

# Cultural issues on accessing mental health services in Nepali and Iranian migrant communities in the UK

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## **Abstract**

Mental health in Black Asian and Minority Ethnic (BAME) communities is a rising public health concern in the UK, with key challenges around accessing mental health services. Our understanding of mental health issues in the growing Nepali and Iranian communities in the UK is very limited. Therefore, this study aims to explore the major factors affecting access to, and engagement with NHS mental health services.

This study used a qualitative approach comprising in-depth interviews with seven Nepali, eight Iranians and six community mental health workers in the south of England. The data were analysed using a thematic approach.

Six themes were identified: (1) stigma and fear; (2) gender; (3) language; (4) tradition and culture; (5) family involvement; and (6) lack of cultural awareness in health workers, all appearing to be major issues. This study contributes to a shared understanding of mental illness within two given cultural contexts to promote early interventions in UK mental health services. Developing cross-cultural perspectives in health care should be a priority in practice.

**Key words: Nepali migrants, Iranian migrants, BAME, Mental health, Culture, Culturally Adapted Services,**

## **Background**

Mental illness is increasingly recognised as an important public health issue, with growing mental health disparities worldwide (WHO, 2019). In England, approximately 1 in 6 adults experience a common mental health disorder (McManus et al., 2016). Research shows that the risk of psychotic and non-affective disorders is higher in immigrants, and their descendants, from Black, Asian and Minority Ethnic (BAME) communities (Jongsma, 2019; Selten et al., 2019).

Moreover, BAME communities are less likely to engage with mental health services (Casey, 2010), wait until symptoms are severe before seeking help, or discontinue treatment (Cooper et al., 2013; DeJesus et al., 2015; Dixon et al., 2016). Explanations for poor engagement with mental health services by BAME communities include: fear of discrimination, mistrust of clinicians (Henderson et al., 2013; Chen & Yang, 2014); unequal access to care (Penner et al., 2014; Kapke & Gerdes, 2016); low awareness of cultural beliefs, and stigma related to mental health (McHugh et al., 2013).

The UK has become more ethnically diverse since 1991, with ethnic minorities representing 13% of its population (Office for National Statistics, 2011). Recently there has been a growth in the Nepali population in the UK from 80,000 to 100,000 (Adhikari, 2012), and there has been an increase in the Iranian residents (n=84,735) (ONS, 2011). There are significant mental health issues among the Nepali population (Simkhada et al., 2020), which presents concern for the National Health Service (NHS). Similarly, Sreberny and Gholami (2016) highlighted that the Iranian population in the UK is diverse and that this community requires culturally sensitive approaches however, knowledge about mental health needs within this community in the UK is very scarce.

Managing cultural differences and raising cultural awareness in the health system are important contributors to delivering quality care. A recent scoping review showed that culturally adapted services improve BAME communities' engagement with services and that such services need to be integrated within existing NHS services (Vahdaninia et al., 2020). A study in the Nepali community also urged further exploration of issues around perceived social and cultural taboos associated with mental health (Simkhada et al., 2020). However, there is limited research on: (1) communities accessing mental health support /services; (2) health needs variations across different ethnic groups; and (3) partnership between these communities and health service providers including Public Health England and NHS England. This study aimed to explore the relationship between culture and access to mental health services among Nepali and Iranian migrants in the UK, both as two understudied communities in the UK.

## **Methods**

This study uses a qualitative approach (Bradshaw et al., 2017), comprising 21 in-depth interviews (van Teijlingen & Forest Keenan, 2004). Six interviews were conducted with Community Mental Health Workers (CMHWs) comprising four females and two males, eight

with Iranians and seven with Nepali in the south of England with a mixture of seven males and eight females from across the two communities. The interviews were conducted by telephone or face to face in late 2019 in Nepali, English or Farsi.

We collaborated with community organisations working with the Nepali and Iranian communities to recruit service user interviewees age 18 and over who had lived in the UK for at least two years. The CMHWs were also contacted through community organisation who was closely working with these community. A mixture of purposive and snowball sampling was used to recruit the participants. The interviews ranged from 20 minutes to 45 minutes long. The interviews were transcribed and translated into English. Bilingual researchers hired to transcribe and translate the interviews. However the research team BS (bilingual researcher Nepali/English) assessed the quality of the Nepali transcripts/translation and MV (bilingual researcher Iranian/English) managed the Iranian transcripts/translation. BS and MV conducted the first round of data analysis. The data were analysed thematically (Braun & Clarke, 2006), through re-reading the transcripts, generating initial codes and clustering these into related ideas to develop themes (Crowe et al., 2015). Two authors EvT and HB reviewed and agreed the final codes.

Ethical approval was obtained from the University ethics committee. All participants gave informed consent prior to their interviews and quotes are only identified by; Nep (Nepali) or Irn (Iranian); F (Female) and M (Male); CMHWs and a number to maintain confidentiality. The research team, HB who is a CMHW helped to prepare participants information sheets which contained an additional information leaflet about local NHS mental health services. Participants were also given information what to do if the individual experienced mental health difficulties after the interview.

## **Findings**

Six overlapping themes were identified: (1) stigma and fear (2) gender; (3) language; (4) tradition and culture; (5) family involvement; and (6) cultural awareness in health workers.

### **Stigma and Fear**

Mental health is not openly discussed in either community, due to fear, stigma and/or judgement, hence symptoms are often hidden.

*“My main reflection is the idea of people being quite reserved. Their experiences of mental health disorder (Iranian population) and I don’t know if it is military culture of not wanting to make a fuss or whether it is Nepalese cultural or kind of ethical or preference, I don’t know..., I do think there is some stigma about it or lack of recognition, I am not sure what it is” (CMHW1).*

Stigma around mental health was reported as a major barrier to talking openly and seeking early help. This was mirrored in reluctance to take part in our study on mental health, for example, one interviewee only agreed to take part by telephone:

*“Well there is a lot of stigma related to mental health problems. I do not want people to talk about my problem. ... People mainly have negative reactions, not only it doesn't help, but it even makes it worse” (Irn. M3).*

Similarly, young women shared conversations with family about mental health problems and how this was perceived negatively.

*“Mental illness is seen badly to an extent. Sometimes when they talk about people..., umm sometime mother says ‘Oh! that person has gone insane’. That person might not be insane. He/she might just be feeling unwell. ... people use different terms such as autistic, dumb, loner. I think the wording itself is a bit negative. Therefore, I think it is seen in negative way. if some people have mental health problem. Then they are explained as dumb, loner, insane” (Nep F4).*

Fear of disclosure of their mental health problems to others also was a barrier to seeking professional help in both Nepali and Iranian communities. Perceived confidentiality issues have been identified as a barrier in both communities accessing services for fear of gossip.

*“My big issue at the moment working with the Nepalese is the issue about confidentiality... they have fear of somebody from Nepal seeing them here and they will gossip... Nepalese workers here have experienced someone saying I don't want that person in my room. Because she is Nepali and she can gossip” (CMHW 2).*

*“It brings trust issues, as an Iranian psychotherapist, they'll think oh she's Iranian, no, this will go out! This is not going to be confidential, it will be talked about... the first thing comes to their mind is ok, may be this is going to go out, because she's working within the community as well” (CMHW 5).*

Fear of side-effects of medicines on one's daily routine and possible dependency resulted in delays in seeking mental health care.

*“Negative experience is the medication side effects and sometimes, as I receive the high dosage of them, you cannot do your routine things, for example you know when I leave the bed sometimes, you don't want to do anything at home and just they keep you in a flat level, not up or not down” (Irn, M2).*

Stigma around mental illness is widespread in both communities, leading to negative attitudes, and fear of revealing personal weaknesses to others, especially within their own community.

## **Gender**

Cultural norms of masculinity impact access to mental health services. Men and women perceived mental health problems differently. Male respondents noted that men under-utilise mental health services due to the perceived impact on their social status and job.

*“... we do not do it consciously, but I think subconsciously it happens. We should not be weak... Especially about mental health, people think that when other know about their mental health issues that will affect their status in society and even in career” (Nep M2).*

With men delaying seeking care:

*“when first I experienced mental health issues many years ago, I was very resistant and hesitant to use any mental health services and even avoided visiting my GP.... After a few years, my situation got to a point that I had to seek help from GP for mental health services... my wife has been supportive during those times and also, after I visited my GP and started taking medication” (Irn, M1).*

There is suggestion that both genders had reservations regarding accessing services, albeit for different reasons. Accessing services may be seen as a weakness by females; by admitting a mental health problem to others.

*“To be honest, I didn’t talk great deal on my mental health to people, but I don’t like talking about it...I don’t like being a weak because I am quite a strong-minded person” (Nep F3).*

Moreover, a health worker noted a gender disparity, finding women more comfortable to talk about their problems than men:

*“Women tend to share their experience more and talk more...” (CMHW 2).*

Recognising gender differences in acknowledging mental health problems to others and/or accessing services is crucial as being a perceived social issue and so is recognizing that needs differ between men and women.

### **Language**

Language barriers impacted on accessing mental health services in both communities. Some interviewees felt that being able to talk about one’s feelings is much easier in their own native language.

*“...much better if there were psychologist/psychiatrist that can speak in Farsi - my own language, even if your English language skills are quite good, you cannot express the feelings through English and prefer to use your own native language” (Irn. M3).*

Misunderstandings due to language problems led to frustration for participants, in both communities:

*“When people here cannot communicate in their language other people will definitely get irritated because they cannot understand each other. When they cannot understand each other both of them gets frustrated and I think because of this sometimes it (diagnosed mental health) might get misdiagnosed as well” (Nep F4).*

This issue was also identified by professionals:

*“Major barrier is the language people use, not literally like Nepalese and English language but the way much things are described. That to me seems to be a barrier.... I don’t think you can go into a community and say this is how you feel, and this is the way you need to describe how you feel. I don’t think that works..... we would have to develop a shared understanding. Certain words and language are not always acceptable for someone. You know I have worked for people before from a non-formal kind of United Kingdom indigenous British born background who don’t like the word psychosis or don’t like the word depression” (CMHW1).*

Language issues are prevalent in both communities and act as a very important barrier to engaging with mental health services.

### **Tradition & culture**

Culture often focused on religious beliefs, especially praying which is regarded as beneficial to reducing stress and anxiety. Both Nepali and Iranian communities often had traditional beliefs. Participants described the preference for priests and traditional healers to address mental health issues.

*“It is just in Nepal if we have some problem we go to worship. So likewise, we also do same, thinking it might help. We ask priest to come here. He comes and listen to us” (Nep M3).*

Some made the effort to travel back to their birth country to access trusted traditional healers.

*“I frequently visited traditional healer ... I even went to traditional healer here (UK) as well... My husband said I am not well, and we need to go there” (Nep F2).*

Iranians also found that praying was helpful when experiencing mental health problems.

*“Praying can help me to calm down” (Irn F4).*

People express their problems differently depending on life experiences, customs and beliefs. People often present with physical complaints instead of psychological ones. This results in initially being seen by other services at the start of their journey into mental health services, as one service provider explained:

*“Particularly in my recent experience with Nepali community and I noticed this from other communities, in kind of Asian sub-continent East Asia often complaint is of physical nature... ended up in hospital... being treated for potential malnutrition and pain and gastric complains and things like that” (CMHW1).*

These quotations highlight that migrant communities still have their traditional beliefs and practices when it comes to mental health problems.

### **Family involvement**

Both health care providers and service users reported the strong influence of family on accessing mental health care. Such involvement has both positive and negative impacts. Health workers observed there is a lot of family involvement to patients within the Nepali community, which may lead to a delay in and/or reluctance to seek outside help.

*“The families of the people in the Nepalese community, showed a lot of burden and tolerated a lot of difficulty and almost being reluctant maybe to say I am not coping....” (CMHW1)*

Family influences in decision making often dictated their care.

*“Because of family pressure I didn’t take medication when I first diagnosed with postnatal depression... They didn’t understand... what I was going through... I punished myself by not taking the medication” (Nep F1).*

It is interesting to note that family had greater influence, when older family members or husbands made decisions to seek care or take medicine. Older members of the family often dominate decisions and whilst offering support to family members, it can also be a barrier to engagement with services.

*“This has got one benefit that they get good support and proper care. But sometime some decision they take is barriers as well. Everything is decided by parents” (CMHW3).*

The Iranian community reported an unease to discuss mental health issues with family.

*“It is difficult to talk freely with your family as they mainly have negative reactions. It not only does not help, but even makes it worse” (Irn M3).*

Family involvement in the decision-making process around care and treatment could be linked to stigma as well as a lack of information of available services.

### **Cultural awareness in health workers**

Training on different cultural understanding is reported to improve mental health care to both the Nepali and Iranian communities. Professionals also expressed that a better understanding around different cultural practices would help them to provide culturally sensitive services to minority clients.

*“...the thing is when I come in as a professional, I wouldn't say I specifically had cultural training... any sort of training where I can be better at my job to understand how cultural differences can impact different people and different clients” (CMHW 6).*

Participants believed having support from staff with similar cultural backgrounds would be beneficial and encourage the discussion of personal difficulties. A Nepali female participant expressed how helpful and supportive an Asian healthcare worker, which had been a good experience for her.

*“May be having more professionals that are from similar background to us understand little bit more on how different depression is taken in our community...she was giving me personal experiences to make me stop being into by myself” (Nep F1).*

Participants also reported that preconceptions/stereotyping towards certain migrant communities could hinder health workers providing appropriate mental health care.

*“If the system be closer to your culture and be aware of the migrant's problems. Also, I think as we Iranians have some special situation regarding politics and media propaganda... wrong impressions of that unfortunately, so I think our problems as Iranians could be even different than other migrants” (Irn M4).*

### **Discussion**

This study highlighted six inter-connected themes related to access to, and use of, mental health services in two UK ethnic minority groups. Neither Nepali nor Iranians easily accept mental health problems and hence do not seek help at the onset of symptoms. The Nepali often present

with physical problems when they have mental health issues, and this was reflected in the accounts of both community members and health workers.

Somatic symptoms are more socially acceptable than psychiatric symptoms in many Asian cultures (Zhang et al., 2020). This could contribute to misdiagnosis, inappropriate care and late intervention. Mostafaei et al. (2019) reported somatic symptoms to be common in Iran, however none of the Iranian participants in the study reported somatic symptoms. It indicates both expression and acceptance of mental health problems in BAME communities could be different.

This study noted gender differences in Nepali and Iranian communities which influences the access and use of mental health services. Stigma towards mental illness is more apparent in men. Hegemonic masculinity may have played a significant role in gender disparities in seeking support. Hegemonic masculinity is argued to be socially privileged, culturally dominant, and legitimises a hierarchy of gender relations among men (McKenzie et al., 2018). Cultural and patriarchal norms also impact the behaviour of male participants-with regards to their mental health in the Nepali community. Having a mental health problem is seen as a sign of weakness and shame among men. Being able to manage their job, earn a living and maintain social status seems to be an important aspect in the Nepali community. Masculinity and men's health-seeking behaviour is a global issue, and may explain delays in seeking help when they experience illness (Galdas et al., 2005). The feeling of shame prevents men from seeking help for mental problems (McKenzie et al., 2018). Female participants saw mental health problems as meaning they were weak and unable to fulfil domestic roles and do household chores.

Understanding gender issues in relation to engagement with mental health services within BAME populations could benefit from further exploration, particularly male mental health, as the men involved in the study reported not acknowledging the need for support.

Our study identified cultural beliefs and misconceptions about mental disorders encouraging negative attitudes around mental health. Poor mental health carries significant stigma in both Nepali and Iranian communities, with both happy to attend their GP surgery, but not specialist mental health services. Misconceptions about mental health problems and the associated stigma in the Nepali community, contribute to delay or cause barriers to seeking help (Luitel et al., 2015). Mental health is highly stigmatised in many Asian cultures (Zhang et al., 2020). There is also evidence that early discontinuation of anti-depressant treatment is more common in both first and second-generation migrants (Sundell, 2011) and increases the risk of re-admission to inpatient services in Iranian people with mental health issues (Omranifard et al., 2008). This calls for mental health awareness raising among vulnerable populations as well as campaigns for greater support for initiation and maintaining treatment among vulnerable individuals.

Fear of long-term dependency on medication was reported in the Iranian community. This may partly be due to over-diagnosing and over-treatment of depression by UK GPs (Dowrick, 2013; Spence, 2013). Similarly, perceived fears of being seen as 'mad', being gossiped about, seen as being weak, and being judged by others was discussed in the Iranian community. Loss of societal status/job and shame (*laaj*) due to poor mental health are reported to delay access and engagement with mental health services in both the Nepali and Iranian communities in the UK. Previous studies in Nepal, consistently reported stigma worsens the experience of an illness and often leads to a lack of access to care, internalized feelings of shame and social shame (Kohrt & Hruschka, 2010). Therefore, early intervention to reduce social and cultural taboos about poor mental health could benefit both the Nepali and Iranian communities.

Language barriers in accessing health care amongst both communities was identified as a major issue as mental health is not an openly discussed topic in these two migrant communities. A systematic review reported language barriers (Satinsky et al., 2019) as causing multifactorial issues in accessing services and expression and understanding of problems for community members. Kohrt and Harper (2008) discussed that it is not only the problem of translation and conveying services to community members but also the issue of idioms of distress cross-culturally. Nichter (2010; p 405) described this as a ‘socially and culturally resonant means of experiencing and expressing distress in local worlds’; a phenomenon affecting the assessment of and planning for an individual’s care. A recent study in the Nepali community found language barriers were one of the reasons for not accessing mental health services (Simkhada et al., 2020). Similarly, a review assessing the impact of migration on the health of Iranians, showed that language insufficiency was linked to poor mental health among Iranian migrants (Shishegar et al., 2015).

Some participants discussed the dynamic of traditional beliefs and faith healing being part of their treatment and managing difficulties in both Nepali and Iranian communities, such as the use of traditional healers, seeing a priest or engaging in worship when they struggle with poor mental health. Beliefs about bad karma or luck are common in the Nepali population, but different in the Iranian community, and the latter believing in praying to calm psychological distress. The findings identify the practice of inviting priests and gurus to worship in the removal of bad luck and reducing stress in the Nepali community. Religion plays an important role in mental health care in South Asian communities (Behere et al., 2013). Religious or spiritual coping was found to be common when people face psychological difficulties among six ethnic groups in the UK (Bhui et al., 2008). It is important to understand how religious and spiritual coping could help and impact on long term healing and treatment. Similarly, a study in East Africa reported there are similar practices and recommended in developing collaborative practices between traditional and biomedical practitioners on mental healthcare (Solera-Deuchar et al., 2020). There may be an opportunity to explore how the creation of user-friendly services to BAME people in the UK could be achieved. Furthermore, it has been discussed that definitions of health, illness and care may greatly differ in Middle-Eastern communities i.e. the Iranian population to that of Western mainstream culture and thus, the healthcare-seeking behaviours could greatly vary with that of Western norms (Martin, 2009; Shishegar et al., 2015).

Mental health services need to develop an understanding of the needs of a culturally diverse community. Future research could explore creating an integrative collaborative model of care such as incorporating traditional healers, gurus and priests in mental health service provision. Appreciating idioms of distress in the assessment process, to promote a shared understanding of needs and integrating religious and spiritual coping mechanisms in modern health care practice could be beneficial to both Nepali and Iranian communities.

Community mental health workers identified a lack of cultural awareness training and that limited knowledge on differing cultures may impact on the provision of care they provide to BAME communities. However, it could also be the confidence of the practitioner to give culturally sensitive and relevant care to clients, which are barriers to providing culturally sensitive services. This study highlights the importance of cultural awareness and cross-cultural training for healthcare professionals to help improve quality of care and meet cultural and religious needs in BAME people (Kaihlani et al., 2019; Kang & Moran, 2020). Training needs to focus on enhancing understanding of the different cultural and religious values and practices that influence health care choices in minority groups (Hassan et al., 2020). Cultural awareness

requires an openness on the part of the professional, who should pay particular attention to issues such as stigma, religious belief that can impact individual attitude, behaviours and practices. A systematic review has also concluded that knowledge and skills of health professionals is a major issue for utilising health services, including mental health services in migrant populations (Parajuli & Horey, 2020). Therefore, managing cultural differences in healthcare should be a priority when dealing with culturally and linguistically diverse communities.

Family in the Nepali community often take a lot of responsibility and end up looking after the person with mental health problems. There is a greater emphasis on family influences in decision making when someone is experiencing poor mental health. This again could be due to stigma attached to poor mental health or that family take greater responsibility when people get unwell. A study in Asian Americans found that people tend to make decisions based on benefits to the family rather than individual family members, family harmony often becoming a primary focus for Asian with mental health problems (Kramer et al., 2002).

In the Iranian community, contradictory opinions were reported about the role of family in relation to their mental health issues. A male participant (in his 70s) highlighted the supportive role of his wife in identifying a mental health need and accessing care. However, the other male interviewee (in his 30s) stated the worries of disclosing his problem to family as it may not be understood. Broadly family has an important role in Iranian culture, with families uniting and supporting family concerns and familial decisions. Evidence from analyses with mental health stakeholders in Iran indicate that families and patients are very concerned about stigma associated with mental illness and therefore many avoid seeking treatment (Taghva et al., 2017). International studies, which also explored the subject of cultural stereotyping, have identified anti-immigration policies and the loss of familial support to be contributory factors in accessing and engaging with mental health care in Iranian communities (Candel & Fayazpour, 2019). This may be a factor in the UK and there are pros and cons to familial involvement with these dynamics being of benefit to explore during assessment of needs.

Community mental health workers noted that culture and ethnic background appeared to influence family dynamics and their involvement in the person's care. Whilst there were some advantages to health workers being from the same cultural background as service users, conversely it led to a lack of trust in staff, who were from the same community due to fear of exposure.

There are some similarities of factors between the two studied communities such as stigma, language barrier and gender; however, there are also differences unique to each community. For example, in the interviews conducted with Iranian community members socio-political problems were identified. In the Nepali populations there was significant discussion around the negative connotation of having difficulties with one's mental health.

Community mental health workers also discussed the use of language to discuss mental health and language barriers, how these posed issues in identification of mental health needs and giving of care.

### **Strengths and Limitations:**

This is one of the first papers of its kind comparing the two understudied population groups in the UK, however the small sample size and individuals participating in the study are from one area of the country are limitations of the study and have implications for practice and require further study.

## **Conclusion**

This study identified several factors influencing access and engagement with mental health services and treatment within Nepali and Iranian communities in the UK. There are key shared issues regarding access and engagement with services. It is important to note that different cultures also have their own unique issues regarding access and engagement with mental health services. Recognising cultural factors can help improve the quality of, access to and engagement with, mental health services.

Improving cultural awareness in healthcare needs to be of priority to improve access and engagement to mental health services. Healthcare professionals must be conscious and respectful towards other people's culture and beliefs, to ensure they can provide effective care to meet the need of a diverse community. Awareness training programmes for staff on cultural practices and beliefs might be beneficial in better supporting BAME communities. Such programmes could include improving health workers' knowledge of the cultures of these communities as well as the interface with mental health care to help reduce stigma, fear and gender inequality.

Language barriers could be addressed by engaging local community charities, translators and family in the treatment and care as necessary. Developing good networks between health and social care providers and community members and organisations could be met through outreach projects.

### **Relevance for clinical practice.**

Developing a transcultural understanding of mental illness, with cultural sensitivities may ensure the use recognised and appropriate care pathways.

Therefore, understanding how different BAME communities deal with mental health problems is important in raising awareness of mental health care delivery to these populations.

The findings can remind practitioners to recognise the role of the family and community values in supporting individuals accessing care from a cross-cultural perspective and that needs are multifaceted. Identification of such issues can help facilitate improved quality of care at a diverse level. This includes addressing stigma, socio-political implications, the role of the wider support network and incorporating traditional, cultural and spiritual needs to provide individual, non-discriminate care. This should be at both service level and assessment and care planning level to be most effective in implementing change.

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**A conflict of interest statement**

There is no conflict of interest

**An ethics approval statement (if relevant)**

The ethical approval was obtained from Bournemouth University

**Keywords**

Nepali migrants, Iranian migrants, BAME, Mental health, Culture, Culturally Adapted Services

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