether they had received any prejudice or discrimination in relation to their identity, in order to gain an insight as to whether they had experienced any negative reactions to their identity and what impact this may have had on their wellbeing. Participants were then asked '*As has been mentioned some people find that how they see themselves can influence their experience of depression. What is your experience of this?*' The aim of this question was to gain an insight into how participants viewed their identity in relation to their experience of depression. Again this question was primarily focused on their ethnic identity (probes were used along this line of enquiry). The last question for this section was '*How do you feel that society views depression and mental health?*' exploring what impact societal views of depression may have had on participants and the relation of this to their experience.

5. Depression and Health

This last section was focussed on participant's experience of depression in relation to their general physical health and wellbeing. The first question was '*How do you view your general physical health?*' in order for participants to discuss how they viewed their levels of physical health and whether they felt they were healthy or not physically. Participants were then asked '*Do you think your depression has had an effect on your general health?*' It is well known that depression can have an impact on individual's physical health therefore this line of enquiry was focussed on gaining an understanding of what this experience was like for participants and whether they felt depression had a negative (or positive) impact on their health. Participants were asked about the impact of depression on their health behaviours i.e. diet, exercise, sleep etc. and were asked to compare this in relation to their health before they experienced depression. The last question participants were asked was ‘*Taking all things into consideration, how would you rate your general quality of life before your depression?*’ This was used as a closing question to help bring everything together, as a probe participants were asked how their rating of their general quality of life has changed since they have experienced depression.

DProf HP RD1 Registration - Approved - Sabrina Robinson

From: **d.henry@londonmet.ac.uk** on behalf of **Graduate School London Met Uni** (gradschool@londonmet.ac.uk)
Sent: 23 November 2011 15:08:34
To: sabrina.robinson@hotmail.co.uk
Cc: Anna Baker (a.baker@londonmet.ac.uk); Joanna Semlyen (j.semlyen@londonmet.ac.uk); Elizabeth Charman (e.charman@londonmet.ac.uk); Christopher Branford White (c.branfordwhite@londonmet.ac.uk); Paul Angelo (p.angelo@londonmet.ac.uk)
1 attachment
FLS - ROBINSON, Sabrina - RD1 Registration - Oct 2011 (with feedback).doc (140.6 KB)

Dear Sabrina,

I am pleased to confirm that at its recent meeting the FLS Research Student Progress Group approved your application to register on the DProf Health Psychology programme with effect from 21 October 2011. As a full-time student the Progress Group will be reviewing your progress every 6 months, so we will be requesting some work in progress in time for the Spring 2012 meeting. I hope you find the attached feedback helpful.

Please ensure that you engage with the workshops and on-line courses available through the Researcher Development Programme. Details can be found on the website here: http://www.londonmet.ac.uk/research/the-research-and-postgraduate-office/current-students/researcher-development-programme.cfm.

If you wish to attend any taught modules from the Postgraduate taught scheme please discuss this with your supervisors and return a registration form to the Research Office to enable us to register you are the appropriate modules. Forms can be downloaded from our website here: http://www.londonmet.ac.uk/research/the-research-and-postgraduate-office/current-students/taught-modules.cfm

Please contact me should you need any support or advice.

With regards,
Doreen.
Mrs Doreen Henry
Research Office Administrator

London Metropolitan University
School of Psychology
Faculty of Life Sciences

The Experience of Depression in Black and Minority Ethnic Women

Participant Consent Form

Researcher: Sabrina Robinson, Trainee Health Psychologist

Please Tick

1. I confirm that I have read and understand the information provided to me about this study in the 'Participant Information Sheet'. I have had the opportunity to consider the information and if needed ask questions that were satisfactorily answered. ☐
2. I understand that participation in this study is voluntary and that I am free to withdraw in the two weeks after the interview (up to the point where the data from the interview becomes part of the analysis) without any disadvantage or having to give a reason. ☐
3. I understand that the information I provide will be kept strictly confidential, will be filed in a secure locked cabinet only accessible to the researcher and will be anonymised for the use of the research. ☐
4. I give consent to the interview being audiotaped using a dictaphone and transcription of the interview, and the use of direct quotes in the write-up of the study which I understand will be anonymised. ☐
5. I give consent to taking part in this research. ☐

Name of participant:
Date:
Signature:

Name of researcher:
Date:
Signature:

Demographic Information

Was verbal consent obtained from the potential participant before asking the questions below? Yes/No

1. **Date of Birth** (dd/mm/yyyy) __ __ __ __ __ __ __ __ _
2. **Ethnicity**

Asian or Asian British
☐ Bangladeshi
☐ Indian
☐ Pakistani
☐ Any Other Asian Background

Black or Black British
☐ African
☐ Caribbean
☐ Any Other Black Background

Mixed
☐ White and Asian
☐ White and Black African
☐ White and Black Caribbean
☐ Any Other Mixed Background

White
☐ White British
☐ White Irish
☐ Any Other White Background

Other Ethnic Group
☐ Chinese
☐ Any Other Ethnic Group
Please state:

3. **Gender**

☐ Female ☐ Male ☐ Transgender

4. If you were not born in the UK what is your country of origin?
5. **Religion or Beliefs**

☐ Atheism
☐ Agnosticism
☐ Buddhism
☐ Christianity
☐ Hinduism
☐ Humanism
☐ Islam
☐ Jainism
☐ Judaism
☐ Sikhism
☐ Any Other Religion/Belief
☐ No Religion or Belief
☐ Rather not say

6. What is your first language?

Thank you for your time.

APPENDIX 10

London Metropolitan University
School of Psychology
Faculty of Life Sciences

The Experience of Depression in Black and Minority Ethnic Women

Debriefing Information Sheet

Firstly, I would like to take this opportunity to thank you for taking part in this research. The purpose of the research to which you have contributed was to explore black and minority ethnic women's individual experiences of clinical depression, considering:

- Your views on and knowledge of depression
- Your help seeking behaviours
- How you view your identity and how you feel this relates to your depression
- Depression and your health status

Existing academic literature supports the idea that there is a relationship between women's identity and their experience of depression, with factors such as community views, cultural beliefs, societal opinions and availability of support being linked to an individual's experience of depression. Also some literature supports the idea that depression can have an impact on an individual's general health status.

However, there is little research looking into the processes that may be involved in this relationship, or what this experience is like from a personal perspective. Researchers have argued that further research into these processes may be helpful in promoting prevention of and recovery from disorders such as depression and better management of general health.

I would like to take the opportunity to remind you that all discussion which has taken place in the interview you have just participated in will be treated with the strictest of confidence and no information will be disclosed. I would also like to remind you of your rights to withdraw from this research within the next two weeks (up to the time of data analysis) without good reason or penalty. If I do not hear to the contrary I will assume that you are happy to continue.

Sources of Support

It is understood that sometimes people may find the subject matter discussed distressing. If answering any of these questions leads you to feel distressed and you would like to speak to someone about your thoughts, please see details of a range of organisations to seek relevant support below.

Samaritans
Confidential support for people experiencing feelings of distress or despair.
Phone: 08457 90 90 90 (24-hour helpline)
Website: www.samaritans.org.uk

Sane
Charity offering support and carrying out research into mental illness.
Phone: 0845 767 8000 (daily, 6pm-11pm)
SANEmail email: sanemail@org.uk
Website: www.sane.org.uk

Mind
Promotes the views and needs of people with mental health problems.
Phone: 0845 766 0163
Website: www.mind.org.uk

The Mental Health Foundation
Provides information and support for everyone with mental health problems or learning disabilities.
Website: www.mentalhealth.org.uk

NHS Choices
Website: http://www.nhs.uk/Pages/HomePage.aspx

Change4Life
Phone: 0300 123 4567
Website: http://www.nhs.uk/Change4Life/Pages/change-for-life.aspx

You are welcome to contact me again to discuss any aspect of your participation in this study, to share any concerns you might have or to ask questions.

Sabrina Robinson
Trainee Health Psychologist
FAO: Professional Doctorate in Health Psychology
School of Psychology
London Metropolitan University
166-220 Holloway Road
London, N7 8DB

E-mail: sabrina.robinson@hotmail.co.uk
Tel: 07545 120 622

If you have further concerns that you would like to raise with London Metropolitan University, you can contact my Academic Supervisor:

Dr Joanna Semlyen
Academic Supervisor
School of Psychology
London Metropolitan University
166-220 Holloway Road
London, N7 8DB
E-mail: j.semlyen@londonmet.ac.uk
Tel: +44(0)20 7423 0000

Thank you for your time and for taking part in this research.

LONDON METROPOLITAN UNIVERSITY DISTRESS PROTOCOL

Protocol to follow if participants become distressed during participation:

This protocol has been devised to deal with the possibility that some participants may become distressed and/or agitated during their involvement in this research. There follows below a three step protocol detailing signs of distress that the researchers will look out for, as well as action to take at each stage. It is not expected that extreme distress will occur, nor that the relevant action will become necessary. However it is included in the protocol, in case of emergencies where professionals cannot be reached in time.

Mild distress:

Signs to look out for:

1) Tearfulness
2) Voice becomes choked with emotion/ difficulty speaking
3) Participant becomes distracted/ restless

Action to take:

1) Ask participant if they are happy to continue
2) Offer them time to pause and compose themselves
3) Remind them they can stop at any time they wish if they become too distressed

Severe distress:

Signs to look out for:

1) Uncontrolled crying/ wailing, inability to talk coherently
2) Panic attack- e.g. hyperventilation, shaking, fear of impending heart attack
3) Intrusive thoughts of the traumatic event- e.g. flashbacks

Action to take:

1) The researcher will intervene to terminate the interview/experiment.
2) The debrief will begin immediately
3) Relaxation techniques will be suggested to regulate breathing/ reduce agitation
4) The researcher will recognize participants' distress, and reassure that their experiences are normal reactions to abnormal events and that most people recover.
5) If any unresolved issues arise during the interview, accept and validate their distress, but suggest that they discuss with mental health professionals and remind participants that this is not designed as a therapeutic interaction
6) Details of counselling/therapeutic services available will be offered to participants

Extreme distress:

Signs to look out for:

1) Severe agitation and possible verbal or physical aggression
2) In very extreme cases- possible psychotic breakdown where the participant relives the traumatic incident and begins to lose touch with reality

Action to take:

1) Maintain safety of participant and researcher
2) If the researcher has concerns for the participant's or others' safety, he will inform them that he has a duty to inform any existing contacts they have with mental health services, such as a Community Psychiatric Nurse (CPN) or their GP.
3) If the researcher believes that either the participant or someone else is in immediate danger, then he will suggest that they present themselves to the local A&E Department and ask for the on-call psychiatric liaison team.
4) If the participant is unwilling to seek immediate help and becomes violent, then the Police will be called and asked to use their powers under the Mental Health Act to detain someone and take them to a place of safety pending psychiatric assessment. (This last option would only be used in an extreme emergency)

Amended version of guidelines produced by Chris Cocking, London Metropolitan University Nov 2008

Interview Transcript 1 (Anita) Themes Table

THEMES	PAGE	KEY WORDS
<u>The Meaning of Receiving a Diagnosis:</u>		
Diagnosis is being pointed in the right direction	27	he pointed me in the right direction
Questioning diagnosis	19	I don't think she's suffering depression
Disbelief over diagnosis	5	It never crossed my mind
Embarrassment over diagnosis	18	I felt embarrassed
Diagnosis provides an explanation	23	I think it was a big help to know
Understanding the reasons	29	she made me understand some of the reasons
<u>Depression is Another World:</u>		
Depression another world	17	you know off in another world
Depression as a joke	5	we use to joke about it
Depression as a phase/stage	2	if I ever get to a stage now
	2	I was going through a phase
Depression as a frame of mind	2	Get myself out of that frame of mind
Levels of depression	21	something like ten percent
Depression stages	21	I'm glad I was never at that stage
Negative perception of self	41	you feel like a slob
Only seeing the negative	25	there was nothing positive
Loss of self	6	I don't feel like myself
Loss of part of self	11	you lose self-confidence you lose self-esteem
Fluctuations in mood	1	one day I was still fine
Feeling like the living dead	42	I felt like a zombie
<u>Relationship with Health Professionals:</u>		
GP's don't understand	13	They don't know what they've done
	15	how it affects a person is not good
Doctor authority	30	the doctor made me think
GP dismissive	16	off you go take these
GP's should be open	14	why not just openly say
GP's should get to know their patients	14	they never sit to get to know their patients
GP's only deal with the physical	20	I don't know how their job role is
GP focussed on the physical	16	ninety-nine percent of the time
GP last resort	37	going to the GP is the last thing I would do
Changing way of thinking	29	think like this
Perception of counselling	30	a different kind of good way
Intensity of counselling	7	they were really intense
Counselling the unknown	9	the six intense sessions
Need a connection for counselling to work	8	I didn't connect with the other one
Strange to be listened to	31	quite strange for me
You don't get support without the ask	31	without the ask it doesn't happen
<u>Having a Strong Sense of Identity:</u>		
Strong sense of identity	32	I see myself as being Bosnian
Invisible minority	34	wouldn't automatically assume I'm Muslim
No impact of identity	39	it didn't even cross my mind
Cultural affiliation	33	I've adapted to their lifestyle
No impact of societal views	39	it didn't affect me
You shouldn't change to fit in	32	to fit in with a group
Assumptions	36	they automatically assume
Racist behaviour offensive	35	I find them quite upsetting
Racism due to lack of education	35	uneducated people
<u>Cultural Denial of Mental Health:</u>		

Cultural denial of mental health	39	opened up to these kind of channels
Recognition of negative impact of culture	46	because of the fact that they are Pakistani
Cultural ignorance	38	no such thing as mental health
Cultural perceptions of mental health	38	different cultures see it very differently
Impact of the war	38	because of the events they've suffered
Negative perception of mental health	37	not in a good way
Language barriers	39	not available in their language
Medication Induced Numbness:		
Medication induced numbness	6	You didn't have the feeling
Antidepressants first line support	22	initially it was through the antidepressants
Medication withdrawal	7	the sort of withdrawal symptoms
Dislike of medication	12	I missed them
Painkillers work the best	27	I think that worked the best
Antidepressants make you feel nothing	22	It couldn't affect me
Life After Depression:		
Regaining a sense of normality	46	Sense of normality
New sense of hope	47	hope and to look forward
Having fun	26	a little bit more fun
Positive outcome of depression	40	it's been quite positive
Joy and happiness	24	now I can go enjoy it
Helping others helps self	21	I'm more determined to help these people
Looking to the future	43	you think of tomorrow
Ability to be alone	45	I love spending time alone
The depression went away	22	the more it just went away
Experiencing happy moments	24	happy moments made it better
Desire for normality	18	just doing normal stuff
Fitting into place	17	everything just started fitting back into place
Opening up	10	we started to open up to each other
Getting back to pre-depression self	23	we'll talk about it
Shift in openness	26	now I speak about it openly
Life before depression normal	4	just everyday life
Looking after self	45	I would wanna look after myself
Physicality of Depression:		
Feeling unhealthy	41	Feel lethargic all the time
Physical complications	1, 5, 6, 11, 15	I ended up needing to go to the hospital
Emotional feelings and physical symptoms	16	it's like a thumping feeling
No physical explanations	27	there was nothing wrong
Benefits of physical activity	42	it makes you feel a lot better
Aversion to food	44	I wouldn't eat for days
Exercise and happiness	43	It made me smile
Exercise to develop confidence and self-esteem	44	my esteem I started to feel better
Physical side-effects	42	constantly making me feel sick
Physical symptoms	17	tired all the time
Relationships with Others Pre and Post-Depression:		
Problematic family relationships		
Friends dragging her down	2	we used to constantly clash
Problematic relationship	3	we just weren't seeing eye to eye
Suppressing feelings	24	we were kind of dragging each other down
Cultural expectations lead to clashing	10	being sort of suppressed
Feeling needy and clingy	3	I wasn't up to the expectations of my culture
Searching to fill a hole	5	I was clinging onto
Influence of past experiences on development of	34	I was constantly searching
depression	32	Maybe previous pas experiences

Changes in relationships with others		
Improvements in relationships with others	26	our whole friendship sort of changed
Bonding with others	23	we'll talk about it
Importance of support from family and friends	44	it was a fun time
Improved relationships	18	I had a lot of support
Lack of understanding	10	Everything became normal again
<u>Passivity and Losing Control:</u>		
Passive choice	7	I thought oh well
	9	let's give it a go
Passive loss of control	2	you just allow it to carry on
Depression active, person passive	1	it makes you feel
Passive choice to be depressed	19	people have made you think that
Choice	15	pump me full of drugs
Lacking willpower	24	I didn't have any kind of willpower
Loss of willpower	11	you don't have willpower
Lack of willpower	44	you don't have the willpower
Depression makes like miserable	46	it was making my life very miserable
Depression makes you different	20	it made me different
Control (gaining)	7, 10, 22, 26, 28	I did thing my way
	18	
Control (taking)	23	help yourself
Control and management		how to go about controlling it
<u>Coping Alone:</u>		
Coping alone	7	All on my own
Benefits of self-help	2	snapped out of it cause I got self-help
	29	all the research myself
Educating self on depression	28	read the leaflets
Lack of understanding of depression	6	I didn't really understand
Isolation	2	I was isolated
Isolating self	17	I didn't wanna be around people
	23	I would just block everyone out
Seeking understanding of depression	1	Go and research and look it up
Religion opens your eyes	37	it's opened my eyes to so much
Religion as a source of support	36	it gives me a way of dealing with things
<u>Other</u>		
Inability to move forward		
Rumination		
Peer support		
Supporting others		
Experience different for everyone		
Ruminative thinking		
Inability to look forward to the future		
Mixed anxiety and depression		
Impact of depression on job role		
Repetitive routine		
Depression intriguing		

APPENDIX 12

Interview Transcript 2 (Kay) Themes Table

THEMES	PAGE	KEY WORDS
Western Medicine:		
Western medicine symptomatic	17	it's all symptomatic
All about the medicine	8	just medicine medicine and medicine
Antidepressants first line response	16	just tablets I suppose nothing else
Fear of going against western medicine	17	to go against it there just a bit frightening
Antidepressants a temporary measure	18	the temporary measure is tablets
Doctors trained for the physical not mental	6	doctors are trained for physical illness
Spirituality and Religion:		
Strong positive influence of spirituality	13	spirituality mainly yea
Influence of religion	3	I went to school to a convent
Spirituality vs. Religion	1	spirituality now rather than religion
	13	no religion is involved
Spirituality to deal with the physical complications	29	I don't know if it's spirituality
Spirituality is a way of life		
	14	oh yes
Confidence, Choice and Control:		
Shift in confidence	24	Now confidence level is up
Growing in confidence since experience of depression	2	feel less shy about talking it
Gaining assertiveness	22	maybe the last seven eight years
Increased awareness and assertiveness	11	I allowed to do what I feel is right
Control (gaining)	8	increase awareness
Lack of self-confidence	23	I sort of took my stand
Choice	29	that was lack of confidence
	1, 3, 5,	I was married and my husband came
Choice and first steps	16, 19	
	6	he was the one who prompted me to go
Desire to End Own Life:		
Desire to end own life	2	I was suicidal
Shock over unsuccessful suicide attempt	9	shock really I was thinking how
Seeking meaning for suicide attempt survival	2	maybe God thinks I need to be here
Unaddressed suicide	10	let it go
Desire to switch off	9	wanted to shut the whole thing off
Depression Affects Everything:		
Depression makes everything difficult	15	it made everything really difficult
Significance of finding every day activities difficult	1	read on my own a lot but now I find it difficult
Depression affects everything		
Inability to work	16	everything less
Depression identity	7	I can't keep up the standard
Pressure of the day to day	24	when I was depressed
Perceptions of self	2	that put a lot of pressure on me
Inability to concentrate	15	if they knew how I was feeling
Fear of being left behind	4	I just couldn't concentrate
Inability to do a simple everyday task	7	you don't feel left behind
Struggling and coping	30	forgotten what you read on the first page
	16	even though you struggled
Rationalising Depression:		
Rationalising depression	17	now that I have rationalised
Life struggle	7	always the life the struggle

Questioning onset of depression	4	maybe it started long before
Finding understanding	21	somebody who would understand
Increased awareness and understanding	6	increasing the awareness and understanding
Depression is a bad period	5	it got me through the bad period
Early onset of depression	30	started before I realised
Biochemistry of depression	17	biochemistry is the result
Seeking answers	12	gave me an answer that I could accept
Depression in built	18	hereditary inclination for depression
Depression starts creeping in	4	started creeping in
Taking a different turn	3	I took a different turn
Talking therapies over medication	18	that's more important than medication
Talking to move on	6	I can't move on until I talk
Benefits of being listened to	23	they just listened which was good
Having to be proactive about diagnosis	5	if you asked questions you got answers
Problematic Relationships a Catalyst:		
Problematic family relationships a catalyst to depression	12	yea it's mainly that
Not being acknowledged	10	didn't acknowledge me
Lack of support from husband	11	he just turned a blind eye
Husband lacks empathy	23	my husband has no empathy
Lack of communication with husband	15	communication was getting less
Inability to forgive and forget	12	I can't forgive I can't forget
Problematic family relationships	10	that really put a…dagger into me
Being detached from attachment	13	be detached with attachment
Resolution of conflict	11	third day I went with him
Recognition and acceptance	19	first thing is to accept you need outside help
Mistake to expect anything from others	24	that's also a mistake isn't it
Sharing Experience:		
Passing the message on	27	I can tell them not to get frightened
Volunteering as an outlet	25	volunteering…that's an outlet
Giving back to try and find happiness	25	I started working at a local psychiatric
Negative impact of listening to others	26	they felt better I felt bad
Ability to talk openly about depression	22	now I sort of you know talk freely
Change in perception of mental health in society	27	society didn't want to know
Realisation you are not alone	8	see that other people have problems
Positive outcome from experience of depression	16	in a way it has been a good thing
Receiving empathy	21	empathy from people who understand
Desire for encouragement	19	oh yes otherwise I wouldn't have
Physical Complications:		
Physical complications	2	I was continuously was sleeping
	7	always feeling tired
Physical health rated as minus when depressed	28	maybe into the minus sometimes
Good personal physical health	28	yea I think it's good
Overeating to deal with emotions	30	because you were so anxious and frustrated
Changes in health related habits	29	before I use to overeat
Other		
Diagnosis provides relief Desperation to get better Fluctuations in mood Isolation Recovery Time barriers to support Impact of depression on others Anger and depression		

Benefits of team sports
No experience of prejudice or discrimination
Quality of life shifted over time
Identity as a wife and mother
Protecting others from depression
Support of alternative therapies

APPENDIX 12

Interview Transcript 3 (Madison) Themes Table

THEMES	**PAGE**	**KEY WORDS**
Fulani Identity:		
Fulani identity	3	my tribe the Fulani people
Falling in love with birth country	10	I sort of fell in love with the place
Learning about her cultural background	21	I read a lot
Cultural affiliation	57	my life I’ve done most of it here
Growing love for birth country	29	it’s such a beautiful country
Using mother tongue	12	Creole
Strong love for birth country	16	I love my country
Relationship with Personal Culture:		
Going against cultural traditions	14	I’m not putting my daughter
Questioning cultural traditions and rituals	47	that’s not in the Qu’ran
Forgotten culture	10	I had forgot my language
Expectation to follow in her culture vs. having her own mind	46	in my culture you have to be a sheep
Missed cultural learning	17	in my society I don’t fit
No understanding of mental health in home country	62	definitely no understanding
Inability to integrate in her culture		
	57	I can’t integrate fully in my culture
Isolated in White Man’s Soup:		
Isolated in white man’s soup	38	isolated put into white man’s soup
White people make Black people feel less	45	I don’t want no White person
Racial bullying	21	they use to take the piss
Demanding respect	26	you have to respect me
White man don’t want you to be on top	58	white man don’t want you to be on top
Assertiveness and frustration over not being accepted	38	assertive I have to be
Aggression and being held back		
White people unclean	37	I’m kind of aggressive with people
Neighbourhood hostility	54	White people put me off
Self above others who are not her people	44	I have that feeling around here
Being taken at face value	44	I’m up here
Protecting son	37	what you see is what you get
Protecting son from becoming a black stereotype	48	I didn’t want that
Protecting son from the White man	45	don’t want no Black stereotype youth
Belief others are scared of her	74	let the white man fling my son
Maintaining perfection as a Black woman	59	you don’t like me you’re scared
Feeling put down by others	75	I have to do everything perfect
	59	a put down thing going on
Addiction:		
Addiction a treadmill	42	the treadmill it’s a psychological
Inability to stop	66	I tried to stop really really hard
Drinking has always been part of my life	36	drinking has always been part of my life
Inability to break the habit	66	went back to my old ways
Dope before necessities	67	I haven’t got money to buy milk
Addiction psychological and physical	64	it is psychological
Smoking embarrassing and isolating	84	it’s embarrassing it’s isolating
Substance abuse and confusion	5	started smoking cigarettes at nine
Spliff is just part of my life	83	I smoke like how people smoke cigarettes
Shutting self away and hiding behaviours	65	I get home I shut that door
Beating addiction	51	happy cause I’d finally beat it
Lack of Love in Childhood:		

Missing out on the basics in childhood	8	I didn't get the basic
Jealousy	80	I'm kind of jealous
Psychological and emotional suffering	84	psychologically emotionally I suffered
Missing out on love	4	they had all the love
Anger over not receiving unconditional love	76	I'm angry for losing my mum
Problematic relationships	16	like a slave in the house
Loss of mother	33	I went to her and she was dead
Treated like a skivvy	21	treated me like a skivvy
Tumultuous family relationships	23	she needed me
Living in a strict loveless environment	4	very strict there wasn't no love
Problematic relationship with sibling	18	broke our whole relationship
Slavery and a lack of love	7	the slave there was no love
Sister a replacement mother figure	3	she's like my mum
Early loss	1	I came here due to my mother
Living with real family	5	my actual family
Relationship breakdown with sibling	56	our relationship broke down
Free vs. strict environments	2	coming from a free background
Reluctance to disclose to family	53	I don't want I tell them
Stereotyped by siblings	76	they see me as a problem
The Drugs Don't Work:		
Drugs make me madder	60	it makes me go madder
Smoking and psychosis	22	I know why I'm psychotic
Drinking affects everything	74	it affect everything
The substances will affect you one day	64	it's gonna clap you one day
Lacking Concentration:		
Struggling to concentrate	75	I'm struggling
Depression has an impact on thinking	49	I can't put two thoughts together
Inability to complete a simple task	74	I can't even read
Family Pressure:		
Family pressure	52	please go back to your marriage
Family see her as an asset	70	I'm a good asset
African men look at you as an asset	69	they look at you like an asset
Nightmare arranged marriage	35	it was a nightmare
Desire for a proper relationship	68	I want to be married
Being restricted	17	weren't allowed to go out
Husband a psycho	36	he was a psycho
External vs. Internal Health:		
Concern over health implications	39	I'm worried
Inability to sleep	71	forget the sleeping
Desire for deep sleep	72	I wish I could have that again
External vs. internal health	63	I look healthy but I know I'm not
Feeling the physical effect on the body	73	I can feel it going tick ticka
Drinking and sleeping problems	65	years of not sleeping properly
Struggling Alone:		
Struggling alone	43	I'm struggling putting food on the table
On her own throughout her life	35	I've done everything on my own
No-one can stop me but myself	40	nobody is going to make me stop
Ability to discipline others but not self	79	I can discipline
Responsibility from a young age	18	I'd always be there to look after the kids
Me against the world	15	I'm against the world here
Learning to look after yourself	34	we looked after ourselves
Rationalising Depression:		

Looking for a reason why things went wrong	8	all of this went wrong when my parents died
Being a functioning depressive	62	I'm a functioning depressive
Identifying you have a problem	77	I'm identifying that I have this problem
Knowing depression	37	I know I'm depressed
Depression is internal	37	my depression is internal
Depression is constant	63	depression is a constant
Depression brought on by loss	2	my depression that's when it started
Comparing illnesses	62	it's not the same as being psychotic
Identifying something wasn't right	36	why I feel this way
Belief she has had depression all her life	79	I think I've had depression all my life
Desperation and feeling down	61	I get really desperate
Alternative Treatments:		
Trying alternative treatments	42	the whole shebang I've done it
Questioning advice	49	my doctors been persuaded me
Benefits of relaxation	54	I just run around so much
Connection between mind and body	54	when I pray I feel better
Benefit of alternative therapies	68	I've tried everything you know
Refusing 'psychotic' drugs	41	I refused to take the psychotic drugs
Clinic a nasty place to be	62	it wasn't what I expected
Health benefits to attending 'nightmare' clinic	50	you should have seen my hair
Fear of medication	77	it just made me worse
The psychiatrist picked my life apart	36	we totally picked part my life
Religion:		
Belief and faith	84	my belief my faith
Prayer and routine	51	pray and then sleep
Religion and rituals	33	apusara
Spiritual experience	30	I believe his spirit came
Blessed by God	84	I'm so blessed
Learning about religion	55	the prayer I taught myself
Sleep, exercise and religion	79	sleeping helps a lot, and exercise and prayer
Choice:		
Choice	1, 2 ,4, 8, 13, 36, 39, 41, 68	put in a position
Choice and punishment	29	you think we're gonna leave you to go back
Choice and being bad	24	I carried on with my badness
Choice and psychological pressure	51	you have to be married
Hatred of the Self:		
Self-hatred	40	I hate myself
Fear of being seen as dumb or stupid	78	does that make me stupid
Trapped personal offerings of self	39	I've got so much to give
Own worst enemy and lacking discipline	67	I am my worst enemy
Negative perception of external self	65	I don't feel beautiful
Suicide attempt	55	I tried to commit suicide
Guilt and hatred of self	25	I've just hated myself ever since
Others can see the struggle	41	we can see that you're struggling
Self-hatred and being a victim	37	I hate being a victim
Not a rounded person	76	I'm the only one
Vulnerability	20	I was vulnerable
Failure and isolation	44	I feel so isolated
Weakness	52	kind of strong but I'm not
Not belonging	7	you don't belong

Suicide a shameful act	57	I don't want them to be ashamed of me
Strong sense of self	29	I have my own mind
Having a lot to give	41	I've just got so much to give
Destroying self	68	I'm just destroying myself
Regrets and guilt	9	I regret it so much
Lifetime of feeling suicidal	57	all throughout my life I felt that way
Isolating self	40	I don't want anybody near me
Positive perception of self	60	I'm a very optimistic and positive person
Finding self	17	so I'm coming out of myself
Embarrassment over failure	50	when I failed that final exam
Guilt and regret	74	I feel so awful for doing that
Frustrating and upsetting ruminative thinking	66	just going round and round
Substance abuse and self-hatred	64	isn't it self-hatred
Smoking is a hindrance	41	smoking has hindered me
Holding Your Line:		
Controlling destiny	62	trying to control my destiny
Substances to suppress feelings	41	suppress everything
Desire to not go down the drain	55	I don't want to go down the drain
Fighting depression	60	I consciously fight it
Substances hold your line	42	with my line just hold it
Fighting to not go down the drain and protect self	49	I'm fighting I'm fighting it
Putting up defences		
Desire to release substances	60	I ain't got nothing to say to you
Desire to rid demons	68	just get it out
Smoking to fill a void	85	directive
Exhausted thinking what to do next	22	feel full up
The depression won't beat me	83	I'm exhausted about thinking about it
Need to take control to move on	61	I won't let it beat me
Desire to stop the vicious cycle	50	it's got to come from me
Depression is a private thing	61	if I get out of the vicious circle
Acceptance	61	it's a private thing between me and my doctor
Maintaining a balanced diet to hold yourself up	47	sometimes things happen for a reason
Assertiveness and suppression	72	that's what's held me up
Taking control	80	speak your mind
Getting rid of the demon	47	I need to overcome this
Control	71	if I can get rid of that demon
No blame or bitterness	70	the control is still there
Fear of the future	35	no more bitterness
No regrets	70	I don't want that for me
Smoking due to the negative	43	I don't regret that
	21	for all that was going on
Abuse:		
Living in the middle of a paedophile ring	5	they talk about a paedophile ring
Violent repercussions for wrong doing	19	I got battered
Becoming hard to abuse	7	I'd become hard to it
Rape ordeal painful and humiliating	56	so painful, so humiliating
Abusive relationship	53	he broke my jaw
Stopping the abuse	16	I had stopped all like the abuse
Slavery leads to anger and frustration	9	all the anger all the frustration
Fighting white, dirty, disgusting men	7	white dirty disgusting nasty
Introduction to the Bundo Society:		
Introduction to the Bundo Society	11	we are going to introduce you to society
FGM	12	I could feel each slice
Protecting others from FGM	13	I don't see why you should do it raw
Shocking experience	15	I was so shocked

Cultural stigma if not circumcised	13	they look at you funny
Inhumane treatment	13	like a bunch of cattle
Protesting and fighting	11	I said no
Other: Talking about it makes you a drama queen Stigma due to mental health identity Ruminative thinking Finding a sense of freedom Fluctuations in level of depression Rekindling relationships Family provided advice Comparing self to others Being brought up properly Desire to go back home to Africa Belief in signs Closure Turning feelings on others Opportunity Putting trust in others Living in idyllic little England Depression makes work difficult Fondness of career identity Vivid memories of the upheaval Seeking closure Being seen as a bad influence on others Open relationship with daughter Daughter tried to help her take control Positive directive Responsibilities at a young age Caring for others Others feeling blame for her action Telling my story is therapeutic Protective behaviours Marked fluctuations in mood Losing the plot/frustration over son Moving from one bad environment to another Telling her life story Proud of children Denial over diagnosis Validating diagnosis		

Interview Transcript 4 (Nadine) Themes Table

THEMES	PAGE	KEY WORDS
Perfectionism and Survival:		
Trying to fit the perfect image	58	it's part of the whole image and strength
Inability to show weakness	29	had to be strong and we can't show weak
Expectations of being successful	8	we'll all be successful
Desire to have a perfect life	10	just wanna go have a perfect life
Pressure to have it all	14	with the recession and being pressured
Inability to sustain a happy life	29	it's not gonna sustain
Lacking meaning in life	59	just going with the flow
Pressure to fit in/Perfectionism	9	pressure to fit in just perfect
Desire to belong	6	feeling that I belonged somewhere
Inability to fit in	4	I couldn't fit into everything
	9	I could have fitted in
Trying to fit in and blend	50	I try and fit in I think and blend
Seeking a complete life	4	I just want a complete life
Trying to be strong and independent	61	I tried to be strong and always independent
Fear of not living up to the cooperate image	44	I had this proper coorperate image
Inability to achieve perfection	32	it just doesn't work out like
Pressure to have everything	60	the pressure of having everything
Belonging	7	it's a belonging
Image of the ideal woman	4	I had the image of women
Polarized images of women	31	strong or cold or vulnerable and soft
Learning you can't have it all	60	you can't have it all
Striving for the image of an ideal woman	5	they look good they have the partner
Self as a career woman	11	flow of being a career woman
Women are not perfect	5	we're not all this image
Perception of not being a normal woman	23	it's hard enough as a normal woman
Difficult relationships with other women	30	I was against women
Survival instinct to be perfect	30	perfect I think it's like a survival thing
Paying the price	43	there comes a price to pay
Cut throat mentality of surviving	34	very cut throat kind of mentality
Goal to survive	32	goal to survive and make it
Self as a survivor	7	I was like more of a survivor
Growing up too fast	7	I grew up too fast having to survive
Expectations of Asian Culture:		
Expectations of Asian culture	18	it's hard because obviously in Asian culture
	51	you're supposed to be like a certain way
Asian girls closed	50	closed an Asian girl as you can get
Old and new generation Asians	51	new generation understand problems
Shift in Muslim's openness	51	the other Muslim girls were talking
Prejudice among Asian culture	40	more prejudice amongst your own
Problems hidden in Asian culture	51	it's hidden and we can't talk
Asian girls have limits	12	you do stuff within limits
Asian culture not real life	19	in real life I can say parents are human
Living in an Asian world	53	I had to have an Asian world
Perfect Muslim's	20	perfect Muslim with a perfect life
Asian girls seen as bad	51	Asian girls are bad
Expectation to conform in Asian culture	19	the whole conforming…it is still Asian culture
Cultural affiliation	48	I'm comfortable saying I'm British
Different cultural mentalities	15	I might have the different mentality
Culture makes depression lonely	52	culture makes it lonely
Asian culture means children bad, parents good	19	Asian culture you're the bad girl
Subconscious cultural pressure	21	like a subconscious pressure

Asian culture hard	29	they are still hard
Identity pressure	49	I should be religious I should fit into this
Stigmatised by family	15	I'm stigmatised because they don't understand
Vulnerability:		
Vulnerability	6	when you're vulnerable
	15	when I'm vulnerable they take advantage
Vulnerability unacceptable	37	it wasn't accepted
Sensitivity	60	more sensitive to things
Denial and sensitivity	42	denial and just trying to be strong
Hiding away to protect self pride	54	I just hide away at home
Allowing self to be outlet for others (vulnerability)	26	they have to have an outlet
Feeling self-conscious		
Striving to build confidence	43	I'm very self-conscious
Lowered confidence	1	trying to build my confidence
Reduced confidence	56	it downs my confidence
Control (taking)	61	my confidence went so down
Control	28	I learnt to stand on my own
	45	her role to do that controlling thing
Judgement:		
Judgement from other Asian girls	20	they are gonna judge me
Judgement	19, 20, 22, 46	angry when people judge
People make assumptions	21	it's an assumption
Judged by older Asian women	38	older Asian women and I judged
Judged as an Asian girl	18	I feel like I was judged as an Asian girl
Fear of being judged	49	I still think an Asian girls gonna judge me
Shift in levels of judgement	22	before they were judgemental
Assumptions and being labelled	48	I get angry
Experience of indirect racism	49	racism but not really direct
The Self:		
Acceptance of identity	49	now I'm not ashamed of it
Identity of being an individual	48	I just want to be me
Desire to be seen for who she is	49	I would just be me
Learning self-awareness	9	learnt yea about self-awareness
Perception of self	61	some people see me as strong
Masculine and feminine self	30	strong like a male
Finding yourself	7	finding yourself and feeling that you belonged
Confusion about identity	59	I was confused about who I was
Loss of self	44	whole switch of identity
Different versions of self	59	outer me rather than inner me
Personal identity (Asian with no family)	52	there's an identity with having no family
Fitting into different categories	25	I have all these different boxes
Focussing on personal development	14	concentrated on personal development
Depending on self	34	have to depend on yourself
Dealing with it alone	47	was just me on my own
Living a Fake Lie:		
Living a fake lie	33	live that fake lie
Living a front	37	I carried on living a front
Putting on a strong face	30	have to put on a strong face
Keeping depression hidden	14	I keep it more hidden
	47	I kept it hidden
Keeping hold of depression	29	I kept hold keeping it at the back
Not allowing the depression to hit	56	I didn't let it
Inability to express feelings	7	we didn't talk about feelings

Suppressing emotions	10	very logical like a machine
Unexpressed anger	6	anger that wasn't expressed
Hiding depression and self-harm	31	I hid my depression I was self-harming
Self-harming made you feel better at the time	33	it felt better at the time
Self-harming as a release	32	like a release
Self-harming like a scream	43	I wanted to just scream out
Problematic Relationships:		
Problematic relationships	2	didn't have good family relationships
Problematic relationships with men	3	men I have a lot of problems
Family good on the outside, bad on the inside	18	we all looked good and sensible
Unresolved family issues	60	never been fully resolved
Confusion of lacking a mother figure	2	more confusing without a mum figure
Explosive relationship	28	an explosive kind of chemistry
Closed father	2	he was very closed
Inability to interfere with own family in Asian culture	22	you couldn't do anything unless it was your own family
Changes in relationships with others		
Complex relationship	45	I saw true colours of friends
Death of mother never dealt with	27	he had his issues
Abuse and bullying	18	I don't think I fully dealt with it
Abuse mentally damaging	23	neglect and stuff and manipulation
Deprivation in childhood	23	mentally it damaged me
Lack of love in childhood	25	taught like we are nobody
Lack of love or emotion in childhood	26	there is no love
Suffered physical and emotional abuse	3	there was no love or emotion
Controlling stepmother	2	I suffered physical emotional abuse
Fighting in childhood	18	my stepmother was a control thing
Unrecognised abuse	17	I was fighting something
Desire to be free	24	only gave me the link as an adult
Life of turmoil	5	I need to be free
Lack of social skills	2	my life was kind of turmoil
Lacking solid foundations	3	he could have taught us social skills
Logical detachment	13	I don't feel I had the solid foundation
Difficulty sustaining relationships	30	the whole logical detachment
Lacking social skills	53	my relationships aren't all sustained
Inability to mix with others	3	he didn't teach us social skills
Difficulties with attachment	50	I didn't know how to mix
	4	I pull away
Internal Symptoms of Depression:		
Embarrassment and frustration over physical problems	57	that side of things it's embarrassing
Sleep problems	56	overslept and I get really tired
Internal damage from depression	59	I didn't deal with my depression
Loss of healthy behaviours	55	when I feel down I don't wanna go
Physical symptoms are brain getting away from the psychological	58	your brain wants to get away
Health behaviours improve as get better	56	as I got better
Physical symptoms make you feel weak and powerless	58	I felt more weak and powerless
Desire to End Own Life:		
Suicide not taken seriously	35	they didn't take it serious
Diagnosis after attempting to end own life	34	went to the hospital and then they diagnosed me
		I was suicidal and I took an overdose
Desire to end own life	12	
Depression Breakdown:		
Reaching breaking point	5	I came to breaking point

	43	I was just breaking
	45	it get to breaking point
Depression breakdown	14	lost my job after the breakdown
Definition of a breakdown	43	that's why I class it as a breakdown
The depression hit	38	then my depression hit
Desire to break away	44	I needed to break away
Hitting rock bottom and isolating self	44	I isolated myself… I hit rock bottom
Working until breakdown	27	working until I had a breakdown
Desire to shut off the world	13	I just wanna shut off to the world
Loneliness	8	the most loneliest time
	52	I still feel lonely
Depression breakdown and rebuilding	1	I had a depression breakdown
Isolating self	46	I isolated myself
Neglecting and isolating self	31	neglected and isolated myself
Frame of mind	9	I wasn't in the right frame
Being pulled to the negative	13	magnets pull me away to the negative
<u>Culture of Health Services:</u>		
Language barriers to support	41	an older lady who didn't speak much English
Different groups fulfil different needs	39	like I said it's different needs
Different experiences in services depending on culture	40	culture not everyone's had the same experience
Different support groups have different cultures		I don't know if it's a culture
Cultural barriers to support	39	yea I think there is
Need more culturally aware services	41	more culturally aware more aware of needs
White middle class perfection	41	white middle class got no problems
	41	
<u>Support:</u>		
People with mental health issues expected to fit into particular boxes	53	fitting into the system
Need round the clock care	41	with them one hundred twenty four hours
Medical mentality	36	the whole mentality of medical
Benefits of mental health support groups	38	mental health support groups I found
Support from relationship	26	he was around so he was helping
Lack of proper treatment	35	no proper treatment
Groups provide emotional support	62	good like support emotionally
Gathering information	45	always good at like getting leaflets
Doctors put people in a box	38	I think they put you in one box
Lack of support	47	everyone else just kind of switched off
Concept of support groups alien	27	I use to see these support groups
Lack of support options	38	just say counselling on their books
Pressure with a lack of support	12	that pressure and no support
Work a barrier to support	27	my boss wouldn't let me off
Counsellors need to get to know you	17	you have to get to know somebody
Breakdown of counselling relationship	17	you can't make an assumption
Diagnosis provides an explanation	12	I probably was aware of sadness
Diagnosis provides care	36	it felt better cause then I've got a diagnosis
<u>Other</u>		
Genetics of depression		
Early onset of depression		
Openness with friends		
Awareness of depression		
Polarized thinking		
Unrecognised depression		
Learnt behaviours		
Difference between perception and reality		
Reversal of feelings		

Envy
Back to normality
Rebellion
Negative media perception of mental health
Education as an outlet
Lack of understanding of depression
Early onset of depression
Education as an outlet/to gain acknowledgment
Geographical cultures
University a difficult time
Experience opened her eyes
Mental health doesn’t push you

Interview Transcript 5 (Ria) Themes Table

THEMES	PAGE	KEY WORDS
Expectation to Cope and Get On:		
Culture to cope and get on	27	brought up to just cope just get on
Family perception she should be stronger	15	they just think I should be a lot stronger
Fear of being judged	35	you’re not judging me
Maintaining a stiff upper lip	28	don’t speak about it too much
Expectation from others to move on	16	if they can do it why can’t I
Strained relationship with family	14	my family it’s very strained at the moment
Strained family relationships	15	relationships have become very strained
Family perception she wallows in depression	26	they are just telling me that I wallow in it
Family question her diagnosis	33	have you…had a proper diagnosis
Uncomfortable talking about depression	35	I don’t feel comfortable talking about it
Questioning Choices:		
Bad decisions	5	probably the worse thing
Questioning decisions	7, 37, 40	if only I’d done that
Questioning choices	39	I don’t know if that’s a wise thing
Questioning proactivity	21	I could have done something a bit more
Would of, should of, could of	6	I do a lot of this would of, should of, could of
Depression causes horrible confusion	19	totally confused it’s that horrible confusion
Depression affects concentration	6	it was affecting my concentration
Thinking too much	42	I just did things without even thinking
Confusion and questioning	24	I just don’t know I’m just really confused
Questioning relationship	3	I just keep thinking it was the right thing
Questioning level of depression	21	why am I even here
Questioning personal need	45	perhaps my need is over exaggerated
Despair	44	in a bit of despair
Lacking control or choice	10	I felt like I was on a river bank swimming
Passive choice	4	ok we’ll give it another go
Passive choice and questioning decisions	4	maybe I just need to give it time
Mental health has control	29	mental health which is pulling you back
Control equals empowerment	31	I guess that empowerment
Control/inability to think for herself	30	I just don’t feel like I can think for myself
Choice	3	he convinced me to go back
Horrible turmoil	12	horrible turmoil absolute turmoil
Relationship with The Self:		
Self as a complete failure	9	I feel like a complete failure
Guilt	15	I feel guilty
Blaming self	9	I’m just blaming myself
	10	I blame myself for losing
Lack of self-value	2	insurance company…that’s it really
Loss of identity	27	I feel like I’ve lost that now
Consuming guilt	6	carry around an awful amount of guilt
Loss of self	15	I wanna feel like me
Depression a selfish illness	36	depression is a very very selfish illness
Depression Has The Control:		
Struggling with the ever day	32	struggling with you know normal everyday
Lack of control over depression	38	an emotional illness that can drag you
Things begin to snowball	7	things just kind of snowball
Inability to cope with the day to day	20	I suddenly felt I couldn’t cope
Juggling balls	18	there are so many balls you can juggle
	29	like juggling balls in the air

Draining	13	draining very tiring
Loss of routine and focus	22	I've lost my routine
Fear and isolation	12	the thought of going out scared me
Putting others first vs. putting self first	30	thinking of him putting them first
Inability to Think of the Future:		
Inability to plan for the future	40	it's also affecting your plan going forward
Anxiety stops you moving forward	11	anxiety stops me from going forward
	30	it then stops you moving forward
Stuck in the past	9	my name is stuck in the past
Lacking motivation	39	that motivation to get to the gym
Moving out of the box	30	it will bring me outside of the box
I don't want to feel like this anymore	26	I don't wanna feel like this anymore
Depression is being off track	20	everything would be fine I'd get back on track
Feeling lost and like you have nothing	8	I just feel so lost
Desire to stop dwelling on the past	11	I have to stop thinking about the past
Desire for old life over depression	25	half of me wishes I could have that life back
Inability to live in the here and now	12	thinking too much into the future
Challenging thoughts	10	challenging those negative negative thoughts
Depression relapse	33	I'm well again and then I lapse back
Relapse cycle	18	I get well again
Relapse	5	the depression came back again
Struggling to be herself	46	I'm struggling to be myself
Fear of taking action	19	I'm scared to do anything about it
Fear of being stuck	9	terrified I am going to be stuck like this
Inability to think of the future	46	I can't even think about tomorrow
Need to be pushed in the right direction	40	I need someone to push me
Recovery is finding yourself again	46	where I kind of place myself
Lack of hope and negativity	12	all you see…is negativity
Lost and confused	41	I just feel lost lost and confused
Inability to move forward	29	you don't actually move forward
Desire for routine	41	it's how I get that all back
Focussing on the here and now	22	help me focus sort of on the here and now
Inability to see the positives	3	I just couldn't see those positive things
Mental Health Struggle:		
Hopeless and inability to cope	5	not feeling that I can go on
Feeling low and tearful	17	I was just feeling really low
Mental health struggle	8	mental health is just really really struggling
Feeling like you are going to die	10	about to die your heads about to explode
Embarrassment	16	I feel embarrassed to speak to her
Anxiety and feeling alone	3	I'd kind of had little bouts of anxiety
Expectation of being a superqueen	41	superqueen if you know what I mean
Wrong frame of mind	18	I'm not in the right frame of mind
Shame of diagnosis	25	Ashamed almost hid it
Depression a Horrible Disease:		
Depression eats away at your health behaviours	39	depression definitely eats away
Depression makes it hard to bounce back	36	it kind of took me down
Physical health tangible, mental health not	35	mental health you can't see it
Comparing mental health to physical health	34	just like with cancer you know
Depression taking over her body	34	it's just not leaving my body
Depression a horrible disease	24	it's just a horrible disease to have
Depression is an emotional wellbeing	37	it's an emotional wellbeing
Depression is a chemical imbalance	43	it's a chemical imbalance in the brain
Disguising Depression:		
Disguising depression	21	putting sort of a smoke screen over it

Avoidance of the negative	17	block out the negative
Antidepressants like rose tinted glasses	28	antidepressants it’s very like rose tinted
Depression like quicksand taking you down	13	the sand taking me down
Depression gives you a false identity	29	it can give you a false identity
Depression is having a muzzy head	12	you’ve got a muzzy muzzy muzzy head
Awful black hole and lacking control		
Moving Forward in a Positive Direction:		
Moving forward in a positive direction	7	things were moving forward in a positive
Gaining positivity and hope	23	it gives you positivity that there is hope
Rising to the challenge	22	a challenge of getting better
Depression shouldn’t define you	45	not allow the depression… to define you
Regaining focus	8	I had finally got my focus back
	16	kind of helped my focus
Questioning the need for a fresh start	6	just completely starting afresh perhaps
Strength	47	it’s finding the strength
Therapist provided motivation	22	gave me the motivation to get better
Being on a good even keel	21	I was on a good even keel
Desire for previous quality of life	42	I want my quality of life back
You Can’t Just Put a Stick Plaster Over Depression:		
You can’t just mend emotional health		
Being at a crossroads with treatment	38	put a sticky plaster over it
Work a barrier to getting help	17	at a bit of a crossroads now
Opening up to someone neutral	23	barrier…whilst I was working
No quick fix for depression	25	someone at work cause she was outside
Motivation to seek help	42	there’s no sort of quick fix
Antidepressants dictatorial	19	I felt very very motivated
Antidepressants stop the negative drum	15	I don’t want that to dictate who I am
Antidepressants keep you balanced	39	stops the negative drum
Antidepressants first line support	6	they sort of kept balanced
Lack of knowledge of antidepressants	21	always just really about the antidepressants
Taking the happy pills	18	I didn’t even know what antidepressants were
	20	I could just take these happy pills
Other		
Different coping mechanisms		
Each mental health issue is different		
Fluctuating moods		
Feeling lonely despite not being alone		
Change in routine		
Plodding along until the onset of depression		
Previous positive perception of self		
Old identity fun loving		
Accepting loss of the fairy tale		
Depression doesn’t discriminate		
Relationship breakdown		
Work difficulties		
Manic highs		
City worker		
Positive childhood		
Protective of daughter and setting an example		
Financial difficulties go hand in hand with the emotional		
Difficulties at work		
Losing job		
Starting a new relationship		
Prejudice and discrimination within the workplace		
Life is not a bed of roses		

Life before was easy
Seen as nutter, lazy or worthless
More understanding and support needed
Each mental health issue is different

MASTER TABLE OF THEMES

MASTER THEMES	SUBTHEMES
1. CULTURAL EXPECTATIONS AND DEPRESSION: "I JUST NEED TO BE ME"	Cultural Identity and Health: Stress, Pressure and Depression
	Being a Minority: "Isolated, Put Into White Man's Soup"
	Cultural Denial of Mental Health: "There's no such thing as mental health problems"
2. THE NATURE OF DEPRESSION: AGENCY, FAÇADES AND COPING	Depression Has Agency : "Once it gets going and you just allow it to carry on"
	Emotional Feelings Presenting as Physical Symptoms
	"Putting sort of a smoke screen over it"
	Antidepressants: "It's very like rose tinted glasses"

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1. Cultural Expectations and Depression: "I just need to be me"	
Cultural Identity and Health: Stress, Pressure and Depression	
Anita: '*Obviously because I'm not from an English background and I'm not English my culture's different. The fact that I wasn't, I think the fact that I wasn't up to the expectation of my culture it was a bit just kind of a let-down. I felt like I was letting my family down. I wasn't the typical, you know, Bosnian girl that you know goes and gets married and has kids.*'	41-45
Madison: '*I am my own person. You see in my culture you have to be a sheep, when everybody go this way one, one all man go through yea. I'm not like that, I've got my own mind.*'	912-914
Nadine: '*The fact that I haven't got a family makes me feel like lonely or depressed, like I think there's an identity with having no family and having an Asian culture and an Asian woman that brings that.*'	1010-1013
Being a Minority: "Isolated Put Into White Man's Soup"	
Madison: '*Here now, totally isolated, put into white man's soup now, right*'	755-756
Nadine: '*The fact that I haven't got a family makes me feel like lonely or depressed. Like I think there's an identity with having no family and having an Asian culture and an Asian woman that brings that, having to be an independent person, although I mix, I still feel lonely.*'	1010-1014
	606-610

Anita: '*I'm European, I'm a Muslim girl, I'm a female. To be honest I see myself, I see myself as being Bosnian, I don't have any kind of problems with that, I never did have any problems with that. I've never experienced any kind of racism or anything like that, so it didn't, I don't think it has any kind of effect on me, [I'm] quite content in the way that I feel in regards to my identity.*' Cultural Denial of Mental Health: "There's no such thing as mental health problems" Anita: '*They don't talk about it, "there there's no such thing as mental health problems", "you don't have a mental health problem". [ ] I think the mental health problem that they would see as a problem is someone who's gone to a mental health institute or has been admitted. That's the kind of problem and to them that's someone who's already mad or crazy and that's how they see it but otherwise there's no such thing.*' Madison: '*Definitely no understanding.*' Nadine: '*the new generation understand problems, like I said, I'm getting more comfortable with Asian girls than I've ever been because underneath it it's not hidden and there are more issues.*'	727-732 1227 979-982
2. The Nature of Depression: Agency, Façades and Coping Depression Has Agency: "Once it gets going and you just allow it to carry on" Anita: '*things weren't good and it just, you just felt that it all spirals out of control and you just you don't know how to bring it all together. I think that was the, they were the main factors that affected me and then once it gets going and you just allow it to carry on it just gets worse and worse.*' Ria: '*it kind of was like all I can describe, an awful black hole a few days went by and I just felt this awful black hole just literally, almost like a tornado, just trying to take me over and whirl, whirl, whirling, whirling around and if I'd thought I had depression bits and pieces prior, this was nothing compared to what I actually went through and it was just an awful, awful experience*' Emotional Feelings Presenting as Physical Symptoms Anita: '*I used to say this to my doctor, "this is how I feel when I get upset or angry". I still get that feeling, it's like a thumping feeling in your stomach and it makes you feel sick straight away, but it never really registered.*' Kay: '*I can't remember but I feel always the life, the struggle I was always feeling tired and nobody could explain why the tiredness. So when I, when*	35-38 64-69 290-292 117-121 1095-1097

I went to the GP he did the thyroxin and then it was low so I started taking thyroxin, and the tiredness, and you don’t know which one is which.’	767-768
Nadine: ‘*depression, it causes a lot of stress but I had like bladder and thrush and all those women stuff and they said it’s all linked because every time I got stressed I got all those things on and off.’*	409-412
Madison: ‘*all these thoughts are going round and round and round and round in my head, I need to vomit.’*	629-633
“Putting sort of a smoke screen over it”	
Ria: ‘*I am aware that I do this a lot as well, is just keeping myself busy so I don’t have to think about or worry or focus about my mental health, actually it’s sort of like almost like putting sort of a smoke screen over it.’*	83-89
Nadine: ‘*I showed as more the joker, the perfect, tried to make friends but I lived that lie. [ ] the more you live that fake lie the more it comes, and it, and I wasn’t progressing.’*	
Anita: ‘*to be honest I, we used to joke about it cause one second I’d be crying and the next second I’d be laughing. It was really weird, I’d be sitting there with, you know, my cousins or someone and I would be like “ooh I’m so depressed” like joking. I never ever, it never crossed my mind I thought, you know, for real it might be something, it might be something going or happening or going on until my GP suggested that I look it up.’*	107-112
Antidepressants: “It’s very like rose tinted glasses”	
Anita: ‘*the first three weeks felt like they were horrid. I was, I felt worse than I did when I wasn’t on them and it was after three weeks I started to feel a little bit better, but it wasn’t better in a sense that “oh you’re happy” it was just you didn’t, you didn’t have the feeling of feeling sad to be honest, it was you just felt numb.’*	247-250
Ria: ‘*the antidepressants, it kind of mellows you out and you’re living in, like, rose tinted glasses. You’re not seeing the reality of the other side if you know what I mean, so to someone from outside looking in it looks like you don’t care, but you do care.’*	1184-1189
Madison: ‘*I won’t let it get to me cause I know the drugs don’t work. The seri and what the setra and what not it doesn’t work for me because it makes me go madder, if you know what I mean. I can’t explain to you, it makes me go a little bit more loop than I was, you know, and I don’t want that I’ve got enough chemicals going in I don’t want another lot right, so this is psychological.’*	547-552
Nadine: ‘*I think I took antidepressants all that time on and off, but I kept*	

trying to go off them because the doctors gave the impression that, well, [they] wanted me to go off them. They said "you'll have this happy life if you get your friends, get your social life, then it will work" but it doesn't always work like that, your mood, if you're still low even with all that it's not gonna sustain.'	