Becoming 'another brick in the wall':

A thematic analysis of Central and Eastern European immigrants' experiences of psychological distress and help-seeking

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This is to certify that this research report is my own unaided work.

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Contents

Abstract

Background: Since 2004, a large number of immigrants from Central and Eastern Europe (CEE) have taken up residence in the UK. This study explored how the experience of immigration impacted on the wellbeing of sixteen participants of Central and Eastern European origin and whether they sought help for psychological distress. Despite the increased knowledge and understanding of help-seeking attitudes towards mental health issues of various minority groups in the UK, the experiences of the Central and Eastern European communities remain understudied. It is this gap, which this current study aimed to fill. It also highlighted some of the ways in which CEE immigrants' required support.

Method: In order to gain in-depth data, semi-structured interviews were conducted with four male and twelve female immigrants from Central and Eastern European countries living in the UK. Interview transcripts were analysed using inductive thematic analysis following the seven steps outlined by Braun and Clarke (2013), within a qualitative paradigm and a critical realist framework.

Results: Four overarching themes were identified in the analysis, which indicated that socioeconomic factors contributed to feelings of distress within the sample, a high level of mental health stigma was present, and complex factors influenced help-seeking behaviour and determined immigrants' needs. Major factors negatively influencing immigrants' wellbeing within the sample were housing and job issues; prejudice and discrimination experiences; distress caused by language difficulties, and socioeconomic circumstances. Most participants felt that they could manage emotional difficulties themselves and held a holistic view

of a persons' wellbeing. Gender, culture and previous experience were significant factors influencing decisions to seek help for emotional difficulties. A closer focus on the political and socioeconomic context suggested that, for these participants, deep inequalities in UK society remained despite efforts by the National governing institutions over the last decade to eradicate these. Most participants proposed that the best way to address their needs was to engage with their communities first, rather than to seek help from formal services.

Discussion: The results provide a thorough description and understanding of the participants' experiences, meanings and needs concerning their wellbeing. Possible practical implications for working therapeutically with this minority group are discussed from a social justice perspective. Importantly, this includes the recommendation to apply contextual approaches such as relational cultural theory to current ways of working.

Conclusion: Most participants shared that settling in the UK was a stressful process influenced by cultural and socioeconomic factors that affected negatively their experience in the host country. Protective factors such as a good social network, English proficiency and equal economic opportunities contributed to positive experiences, whilst prejudice, discrimination and a lack of a culturally sensitive service provision had negative implications on their wellbeing. Addressing immigrants' needs requires active engagement with these minority communities, which ideally would include acknowledging contextual factors affecting their wellbeing, highlighting discriminatory practices and policies, and building intrinsic forms of resilience.

Chapter 1: Background of the study

1.1 Introduction

This thesis explores how the experiences of immigration to the United Kingdom (UK) influence Central and Eastern European (CEE) immigrants' wellbeing. It considers how such immigrants deal with psychological distress, with the aims of increasing knowledge of CEE immigrants' experiences and highlighting their emotional needs.

The National Institute for Mental Health in England (2003) emphasised that ethnic minority groups tend to have poorer mental health compared to the majority of the population. The British Psychological Society also states that researchers need to recognise social contexts and to engage in anti-discriminatory practices that are appropriate to the pluralistic nature of contemporary society (BPS, 2005). In addition, it is a moral obligation for the counselling psychologists to deliver culturally sensitive therapy to their clients (BPS, 2005; Zhang & Burkard, 2008), while increasingly working with clients from many different cultural backgrounds.

The countries of Central and Eastern Europe have often been seen as significantly different from Western European countries, especially during the Cold War period. Robila (2008) asserts that CEE populations had similar experiences under the communist regime and hence it is legitimate that they be examined together in this study. Note that for the purpose of this study, the term

CEE countries refers only to the Accession 8 countries that joined in 2004 (the Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, and Slovenia) and Accession 2 (Bulgaria and Romania) countries that joined the European Union in 2007.

Historically, after the Second World War notable numbers of Eastern Europeans were permitted to settle in Britain, 'many of whom were actively recruited to work in Britain as part of an overseas workers scheme - one of the very few episodes of a 'guest workers' scheme in British history' (Migration Watch UK, 2016). The enlargement of the European Union in 2004 has brought a new wave of immigrants from Central and Eastern Europe, which has attracted many researchers to study their labour mobility, migration patterns and experiences, and community cohesion (Anderson et al., 2006; Ciupijus, 2011; Friedrich, 2015; Markova & Black, 2007; Spencer et al., 2007). It is worth noting that individuals from Bulgaria and Romania (Accession 2) had to follow regulations and policies that were more restrictive then Accession 8 countries until January 2014 (Fox et al., 2012). Bulgarians and Romanians were required to apply for an Accession Worker Card, while highly skilled A2 immigrants (for example, students, self-employed and their dependants) could apply for a registration certificate.

While the numbers of CEE immigrants living in the UK have increased significantly after the accessions in 2004, only a few studies specifically address their experience s and needs concerning their mental health. One such research

suggested (Weymouth Rethink Community Engagement Project, 2008; a project aimed to increase engagement of people from black and ethnic minority groups with mental health services) that in order to provide equitable services to the immigrants from CEE, researchers need to engage actively in obtaining valid, and meaningful accounts of immigrants' experiences, views, values and needs.

1.2 Literature Review

This literature review covers five primary areas of inquiry. First, in order to contextualise the present study, it considers research on the impact of immigration on immigrants' mental health and wellbeing. Second, information is briefly given about CEE immigrants' background to introduce the reader to some of the specific characteristics of this population. Then, some findings of the existing research on CEE immigrants to the United Kingdom are highlighted. All of these build the case that this population's mental health has been overlooked in the research literature. Fourthly, theories of immigration and their relationship to counselling psychology are considered. Finally, evidence supporting a need for multicultural competency and a social justice approach in counselling and psychotherapy is offered, with a brief outline of some relevant models.

1.2.1 Immigration and mental health

This section of the study presents a review of the literature on the mental health of immigrants and their help-seeking behaviour. It also brings to attention

some research that highlights the negative impact of the immigration process on immigrants' mental health, and considers their help-seeking patterns. Finally, it argues that the mental health services in the UK are not adequate for the needs of the minority population.

Mental health problems significantly affect the general UK population and impose a great burden on individuals, families and society. The estimated cost of mental illness in England alone is over £105.2 billion a year, through the costs of medical or social care, production output losses, and the cost of disability, suffering and distress (Centre for Mental Health, 2010). About a quarter of the population experiences some type of mental health problem in the course of a year, with anxiety and depression being most prevalent (Mental Health Foundation, 2015). Women are more likely to seek treatment than men, whilst suicide rates were found to be three times higher in men than in women. Depression also affects one in five older people. Self-harm rates in the UK are one of the highest in Europe, at 400 per 100,000 (Mental Health Foundation, 2015). The Mental Health Network in the United Kingdom (2011, p. 1) concludes that it is 'encouraging to see patients spending less time in hospitals – pointing perhaps towards the increasing use of community-based treatments. However, it is concerning that people on a Care Programme Approach (which is only offered to people with severe mental health problems or complex needs) do not feel they are getting the support they need in terms of employment, housing and financial advice.' It is therefore important to note that whilst this study addresses the

mental health experiences of CEE participants, the discussion is set within a context where mental health provision may not adequately cater for the general population.

One commonly used definition of 'immigrant' is a person born outside a given country who has moved to live in that country (The Migration Observatory, 2016). It is important to note that immigrant and ethnic minority group are not synonymous (Salt, 1996) and are not used interchangeably in this study. Bulmer's (1996) defined that: 'An ethnic group is a collectivity within a larger population having real or putative common ancestry, memories of a shared past, and a cultural focus upon one or more symbolic elements which define the group's identity, such as kinship, religion, language, shared territory, nationality or physical appearance. Members of an ethnic group are conscious of belonging to an ethnic group.'

Bhugra and Gupta (2011) describe migration as an individual's re-location of their place of residence for any length of time. For the purpose of this study, the term immigration will refer to both immigration and migration processes. Migration involves three major sets of transitions: changes in personal connections and the reconstruction of social networks, the shift from one socio-economic system to another, and the change from one cultural system to another (Bhugra, 2004a; Bhugra & Gupta, 2011; Rogler, 1994). The immigration process can also be seen as involving consistent and overlapping stages - pre-migration, migration and post-migration resettlement - where each stage is associated with specific risks

and exposures (Bhugra & Gupta, 2011). This major life event requires the mobilisation of many resources and strategies by individuals, in order to adjust to life in the host country, which may also increase immigrants' vulnerabilities to emotional distress (Monteiro & Serra, 2011). In contrast, successfully managing the immigration process may facilitate a sense of achievement, enhance immigrants' wellbeing, and at the same time benefit the host country (Dovidio & Esses, 2001).

Immigration to the UK from Commonwealth countries such as India, Pakistan and the West Indies has been well documented (see Coleman & Salt, 1992; Dustman and Fabbri, 2005; Vertovec, 2006). As a result, the impact of immigration on individuals from these countries has received considerable attention from researchers. For example, research has found that Indian male immigrants (Sikhs) abused alcohol frequently because of psychological stress (Cochrane & Bal, 1989); Caribbean immigrants were diagnosed with schizophrenia three to six times more often than non-Caribbean individuals (Littlewood & Lipsedge, 1988), and suicide among South Asians in the UK was twice the national average (Patel & Gaw, 1996). Findings such as these suggested that some immigrants from these countries might experience mental health problems following their migration to the UK.

Dodge et al. (2012, p. 230) defined wellbeing as follows: 'wellbeing is when individuals have the psychological, social and physical resources they need to meet a particular psychological, social and/or physical challenge'. They go on to

add that 'when individuals have more challenges than resources, the see-saw dips, along with their well-being, and vice-versa.' According to the World Health Organization website (2014), 'Mental health is defined as a state of well-being in which every individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.'

Many researchers have studied the impact of immigration on immigrants' wellbeing and mental health. For example, meta-analyses conducted by Lindert et al. (2009) and Abebe et al. (2014) suggested that immigrants are at least as likely to experience mental health problems as non-immigrants, and might be at an increased risk of suicide and psychosis. According to Bhugra and Gupta (2011; p. 2) 'alienation from one's own culture may well bring about isolation and will affect an individual's identity. The process of migration can itself add stress and contribute to this process.' However, they also argued that most of migrants are able to adjust well to their host country. The authors noted that socio-economic circumstances could either aid or hinder immigrants' adjustment. Font et al. (2012) suggested that immigrants could be a vulnerable population affected by exposure to negative psychosocial factors. The researchers found that the increased risk of mental illness among some immigrants was primarily connected to a higher risk for acculturative stress, low social support, deprived socio-economic conditions, multiple negative life events, experiences of discrimination, and traumatic pre-migration experiences (see also Bhugra & Gupta, 2011; Lindert et al., 2008, Loue, 2009; Stepleman et al.,

2009; Karlsen & Nazroo, 2002). Furthermore and for the same reasons, Lindert et al. (2008) suggested that some immigrants could be at a greater risk of suicide and psychosis.

Somewhat contrary to this, however, is the finding of some researchers that the prevalence of common mental health problems among immigrants was lower than in the majority population, albeit initially (Kirmayer et al., 2011; Rechel et al., 2011; Wu & Schimmele, 2005). It would appear that for some immigrants, after they settle down in their host country, factors such as low socioeconomic status, discrimination and prejudice (Yakushko & Consoli, 2014), lack of English language proficiency, poor housing (Pearson et al., 2007; Villatoro et al., 2014) and insufficient acculturation may contribute to higher rates of depression and anxiety (Finch et al., 2000). Kirkbride et al. (2008) also suggested that factors such as social adversity or discrimination combined with ethnic-specific factors (e.g. lack of socio-cultural support) might operate in the onset of psychoses. Rates of schizophrenia might be explained by conditions within the host country, including factors such as the discrepancy between expectations and actual achievements (Bhugra, 2004b). However, not all immigrants experience prejudice and discrimination, and it has been found that factors, such as good socioeconomic status, resiliency, resources and social support might enhance their wellbeing (Durden et al., 2007; Stepleman et al., 2009). In conclusion, it appears that socioeconomic factors may affect positively or negatively levels of distress and mental health problems among immigrants.

An analysis of particular social factors (e.g. social exclusion) has also revealed underlying themes of powerlessness, injustice, prejudice or 'social defeat' that might contribute to experiencing psychological distress among individuals of both minority and majority populations (Gilbert & Allen, 1998; Pearson et al., 2009; Tew, 2011; Tew et al., 2011). Hughes et al. (2009) speculated that these factors might be exacerbated by oppressive or paternalistic service responses, which may further undermine an individual's sense of agency. Social oppression concerning people's identities might be connected to a higher prevalence of mental health difficulties, such as for some ethnic minority groups (Fearon et al., 2006) and individuals who are lesbian, gay, transgendered or bisexual (Jorm et al., 2002). From this, it can be argued that mental health services have to reflect on their provision of care by addressing possible inequalities to ensure equitable experiences and outcomes of individuals who use them.

The concept of 'help-seeking behaviour' is an important one to explore when attempting to understand patient delay and action across a variety of health conditions, not just mental health. The term has been described as part of both illness behaviour and health behaviour (Cornally & McCarthy, 2011). Rickwood and Thomas (2012; p.180) defined help-seeking as: 'an adaptive coping process that is the attempt to obtain external assistance to deal with a mental health concern'. Even for non-migrant populations this can be a complex decision-making process (Cornally & McCarthy, 2011); for migrant populations there may be additional

barriers. Selkirk et al. (2012) conducted a broad systematic literature review on immigrants' attitudes towards seeking psychological help. The researchers concluded that although there were substantial similarities in migrants' responses to distress and help-seeking decisions across cultures, there were some differences as well. Common problems identified were the perceived cultural mismatch between immigrants and services providers (i.e. a lack of cultural sensitivity) and logistical barriers to services (such as a lack of information). Jayaweera (2010), Smith (2008) and Stuart et al. (1996) identified similar barriers. Selkirk and colleagues also noted a tendency to seek help from alternative resources, such as family and friends, rather than mental health services. However, the researchers also highlighted that the expression and conceptualisation of distress might be different across cultures in ways that were consistent with their specific cultural values, and which may significantly diverge from the notion of distress defined in Western cultures. Thus, if service providers do not have a sufficient understanding of specific cultures there is a risk of providing support, which is culturally incompatible (Sue, 2004; Sue & Sue, 2013).

Chen et al. (2009) argued that immigrants consistently underutilise mental health services. Additionally, Lindert et al. (2008) also found that immigrants were at a higher risk of being compulsorily detained in hospitals and secure units. A constellation of barriers, such as immigrants' culture, limited service options, stereotyping immigrants, and limited English proficiency seem to prevent minorities from seeking help (Halli & Anchan, 2005; Abebe et al., 2014; Wood &

Newbold, 2012; Wynaden et al., 2005). Therefore, more accessible, broader, and flexible care pathways are needed if such barriers have to be overcome.

It should be noted that factors, such as a lack of availability of services, societal stigma toward mental illness and social isolation are not unique to the immigrant population, but also affect all users of mental health services (Time to Change, 2008; Social Exclusion Unit, 2004; Dinos et al., 2004). However, Koroukian (2009), Corrigan and Calabrese (2005) and Savage et al. (2015) all argued that mistrust and fear of treatment, prejudice and discrimination, and difficulties in communication can present additional barriers to help-seeking for ethnic minorities. Hall (2001) highlighted that unfamiliarity with the mental health services and the use of alternative informal resources can deter professional help-seeking, while Keynejad (2008) stated that ignorance about mental health combined with cultural beliefs could lead many immigrants to perceive mental illness as their own 'fault'. Jorm (2000) claimed that individuals might not recognise symptoms of mental illness. There is therefore a need for mental health promotion strategies to overcome these barriers to help-seeking. Bhui et al. (2005) also highlighted the need for prevention of stigma and discrimination as one of the core objectives of mental health promotion, as this may account for the increased risk of mental disorders to some of the minority groups in the UK.

There is evidence to suggest that it is not helpful to assume that all minority groups have similar help-seeking behaviour. For example, Keynejad (2008) found

that South Asian people would seek help for mental health problems first from medical professionals, whilst in contrast Black African individuals would seek help from less formal services. Despite these differences, a common finding in her research was that participants felt that local services were not culturally sensitive, and that different approaches were needed. Koroukian (2009) supported this view and highlighted the need for multi-culturally trained practitioners. To encourage ethnic minorities to utilise services, she suggested a comprehensive standard of linguistic and cultural competency in the delivery of healthcare services.

1.2.2 The background of CEE countries

This section considers how historical communist regimes in CEE countries may have had an impact on individuals' lives, cultures and values. Attention is then drawn to some of the ways mental health services in CEE countries operated during the communist period, which can shed more light on CEE immigrants' wellbeing and their help-seeking behaviour. Whilst this helps to introduce some of the potentially specific characteristics of CEE immigrants, it also provides an understanding of their particular challenges after the fall of the regimes.

Communism is a political theory based on ideas from Marx and Engels' book 'The Communist Manifesto' (Marx, Engels and Jones, 2002). Central to the views of Marx and Engels are that class war is necessary in order to bring about radical social change, with the aim to create a society, in which all property is publicly owned, and everyone works, and is paid according to their needs (Constitutional

Rights Foundation, 2015). Despite differences in culture, language, laws and traditions (Robila, 2008), CEE populations have had a similar experience under the communist dictatorship. This political framework, by its very nature, pervaded all levels of society and affected significantly individuals' lives. There is therefore a political legacy common to CEE immigrants, which sets these immigrants apart from those of other countries. They also differ from immigrants coming to live in the UK from other parts of the world in other ways. For example, despite having a higher level of education this immigrant group is mainly employed in unskilled occupations, and earns the lowest average wages compared to other immigrant groups (Currie 2007; Rienzo, 2013).

There is also evidence that CEE immigrants differ in their cultural values from other immigrants. According to Robila (2007), they are less likely to express their needs, are less socially assertive, and are more respectful and reserved. However, it should be noted that the study referred to CEE immigrant families living in the USA, and care needs to be taken when transferring its claims to another national context. CEE immigrants living in the UK might have different characteristics. Nevertheless, Shafiro et al. (2003) noted such differences, and attributed these to the values of collectivism and communist ideology. Triandis (1995) defined collectivism as a social pattern consisting of closely linked individuals who see themselves as parts of a larger whole rather than as individuals, and who place the norms and goals of the collective over their own interests. In contrast, individualism is described as a social or familial pattern of

valuing individual goals and needs over group or collective goals (Triandis, 1995). Due to the influence of communism, group collectivism might play an important role in CEE societal culture (Bacacsi et al., 2002; Hofstede, 2001). As a result, individuals from CEE countries may often solicit support for emotional difficulties from their close social network.

During the communist era, significant mental health distress was caused by political abuse of psychiatry (van Voren, 2010), high levels of mental health stigma and negative attitudes towards disabilities (Petrea, 2014). According to van Voren (2013, p. 6) the political abuse of psychiatry 'refers to the misuse of psychiatric diagnosis, treatment and detention for the purposes of obstructing the fundamental human rights of certain individuals and groups in a given society'. Marks and Savelli (2015) indicated that psychiatry was used to suppress mainly political dissidents; although religious people, nationalists, and potential emigrants also suffered from this practice. Some of these practices involved forced hospitalisation, isolation within the hospital, involuntary medicating, and physical abuse from the hospital staff. Lewis (2002, p. 294) also argued that: 'for each political prisoner there were hundreds of people with mental disabilities languishing in the same institutional regime and suffering the same discipline and abuse'. In contrast, Füredi et al. (2006) disputed the magnitude of this 'systematic' malpractice, arguing that a smaller number of individuals were affected. Höfer et al. (2012) indicated that it was difficult to determine the real extent of the problem, and whether it was characteristic of all Soviet Bloc countries, since health-related

statistics were kept secret. Nevertheless, research conducted with former political detainees in Romania (Bichescu et al., 2005, p. 10) found that political detention during the communist regime did exist and had long-term psychological consequences, such as Post-Traumatic Stress Disorder due to trauma and maltreatment 'that outlast the changes in the political system' (see also Adler et al., 1993). This demonstrates that oppressive practices occurred and that these had an enduring negative psychological effect on people.

The political constraints on research during the communist regime increase the difficulty of obtaining data. Van Voren (2015) argued that Pavlov's behaviourism (the study of observable behaviour, whilst ignoring the role of thoughts and emotions) was the only acceptable ideology of mental health research and practice in the Soviet Block. Research into alternative models of behaviour was suppressed in CEE countries by political decisions (Angelini, 2008). As a result, Kaperova (2010) argued that psychological counselling and psychotherapeutic interventions as a form of service were almost non-existent in the Soviet Union until early 1990. Hence, it is important to bear in mind that individuals from these countries may have very limited experience with formal mental health services, such as psychotherapy or counselling, potentially leading to underutilisation of these in their host country after migration.

Some studies have focused on the post-communist transition towards democracy, highlighting that poverty and unemployment in CEE countries remain

a major problem (Dascalova, 2000; Robila, 2004; World Bank, 2002). Political instability and loss of economic security affect all areas of individuals' lives and lead to higher level of distress (Vogli, 2009). For example, changes in the socio-political systems after 1989 (and the fall of the communist regimes) have led to higher demands on families to mobilise their resources and support their members through these difficult transitional times (Adler, 2004; Robila, 2004). Perhaps because of this, individuals from CEE countries have been characterised by their interdependence. This means that families have continued to assist one another, and have a strong belief in intergenerational obligation to care for elderly family members (Robila & Krishnakumar, 2004). However, enforced changes have also increasingly led to the breakdown of the traditional family (Staykova, 2004). For example, the number of single mothers in Poland was found to have increased due to a rise in 'poverty, hopelessness, unemployment, and alcoholism' (Titkov & Duch, 2004, p. 73), with economic hardship being a major factor leading to distress and eventually to separation from partners (Robila, 2004). The break-up of families has led to a need for other sources of support.

Although there has been a recent shift from hospitalisation to community mental health facilities in CEE countries, this process has been slower than in non-CEE countries (Rancāns et al., 2005; Germanavicius et al., 2005; Tomov, 2001). In contrast, mental health services in the UK began to move to community based services as early as 1960 (Lawton-Smith & McCulloch, 2014). The mental health care systems in CEE countries continue to use mental health institutions such as

polyclinics and dispensaries (National Network for Children, 2012). In these countries, the term polyclinic refers to 'an out-patient unit staffed by specialists supported by lower-status doctors' (Gask et al., 2010, p. 106). Thus, individuals may hesitate to use mental health services due to mistrust, fear and stigma.

Increased rates of physical morbidity, mental illness, and alcohol and tobacco abuse are all highlighted as problematic in post-communist countries (Jenkins et al., 2005). Researchers studying the mental health of individuals from CEE countries argue that changes in political regimes increase suicide rates (Mäkinen, 2006; Razvodovsky and Stikley, 2009; Höfer et al., 2012). For example, Samele et al. (2013) found that Lithuanians had a suicide rate 29.4 per 100 000 population in 2010, the highest in the European Union. The authors attributed this to rapid socio-economic transition, increased psychological and social insecurity and an underdeveloped national suicide prevention strategy. In that year, the UK's suicide rate was 8.0 per 100,000 (Department of Health, 2014). Research conducted by Mikolajczyk et al. (2008) indicates that students from Eastern European countries are more likely to suffer from depression than students from Western European countries. Ekblad (2008) found that being born in CEE was an independent risk factor for poor mental health. Mikolajczyk et al. (2008) attributed these results to the political and economic instabilities in Eastern European countries resulting from political changes during the early 1990's.

Saraceno and Saxena (2005) concluded that the extent and burden of mental disorders is high in Europe. They argue that despite the increased attention to human rights, recent efforts to establish community mental health services and the emergence of family and consumer associations, mental health services are inadequate in most Central and Eastern European countries.

1.2.3 Central and Eastern European immigrants' wellbeing and help-seeking

Having discussed the relevant literature considering the background of CEE immigrants and their particular challenges after the fall of the communist regime, this section begins to explore the limited literature on this minority's wellbeing. First, it is argued that individuals from these countries will continue residing in the UK in the future and therefore their mental health is of great concern. Then, some of the challenges for CEE immigrants are highlighted in order to explore how these may contribute to their increased vulnerability to poor wellbeing. Specifically, the focus is on literature that suggests that despite continuous government efforts to eliminate prejudice and discrimination, these still exist in the UK.

After the European Union enlargement in 2004, the estimated residing populations in the UK from CEE countries (Accessions 8 and Accession 2) were 1,257,000 in 2013 (Office for National Statistics, 2013). According to Labour Market Statistics from the Office of National Statistics (2014), the number of immigrants

from CEE working in Britain rose to 895,000 in December 2014 – an increase of 168,000 or 23% for the year. Due to favourable economic conditions in the UK, it is likely that immigration from these countries will continue to increase (Rienzo & Vargas-Silva, 2014).

Immigrants from this minority group, like others, face many challenges while adapting to life in their host country, such as economic difficulties, learning the language of the host country, continuing education credentials, and family discords (Buchwald et al., 1993). Robilla and Sandberg (2011) argued that research on the mental health issues of Eastern European immigrants was scarce. To begin to address this, they conducted research on adaptation patterns of Eastern European immigrants living in the US, providing recommendations for family therapy.

However, the issues for CEE immigrants living in the US might be different from those experienced by immigrants living in Britain. Most UK studies to date have focused on Polish immigrants (for example, Gill and Bialski, 2011; Kozlovska et al., 2008; Lakasing & Mirza, 2009; O'Brien & Tribe, 2014). Kozlovska et al. (2008) suggested that the negative effect of Polish immigrants' feelings of displacement, disappointment with the reality of migration, loneliness and isolation, and frustrations with losing control over career aspirations, depend on their social experiences and coping strategies. According to Lakasing and Mirza (2009), alcohol abuse in this community can be both a cause and a consequence of

depression. Another study (Bassaly & Macallan, 2006) of Polish immigrants found that commitment to Polish cultural values prevents help-seeking. Exploring further the Polish experience of immigration, Selkirk et al. (2012) argued that responses to distress are influenced by individuals' sense of identity, social networks and previous experience with mental health services, and that this affects their decisions whether to seek psychological help.

The few studies that have focused on Eastern European immigrants' wellbeing have argued that poor mental health is prevalent within Eastern European communities in the UK (Patel, 2012; Tobi et al., 2010; Madden et al., 2014). Tobi et al. (2010) and Patel (2012) highlighted that the stress and anxieties carried from countries of origin may combine with stresses of immigration and adaptation to the host country and lead to further distress. Madden et al. (2014, p. 1) claimed that Eastern European populations have 'poorer mental health; higher mortality due to heart attacks and strokes; higher levels of obesity' when compared to the UK average. They found that mental illness is a taboo subject in the Eastern European community and people rarely access services. However, all of these studies mainly explore immigrants' general health needs; mental health issues remain understudied.

Moore's study (2013) focused on immigrants' self-identity and found that the majority of Eastern Europeans considered themselves as 'Ethnic Whites'. While these individuals can be viewed as 'white' in their countries of origins, apparently

they are 'not quite white' enough to blend into the English landscape unnoticed (Moore, 2013, p. 2). The media can portray CEE immigrants as a 'threat' to the stability of British communities, for example by draining public resources such as healthcare, education and benefits (Tereshchenko & Archer, 2014; EHRC, 2010; Burrell, 2006). Dawney (2008, p. 15) claimed that they are seen as 'a boost to the economy and a threat, at times noble, at times exploited, but always and fundamentally different' from the majority group in the UK. Consequently, according to Pantiru and Barley (2014), this can have an impact on how CEE immigrants integrate into life in the UK, leading to marginalisation and social exclusion (see also Fox et al., 2012).

A study conducted by Weymouth Rethink Community Engagement Project (2008) on CEE immigrants highlighted instances of discrimination and prejudice towards them in rural areas of Dorset, UK. It is worth noting that due to threatening e-mails from some members of the majority population, the researchers decided to cancel the interviewing of one North Dorset focus group. Nevertheless, the research concluded that the initial period of adjustment to the UK was the most difficult, that people experienced a high level of mental health stigma, and that participants would not seek help unless issues were severe, such as a mental illness that needed hospital treatment. The Weymouth Rethink project was part of the Delivering Race Equality projects (Department of Health, 2003b), which attempted to implement an earlier 'Outside Inside' plan (by the National Institute for Mental Health in England) for community engagement.

Unfortunately, according to Fernando (2010), the projects turned into no more than information collection exercises, leaving the statutory sector unchanged, while discrimination and racism remained inadequately addressed.

Although many researchers have studied CEE immigrants' experiences at work, access to information, long-term intentions and community cohesion. (see Anderson et al., 2006; Markova & Black, 2007; Spencer et al., 2007), to date, little research has been conducted on the mental health of immigrants and refugees from CEE. Hence, the difficulty to provide a detailed picture of their culture, family relationships, traditions and mental health issues in the UK. Some researchers have therefore argued for more in-depth qualitative research to better understand immigrants' experiences, aspirations, and issues in regard to their mental health within local communities (Markova and Black, 2007; Jentsch et al., 2007; Eade and Valkanova, 2009).

1.2.4 Theories of immigration and counselling psychology

This section of the literature review introduces and critically evaluates some relevant models and theories of immigration, and considers their relationship to counselling psychology. Particularly, Berry's model of acculturation is discussed because of its great influence on how immigrants' adjustment and adaptation are viewed. New models are also proposed, with the argument that these can better address the issues of immigrants.

Acculturation is a process of change that individuals go through because of contact with another culture (Teske & Nelson, 1974). Several models of acculturation have been devised that attempt to show how individuals who have developed in one cultural context adapt to new contexts after immigration. The most influential model in psychology is Berry's model of acculturation (1997). This model emphasises that immigrants are able to choose whether: to assimilate into the host culture, to reject it and retain their own culture, to reject both the host and their own culture, and as a result become marginalised, or to become bicultural. Becoming bicultural is seen by Berry as the ideal outcome of acculturation. However, this model has been criticised for trying to compare individuals, despite their context being very different - even within similar national groups (Rudmin, 2003; Chirkov, 2009). It has also been criticised for ignoring the interactional nature of the process of adaptation (Rothman et al., 2008). According to Yakushko and Consolli (2014, p. 102) the acculturation model is 'further pathologizing immigrants who may not fit the predetermined patterns of acculturation'. Edley and Wetherell (2001) argue that power structures and political discourses implicitly dictate the way immigrants should adapt to mainstream culture rather than leaving space for a personal agenda. Similar criticism has also led to Berry's acculturation model being labelled racist for not acknowledging this (Dijk, 1997).

Tajfel's (1978) social identity theory allows for a degree of personal agenda by explaining the process of selecting both a social identity and strategies to cope with ethnic identity that are devalued by the majority group. According to Tajfel

(1978), self-esteem is connected to ethnic identity, and this influences whether immigrants choose negative or positive interactions with the dominant group. Hernandez (2009, p. 725) argued that there was a 'connection between the potential internalization of negative feedback and factors in the environment that affect the mental health of the individual immigrant and immigrant groups'. Although social identity theory is useful in understanding some of the processes of acculturation, it does not account for the power structures in society that lead to negative experiences in any depth.

Newer models of acculturation have emerged in recent years. For example, Schwartz et al. (2010) have produced a framework for understanding acculturation that places emphasis on the context of receptivity as a crucial factor in acculturation processes. This model highlights that immigrants' ethnic backgrounds, cultural similarities to the host community, and the removal of experiences of discrimination were key to successful integration (Schwartz et al., 2010).

There is, therefore, a multiplicity of models of the immigration process, that vary according to the degree that acculturation is seen as an individual process or is more influenced by the interactional nature of adaptation. The latter also acknowledges issues of power. Awareness of different models is important for mental health professionals due to their moral obligation to evaluate critically theories that have been applied to research and practice with ethnically diverse

clients (Sue, 2004; Fernando, 2010). This is important because applying a relevant model can help empower individuals rather than maintain the status quo (Ivey et al., 2007).

Other theories go beyond acculturation to address other factors important to the process of understanding immigrants' mental health. Relational Cultural Theory (RCT), advocates expanding multicultural and social justice counselling competencies beyond the domains of self-awareness, cultural knowledge, and culturally responsive helping skills (Comstock et al., 2008). It delineates the complexity of human relationships by highlighting concepts of connection and disconnection, and examines the social implications of psychological theory (McCauley, 2013). RCT also recognises the existence of diversity and the inevitability of power differences among individuals, while at the same time describing a way towards healthy coexistence and mutual empowerment. This theory stresses that 'pathologizing' individuals by viewing them as weak and helpless diverts attention away from the important social conditions that can lead to the development of psychological problems in the first place. For example, Birrell and Freyd (2006) argued that the oppressive relationships institutionalised within society have a direct and profound impact on the interpersonal relationships between its members. According to Comstock et al. (2008), RCT can complement the multicultural and social justice movements by highlighting how contextual and sociocultural challenges can obstruct an individuals' ability to participate creatively in growth-fostering relationships in therapy and life.

More recently, Chung and Bemak (2012) have proposed an approach that provides mental health practitioners with better tools to address social stigma and cultural mistrust when working with immigrant communities. Their Multi-Phase Model of Psychotherapy, Social Justice and Human Rights (MPM) focuses on the needs of immigrants, with the aim of developing a culturally responsive mental health intervention model that can assist immigrants to better adapt to life in their new host countries. The MPM consists of five phases of intervention: mental health education; individual, group, and family interventions; cultural empowerment; integration of traditional and Western healing practices; and addressing social justice and human rights issues. All five phases are seen as integral to immigrants' successful adaptation and acculturation (Bemak & Chung, 2008). Chung et al. (2008) have argued that therapists should gain a thorough knowledge of their immigrant clients' socio-political history, existing traumas, experiences of discrimination and racism, and cultural beliefs around mental health and help-seeking. Chung and Bemak (2012) go further to say that counsellors and psychologists should engage with immigrants not only as therapists but as social justice advocates, community engagement networkers, and consultants as well. In this way, practitioners are required to engage actively in addressing and mediating the mental health issues that are faced by immigrants' populations in their daily lives.

Counselling psychology has been actively involved in examining multicultural psychology and the impact of multiculturalism on clinical practice (Pope-Davis et al., 2003; Vera and Speight, 2003; Sue, 2004). Some have questioned the Western psychological models, their assumptions and techniques, and applicability to people of different cultures (Ridley et al., 2005; Benson & Thistlethwaite, 2008; Fernando, 2010). According to Fernando (2011; p.2) 'Western psychology may be called 'scientific psychology' or 'secular psychology'.' He argued that 'Anyone trained within western schools of thought (for example in the disciplines of psychiatry and western psychology and many systems of counselling and psychotherapy) will be taught to see self-sufficiency, personal autonomy, efficiency and self-esteem as the correct basis for discussions about mental health… Current mental health systems in the statutory sector are usually dominated by a model of identifying at best 'mental health problems', and at worst pure biological 'illness', and then devising interventions or 'treatment' usually highly individualized.'

Tsai et al, (2001) argued that what is helpful or distressing within Western psychological models could vary across cultural groups. Western notions of mental health 'have not much addressed cross-cultural variations, gender, religious and age-related variations' (Tribe, 2007, p15-16). In contrast, others have suggested that some traditional Western therapeutic techniques can be used successfully across cultures and have relevance within a social justice framework (Chung & Bemak, 2012). For example, cognitive-behavioural therapy has been used successfully with refugees to adjust to their present circumstances by moving beyond their painful

memories and experiences (Chung & Bemak, 2012). Kordon et al. (1988), Lago and Thompson (1996), and Tribe (2007) emphasised the importance of locating emotional difficulties in their socio-political and cultural context.

In summary, many models of immigration focus either on acculturation as an individual process or as influenced by interactional adaptation. Proponents of social justice and human rights suggest that the latter models can better assist immigrants' adjustment to their new environment.

1.2.5. Multicultural competency and social justice in counselling psychology

This final section describes briefly the values of counselling psychology, its relationships with community psychology, multicultural counselling and social justice. Some implications for practice are also considered.

Traditional scientific psychology has established its position as a discipline based on an intra-psychic approach, where individuals' difficulties are explained as being ingrained in individuals rather than seen as caused or influenced by society (Prilleltensky et al., 2009). Thus, therapeutic interventions addressing a person's presenting problems have been focused at an individual level (Kagan et al., 2011). In contrast, community psychology suggests that approaches need to be based on wider factors such as social, political and economic, and therapeutic

interventions have to be directed at the societal, organisational and community levels (Prilleltensky & Nelson, 1997).

Counselling psychology has embraced the humanistic ethic and values to its core (Strawbridge & Woolfe, 2010). Its main focus has been in developing phenomenological models of practice and enquiry in addition to that of the traditional psychology (DCoP, 2005). Kagan et al. (2010) proposed that counselling psychology should move away from individualistic explanations of distress and focus on social, cultural and contextual ones, widening its therapeutic interventions. Furthermore, Thatcher and Manktelow (2007, p. 34) argue that counselling psychologists should 'recognise that the impact of social reality has a large part to play in either supporting well-being or causing and contributing to distress.' Thus, counselling psychology practice has to be grounded in the negotiation of a contextualised understanding of clients, and the clients' presenting issues and concerns.

Historically, behaviourism, psychoanalysis and humanism were described as the three major forces in psychology (Pederson, 1999; Cassel, 2003). Multiculturalism has been identified as the fourth force in counselling (D'Andrea, Foster & Pederson, 2008) and more recently social justice as the fifth force (Chung & Bemak, 2012). According to Mio and Iwamasa (2003), multicultural counselling recognises power imbalances experienced by clients in both environment and within the counselling process. Historically, the social justice movement in

counselling psychology is often connected to the emphasis on multiculturalism in counselling (Chung & Bemak, 2012). For example, Goodman et al. (2004) included working with marginalised groups as part of their definition of social justice. Thus, understanding minority ethnic individuals' views, beliefs, attitudes and experiences is of utmost importance for counselling psychologists. This implies that mental health professionals need to be more aware of the issues of multiculturalism and social justice, and to work toward elimination of inequalities and injustices in order to create a fairer society. Vera and Speight (2003) took this a step further and argued that in order to do this, counselling psychologists need to take social action when addressing oppressive social conditions such as inequality and an unequal distribution of power in society.

As argued above, understanding complex social justice issues is also a focus of successful therapy; it often includes equal participation and resource distribution, physical and psychological safety and security, and empowerment for all groups (Warren & Constantine, 2007; Chung and Bemak, 2012). Only when this has been achieved can culturally competent services be provided ethically and successfully to diverse populations. Therefore, one important tenet of the profession in the UK has been that psychologists have to be socially and politically aware, challenging the underlying assumptions of the status quo within society with a distinctive anti-discriminatory approach. In the US, counselling psychology has had a long-standing relationship with social justice and its connected values

(Fouad, Gerstein & Toporek, 2006), but this is less explicitly pronounced in the UK (Cutts, 2013; Moller, 2011).

However, there has been a lack of openness about issues of power and oppressive ideologies in the therapy room that might add to socially unjust practices and the development of further mental health problems (Chung & Bemak, 2012). In this sense, research can be seen as a critical instrument in enhancing therapists' understanding of marginalised groups, helping to deliver changes to existing systems and to improve clients' quality of life. Therefore, the aim of this research is to increase knowledge of CEE minority group and their experiences in order to highlight additional factors that might affect immigrants' wellbeing.

1.3 Rationale

The UK population has grown rapidly over recent decades, and one cause of this is increased immigration since 2001, which is in part due to the expansion of the European Union in 2004 and 2007 (Office for National Statistics, 2013). Inequalities in mental health care access and quality have been discernible and have disproportionately affected minority ethnic group members (Department of Health, 2005). As part of a commitment to reduce existing inequalities in access and in health outcomes, government policy has focused on addressing ethnic minorities issues (Department of Health, 2005). The document 'Inside Outside' (Department of Health, 2003a, p. 7) states that there has been 'an over-emphasis on

institutional and coercive models of care; that professional and organizational requirements are given priority over individual needs and rights; and that institutional racism exists within mental health care.'

There is evidence that minority ethnic groups have shown a preference for talking therapies over medical treatment (Keynejad, 2008). This puts mental health practitioners in a position to make a significant contribution to knowledge about the best way to address the needs of individuals from these groups. Understanding the mechanisms that have led to these inequalities or disparities can inform mental health care policies and improve practice guidelines. It can be argued that working with mental health issues in a pluralistic society requires attending to the needs of all client populations, not just the ones that have been addressed in the literature so far.

Furthermore, Weinrach and Thomas (1998) have argued that conducting research only on larger minority ethnic groups is considered demeaning to those minority groups which were not included, depriving them further by denying their realities, which they go on to suggest is incompatible with the values of counselling psychology. There has been a lack of attention in the research literature to the needs and issues of populations currently marginalised in society (Lyons & Bike, 2013). Whilst most research has focused on cultural factors influencing the help-seeking of predominantly Polish immigrants, this study aims to highlight factors that might impact on the mental health of immigrants from

Poland, Bulgaria, Latvia, Lithuania, and Romania, as the latter four groups have been particularly overlooked in the literature to date.

Perhaps most importantly, research up to now has ignored the views of CEE immigrants in regards to their wellbeing. Furthermore, most of the research was conducted from an 'outsider' position, whilst the current study has been carried out by a researcher with a CEE background, who also has extensive experience of working with vulnerable individuals. It is believed that the researcher has been able to build trust with these difficult-to-reach communities and to provide sensitively optimal space for participants to express their views openly. Finally, it is hoped that the use of a qualitative methodology and semi-structured interviews has enhanced participants' freedom to express their views and beliefs, enabling the collection of rich and detailed data.

In order to address the gaps in the research literature, the current research has adopted a critical realist position and a social justice lens in an attempt to 'give voice' to CEE immigrants. It explores how the experience of immigration affected immigrants' wellbeing and whether help is sought for psychological distress. The title of this thesis has the words of one participant in the study, 'another brick in the wall', that highlights a concern that the existing Western models of mental health in the UK, and hence many psychologists working in the field, might support a system which maintains inequalities and injustices in society rather than challenging the status quo.

1.4 Research aims

One aim of this study was to contribute to the existing literature regarding the experiences, beliefs and views of CEE immigrants about mental health by uncovering some of their needs for support. It was hoped that exploring this could give counselling psychologists and mental health professionals a better understanding of the issues that might be affecting the CEE immigrant clients with which they come into contact. It is also hoped that this better understanding could lead to ideas for developing more effective ways of working with individuals from these countries, and for making services more accessible. Furthermore, the aim of giving a 'voice' to CEE immigrants could bring about a deeper understanding of the different groups that make up UK society, and help to prevent the stereotyping of CEE communities that can lead to marginalisation and social isolation.

1.5 Main research questions

This study explored how the experience of immigration impacted on the wellbeing of sixteen Central and Eastern European immigrants and their decisions to seek help (or not) for their psychological distress, while highlighting some possible needs for support.

More specifically, the research aimed to answer the following questions:

1) How does the experience of being an immigrant in the UK impact on the wellbeing of someone from a CEE country?

2) What are participants' views, beliefs and understandings of emotional difficulties or mental health?

3) What might the participant do if they experienced emotional distress?

4) What could stop the participants from seeking support for their emotional difficulties?

5) What kind of support might they find helpful in times of distress?

Chapter 2: Methodology

2.1 Overview

In light of Silverman's (1993, p.1) distinction between 'methodology' and 'method', where the former identifies 'a general approach to studying research topics', and the latter refers to specific research design, the aim of this chapter is to outline both the underpinning research methodology, including the rationale for the qualitative critical realist ontology, and also the specific design of this study. Section 2.2 also considers issues such as epistemology, quality of research and ethics. Section 2.3 provides information pertaining to participants in the study; Section 2.4 outlines the procedure and Section 2.5 details how research analysis was carried out.

2.2 Design

The research adopted a qualitative methodology, using semi-structured interviews to gather data from UK immigrants from Central and Eastern Europe. All interviews were conducted, transcribed and analysed by the researcher. Inductive Thematic Analysis (TA) was chosen as the method of enquiry because of its flexibility and focus on finding rich meanings and patterns across data (Braun & Clarke, 2013).

2.2.1 Reflexivity

Qualitative research emphasises the importance of researchers considering how their involvement has influenced and informed the study (Braun & Clarke, 2013). Willig (2008) describes two main types of reflexivity: epistemological and personal. According to Willig (2008), 'epistemological reflexivity' is concerned with making explicit the researcher's philosophical beliefs about the world and knowledge, and how the design of the study might have shaped the data and findings. 'Personal reflexivity' refers to the ability of the researcher to reflect upon the ways in which their own interests and experiences might have influenced the research. Thus, by engaging in the process of reflexivity, the researcher strives to develop an increased self-awareness of their role in the co-construction of knowledge (Fassinger & Morrow, 2013). In order to enable readers to judge for themselves how useful the findings may be in other contexts the remainder of this section will outline the researcher's social location concerning the research project (Elliott et al., 1999).

a) Epistemological Reflexivity

The author of this thesis adopted a critical realist paradigm that is positioned between positivism and constructivism, which reflects the researcher's assumption that the world is real, objective and knowledgeable, but only known by means of perception, thought and language (Bhaskar, 1989; Danermark et al., 2002; Willig, 2008). According to Fleetwood (2013) critical realism attempts to uncover power-knowledge and socio-political agendas, and give voice to the relatively powerless

that can be used to promote social justice (House, 1990). This framework fits the researcher's ontological position between realism and relativism, whilst reflecting the relativist-realist tension inherent in counselling psychology (Braun & Clarke, 2013; DCoP, 2005; McLeod, 2003; Strawbridge & Wolfe, 2010).

The researcher decided upon a contextualised TA method of data analysis (Braun & Clarke, 2013), where participants are viewed as active contributors rather than subjects to be studied. Therefore, she acknowledged the meanings individuals attached to their experiences, and the broader social context that might impinge on those meanings (Crethar & Ratts, 2008). In this sense, the researcher highlighted issues that might be part of a social justice agenda (Chung & Bemak, 2012). The Division of Counselling Psychology also emphasise the need of its members to 'consider at all times their responsibilities to the wider world' (DCoP, 2005 p. 7). Therefore, the researcher keenly felt the need to try to address the social and structural conditions that might lead individuals and groups to disproportionately experience mental health distress (Kenedy & Arthur, 2014).

The research aims, semi-structured interview schedule, and subsequent analysis were influenced by the researcher's experience in the mental health profession. For example, the researcher assumed that the immigration process might make individuals more vulnerable to distress (Bhugra & Gupta, 2011; Dalgard & Thapa, 2007; Font et al., 2012). In order to counterbalance any bias, assumptions were bracketed in a reflective diary (see Appendix 15) and discussed

with research supervisors (Gearing, 2004; Robson, 2002; Robson, 2011). The analysis also aimed to show varied accounts of participants' experiences and views (Braun & Clarke, 2013).

The study design may have also been influenced by the researcher's own experiences as an immigrant. In line with all qualitative research (Braun & Clarke, 2013; Yardley, 2008), the analyses undertaken in this study are not given the status of 'facts', but are always tentative, and the researcher accepts alternative interpretations. Throughout the analysis, the active role of the author as an interpreter of participants' stories was acknowledged (Kvale, 2007), and biases were critically examined. With this in mind, all themes are grounded in data excerpts to allow the reader to judge for themselves (Braun & Clarke, 2013).

b) Personal Reflexivity

I am a white, graduated woman, originally from Bulgaria who immigrated to the UK in 1998. My interest in conducting this study arose from working therapeutically with people from different cultural backgrounds, including those from Central and Eastern Europe. The current research provided an opportunity to give something back to my community by extending the knowledge of the CEE immigrants' experiences. At the same time, the research also increased my awareness and self-understanding, and allowed a space to face openly my privileged position as a counselling psychologist (Finlay & Gough, 2003).

Mental health was a topic that was hard to discuss with this participant group. Because of this, I had to rephrase carefully the questions asked after discovering during the pilot study that certain phrases, such as 'mental health' were closing down the conversation. The phrase 'mental health' was substituted with 'emotional difficulties', which seemed more acceptable to participants and allowed for greater freedom of dialogue. This perhaps reflected the participants' negative view of the stigma of mental health (Robila, 2004). However, I continued to prompt tentatively until no further information was gained (Braun & Clarke, 2013).

At a personal level, I had both positive and negative experiences of the immigration process. Living in the UK has allowed me to continue my education and self-development. At the same time, I have experienced difficulties with learning English and loss of my previous social network. Although in the past I relied on friends for emotional support, gradually I have started to seek help from professionals for my personal development and I have found this helpful. However, I am aware that people cope with emotional problems in different ways, and so I offered participants an opportunity to express their own views and experiences.

In the undertaking of this research, I discovered the challenge of being seen both as an insider and as outsider of the CEE community (Dwyer & Buckle, 2009; Sherry, 2008; Yakushko et al., 2011). At times, I felt welcomed, whilst on other

occasions I sensed reservations about me. Perhaps some participants felt that I had a greater understanding of their cultural histories, values and traditions, whilst others could have perceived my being middle class and graduated as a barrier. I was open about my interest in this research, sharing that I was not an all-knowing expert; rather I needed their help to learn from and voice their views, within the limits of a doctoral thesis (Fassinger and Morrow, 2013).

Writing up the research project was an interesting but a challenging experience. I struggled to create a coherent and logically constructed argument (Chenail, 1997). Perhaps that was based on my own assumption that I was not 'good enough' (Young et al., 2003) to write in my second language. At times, I feared that I would let down the participants by not producing a valuable research thesis. These feelings were partially based on my personal experience of taking part in a community engagement project (Dorset Mind, 2007), where a report was written and participants' views were presented, but policies and practices remained the same. My feelings of powerlessness and inferiority might also reflect some participants' views of themselves as immigrants. These can be counter-transferential feelings, which can resemble the process of engaging therapeutically with minority ethnic individuals from Central and Eastern Europe (Clarkson, 2003; Elefteteriadou, 2003).

2.2.2 Rationale for the Qualitative Methodology

Until the first half of the twentieth century, there was a bias towards quantification in psychology (Howitt, 2010), which viewed psychological systems as fundamentally mathematical in nature. Quantitative methods that were employed within this positivist paradigm were positioned against subjective, interpretative techniques (Braun & Clarke, 2013; Willig, 2008). Qualitative research (used within a relativist paradigm) has been criticised by positivists as 'merely subjective assertion supported by unscientific method' (Ballinger, 2006, p. 235), with major criticism focusing on the value of small samples (Hamel, Dufour & Fortin, 1993). Countering this, Finlay (2006, p. 319) noted that qualitative research was often inappropriately evaluated in terms of 'validity', 'reliability' and 'generalisability' and instead argued for criteria encompassed by the notions of 'rigour, ethical integrity and artistry'. Morrow (2007) argued that the underpinning paradigmatic stance of the researcher determined largely the choice of methodological approach. Thus, the researcher' decision on a critical realist paradigm and exploration of meanings and experiences led to selection of qualitative methodology.

Rather than attending to a reductionist isolation of specific variables for measurement, qualitative researchers attempt to provide a detailed exploration of the intertwined aspects of their topics, making analysis holistic and contextual (Yardley, 2000). Fassinger and Morrow (2013, p. 74-75) argue that 'Qualitative approaches can help to: enhance relationship and dialogue between researchers

and participants in their communities; minimize the imposition of researcher assumptions on diverse others; empower participants by honouring their strengths, needs, and values and helping them to voice their stories; stimulate collaborative social change efforts by researchers and participants; catalyse theory development; and frame communication and dissemination of research outcomes in ways that are immediately useful to communities.' Rennie (1994) claimed that qualitative methodologies could provide a bridge between research and practice.

Counselling psychology can incorporate both quantitative and qualitative methodologies in research, depending on the questions being asked (Barbour, 2008; Barkham, 2003; Robson, 2002). Qualitative research is seen as particularly suited to promoting counselling psychology's multicultural and social justice agendas (Morrow, 2007). Braun and Clarke (2013, p. 8) claim that qualitative methods allow better access to individuals' subjective worldviews and meanings, particularly to groups that are marginalised, such as minority ethnic groups 'invisible within Western psychology'. Qualitative inquiry is thus seen as appropriate for research of immigrant populations (Lu & Gatua, 2014; Lyons & Bike, 2013; Lyons et al., 2013; Ponterotto, 2002, 2005), making it preferable for the current research.

2.2.3 Ontological and epistemological assumptions

The foundation of critical realism as a post-positivist ontological perspective lies in the work of Bhaskar (1975), and is primarily seen as a British tradition. Critical realism is thought to integrate the advantages of 'ontological realism, epistemological relativism and judgmental rationality.' (Archer, 1995, p. xi). It is therefore positioned between the positivist and social constructivist traditions. An important tenet of critical realism is the need to separate epistemology (knowledge, systems, thoughts and theories) from ontology (being, things, reality and objects). Science is viewed as a product of the social world, which is influenced by a range of social, ideological and political conditions, 'but the mechanisms that it identifies operate prior to and independently of their discovery.' (Bhaskar, 1998, p. xii).

According to Danermark et al. (2002), critical realism is interested in complex networks of theoretical and observable elements that include efforts to go beyond the surface of social phenomena. Society is regarded as a complete unit of structures, practices, and relationships that individuals can reproduce and transform, and without which society would not exist (Alvesson & Sköldberg, 2009). Like other qualitative approaches, critical realism is interested in synthesis and context, while at the same time it strongly emphasises the objective nature of reality, arguing that a focus on social constructions is insufficient and misleading. Critical realism has been argued to be:

'a perspective that combines the realist ambition to gain a better understanding of what is 'really' going on in the world with the acknowledgment that the data the researcher gathers may not provide direct access to this reality' (Willig, 2008, p.13).

By adopting such a position, the emphasis is placed on the root causes and social structures underlying oppression (Abrams & Houston, 2006). As critical realists are seen as primarily concerned with relations between people and structures (Archer, 2010), the approach is thought as a particularly useful framework for investigating mental health (Pilgrim, 2013). Therefore, this study adopts a critical realist position in its exploration of peoples' own constructions of their experiences, views and meanings concerning the studied topic, while considering the impact of wider socio-economic factors in the creation of peoples' reality. This is done in accordance with Madill et al.'s (2000) argument that researchers have to make their theoretical and epistemological assumptions transparent in order to be evaluated appropriately.

2.2.4 Rationale for individual semi-structured interviews

The rationale to use semi-structured interviews was based on the argument that these are compatible with a variety of methods of data analysis (Willig, 2008). Furthermore, semi-structured interviews allow a better exploration of individuals' experiences and perspectives on a given subject (DiCicco-Bloom & Crabtree, 2006), within their specific context (Robson, 2002), and this made them particularly appropriate in addressing the research questions for this study. They also had the

advantage of being flexible in the sequencing of questions, with the opportunity of re-wording questions when necessary and allowed interviewees to spend more or less time on questions (Robson, 2011). Thus, the interview could follow the participant's interests or concerns (Smith & Osborne, 2008) and remain sensitive to their perspectives and socio-cultural context (Yardley, 2000). Furthermore, semi-structured interviews are better suited when a sensitive topic, such as personal experiences of emotional difficulties (Blandford, 2013).

2.2.5 Rationale for using thematic analysis as a research approach

A variety of alternative qualitative methods could have been used to answer the research questions in this study. For example, Interpretative Phenomenological Analysis (IPA) was considered as a possible method of data analysis. IPA originated in the field of psychology, and its theoretical orientation is based on phenomenology, interpretation (hermeneutics) and idiography (Smith et al., 2009). IPA and thematic analysis (TA) have similar features (Braun & Clarke, 2013), such as providing rich and complete descriptions of human experiences and meanings. There are also differences between them: IPA emphasizes 'meanings inherent in human experience and action, regardless of their individual or collective origin', whilst 'critical approaches emphasize the social and historical origins and context of meaning, regardless of the individual or collective forms of embodiment' (Fossey et al., 2002, p.720). Critical research highlights relationships and conditions that shape and constrain the development of social practices in communities by taking into account historical, cultural, and political context (Guba & Lincoln,

2005). As a result, the exploration is directed towards developing an understanding of the studied phenomenon as an instrument to be used to deliver practical transformations of society, rather than as understanding per se (Wadsworth & Epstein, 1998). Given the social justice lens for this study, it was felt that TA was a better fit with the critical realist approach to this study.

Grounded theory was also considered as a possible method of data analysis. Constructivist grounded theory in particular is underpinned by the relativist position and expressed through the assumption that the researcher constructs a theory as an outcome of their interpretation of the participants' stories (Milles et al., 2006). Although there are similarities between thematic analysis and grounded theory, TA aims to summarise data into themes which in turn are explained, rather than attempting to develop hypotheses and theories in relation to the data (Ryan & Bernard, 2000). TA provides greater flexibility and 'is not wed to any pre-existing theoretical framework' (Braun & Clarke, 2006, p. 9), but can be applied across a range of epistemological and theoretical approaches. TA can be used as a 'contextualist' method that is positioned between essentialism and constructionism, as characterised by theories such as critical realism (Willig, 2001). Therefore, the researcher employed an inductive thematic analysis approach in the current study because of its flexibility and lack of theoretical bias.

2.2.6 Approach to quality of the research

Several guidelines were considered in designing the research (Morrow, 2005; McLeod, 2011; Elliott et al., 1999; Yardley, 2000, Tracy, 2010) in order to ensure the quality of this study. The researcher aimed to be 'consistent with the philosophical position (paradigm) and aims informing the research methods' (Fossey et al., 2002, p.723). Consequently, the study was conducted in accordance with Braun and Clarke's (2006) criteria for good thematic analysis, and its evaluation is embedded throughout. Furthermore, the four broad principles proposed by Yardley (2000; Yardley 2008) were also consulted, because of their relevance to assessing the quality of qualitative research (Vossler & Moller, 2015). These are described below.

Sensitivity to context

The researcher conducted an in-depth literature review to situate the study and to provide a relevant context as recommended by Yardley (2000). The researcher's personal experience as an immigrant and her role as a therapist presented an additional perspective in contextualising the study (see reflexivity section, also Appendix 15). The analysis needed to be sensitive to participants' perspectives, and this was achieved through following ethical considerations and using methods of obtaining data, such as open-ended questions, that allowed personal expression (Braun & Clarke, 2013). Attention was paid to unexpected findings that were different from the researcher's understandings on the studied topic and an effort was made to examine these thoroughly.

Commitment and rigour

The researcher's commitment is rooted in her deep interest in the studied topic and literature, and evident through her carefully considered choice of both methodology and method for thorough data collection. This was followed with line-by-line analysis and rich, thematic description of the whole data set, demonstrating the author's investment in the study. The rigour of the data analysis was guided by the study supervisors who reviewed the coding of several transcripts, identification of both themes analysis process, and is evidenced in the audit trail (Braun & Clarke, 2013; Tracy, 2010) found in the Appendices (8,9, 10, 11,12 & 13).

Transparency and coherence

Transparency is evidenced by the explanation of the rules and stages that guided the coding of the data (Yardley, 2000; 2008; Tracy, 2010) found in Section 2.5. Analysis involved coding the entire data set rather than just selected predetermined elements. Excerpts of the textual data were used to illustrate the patterns identified during analysis (Elliott et al., 1999; Yardley, 2000). Transparency was also aided by the provision of disclosure of personal experiences and motivations that led the researcher to conduct the study through the reflexivity process (Tracy, 2010).

The researcher attempted to present a coherent argument by highlighting links between themes, thus providing a meaningful story of the participants' experience of reality. Since the aim of the research was to explore and give voice to

the CEE immigrants' perspectives on the studied topic, thematic analysis enabled a consistent description of their experiences and needs (Braun & Clarke, 2012).

Impact and importance

The researcher hopes that the theoretical and practical impact and its importance will be self-evident. The research explored a minority ethnic group that has been understudied and hence the knowledge produced could be relevant to multicultural counselling and the profession of counselling psychology (Chung & Bemak, 2012, Moller, 2011). The study also has the potential for contribution towards recognising important socio-cultural factors and facilitating social change. The impact and importance of the study are discussed further in section 4.1.1.

Further consideration

Since the research adopted a critical realist position, it was not deemed necessary to provide a copy of the analysis for participants to check and validate the results (Braun & Clarke, 2013). According to Smith et al. (2009), even though the aim of the research was to 'give voice' to participants, understanding and representing their experiences required a degree of interpretation. This means that those were informed to a certain degree by the researcher's own assumptions, values and beliefs. The researcher acknowledges that 'no research is perfect and that it can be criticised' (Taylor, 2001, p. 317) and she was open to suggestions and feedback provided by the research supervisors, which were incorporated into the analysis.

2.3 Participants

The selection of participants was informed by the research questions, although the number of participants was determined by pragmatic considerations (Willig, 2008). A purposive sample of both females and males from different ages and social backgrounds from five CEE countries (Bulgaria, Latvia, Lithuania, Poland and Romania), who were living in two South West counties in the UK were recruited and interviewed. This sampling was seen as a way to recruit members of less researched groups, and is defined as a process in which the researcher 'chooses subjects, places, and other dimensions of a research site to include in the research to enlarge the analysis or to test particular emerging themes' (Bogdan & Biklen, 2003, p. 261). This is a good method for collecting rich, in-depth data according to Patton (2002). Four participants were also selected through snowball sampling (referrals from participants or others involved in the study) as an additional method. Additional information is provided in the sections below in order to increase transparency about the research process (Lincoln, 1995).

2.3.1 Recruitment

Three participants were recruited by community development workers; eleven by key members of the studied communities and through snowballing, and two from international services at universities (see Appendix 3, 4). Community development workers (CDWs) engage with communities to facilitate improvement and respond to peoples' needs through active participation. CDWs facilitated meetings with members of the studied communities, where research

aims and details about the project were discussed. Three participants were successfully recruited in this way. Seven participants were recruited with the help of Bulgarian, Latvian and Polish community members. Some of these individuals introduced the researcher to four more respondents (snowball sampling), who expressed desire to participate in the research. Another six agreed to take part, but did not respond to follow up telephone calls and e-mails. University support services, which provide a range of student related support on academic, immigration and personal issues were approached also, and asked to provide information about this research study. Two participants made contact after receiving information from these services and decided to participate.

2.3.2 Inclusion criteria

This study recruited adult immigrants (18+) from the CEE minority ethnic group in the UK (Accession 8 and Accession 2 countries). All participants were first generation immigrants. A desire to talk about immigration experience and help-seeking concerning emotional difficulties was necessary and addressed at the point of recruitment. This was in line with McLean and Campbell's (2003) suggestion that recruitment should not be merely about increasing sample size, but making attempts to relate research to the interests, values and practices of potential participants in order to engage them in developing findings and searching for ways to apply them (Salway et al., 2011).

2.3.3 Exclusion criteria

The only exclusion criterion was being under the age of 18 and having a background other than CEE.

2.3.4 Participant information

Sixteen participants took part in the study: four from Bulgaria, two from Latvia, two from Lithuania, six from Poland, and two from Romania. Simple demographic information (Appendix 1) was obtained in order to situate the sample (Elliott, Fischer & Rennie, 1999). Twelve females and four males from two counties in the South of England, with mean age of 34, standard deviation 11 and a range of 20-56 years, took part in the study. The recruitment ended when rich data was obtained (Braun & Clarke, 2013), and within this doctorate's time schedule. A summary of participant information is detailed below in Table 1. Full demographic data can be found in Table 2 (see Appendix 1).

Table 1: Demographic data

Nationality	Gender	Name	Age	Number
Bulgarians	male	Miro	25-35	1
	female	Katya	25-35	1
		Krisy	36-49	1
		Sonja	50-69	1
Total Bulgarians				4
Romanians	male	Sandu	50-69	1
	female	Ioana	25-35	1
Total Romanians				2
Latvians	female	Anda	36-49	1
	female	Laura	36-49	1
Total Latvians				2
Lithuanians	female	Indre	19-24	1
		Tanja	25-35	1
Total Lithuanians				2
Polish	male	Piotr	19-24	1
		Marek	25-35	1
	female	Emilia	19-24	1
		Barbara	25-35	1
		Monika	25-35	1
		Agata	25-35	1
Total Polish				6
Total participants				16

2.4 Procedure

2.4.1 Ethical considerations

Ethical aspects were considered throughout the whole research (Fossey et al., 2002). This study adhered to the British Psychological Society Code of Ethics and Conduct (BPS, 2009) and ethical approval was obtained from the University of the West of England Ethics Committee (see Appendix 2). In order to ensure

participants' active involvement and understanding of the research, it participants were informed that interviews could be conducted in their preferred language (Patel, 1999). The researcher is fluent in Bulgarian and Russian, and culturally competent interpreters were offered, however this was not taken up by any participant. This might reflect that the research only attracted participants fluent in English or perhaps unwillingness to involve interpreters. Four interviews were conducted in Bulgarian and translated before transcription by the researcher. All remaining interviews were conducted in English and transcribed by the researcher.

2.4.2 Consent

Information sheets explaining the purposes of the study were given at least a week before conducting the interviews (Appendix 4). Ample time was given before the start of each interview in order to answer questions and ensure participants had good understanding of their involvement. The researcher emphasised to each participant that she/he had the right to refuse to answer any questions and the right to withdraw their participation from the study. Participants were asked also to give consent for the interviews to be also digitally recorded (see Appendix 5).

2.4.3 Confidentiality and anonymity

Participants were made aware that all information collected during the research process would be kept strictly confidential. They were informed that their names and other identifying information would be kept securely and separately

from the voice recording and the subsequent data analysis. Participants were also informed that the researcher's supervisors or representatives from academic and professional assessment bodies would view anonymised parts of the transcription in order to assess the quality of the research. However, only the researcher would be aware of each participant's real identity. They were also informed that anonymised data relating to participants would be kept for 5 years after project submission, which is in accordance with the University of the West of England's 'Code of Good Research Conduct' (2011).

2.4.4 Distress and debriefing

Each participant was informed prior to the interview that although he/she was invited to share personal experiences, they should disclose only as much as they felt was comfortable. It was made explicit that the aim of the interview was to discuss issues around immigration experience, factors that affected their wellbeing and to reflect on their need for support. The researcher was aware that by reflecting on these experiences there was potential for distress. However, the researcher is an experienced mental health practitioner who was able to use appropriate therapeutic skills to conduct the interviews in a sensitive and respectful manner. Participants were debriefed (Appendix 6) after the interview. Time for answering questions was allocated at the end and participants were supplied with information about sources for support if they experienced any distressing feelings.

2.4.5 Interview process

After obtaining informed consent, the researcher conducted all semi-structured interviews face-to-face. The interview guide was piloted during a previous exploratory project on the acculturation of CEE immigrants to the UK. Clarity about research questions was gained through the iterative process of data gathering and continuous returning to literature as well as consulting with individuals who took part in the study (Fassinger & Morrow, 2013). As a result, the interview procedure and schedule was refined (see Appendix 7). Interviews took place at times and locations convenient for the participants. These locations included community centres, hotels, libraries and universities (rented rooms). The interview duration ranged from 30- 90 minutes. Participants were first asked general questions about their immigration experience in order to build up rapport and trust before focusing in on mental health issues, which was a sensitive subject for this minority group. Valuable data was gathered from open-ended questions around meanings and experiences of emotional difficulties, ways of dealing with distress, experiences and awareness of available mental health services, and views about barriers and needs. Participants were prompted when necessary in a facilitative, explorative and naïve curious manner. Digitally recorded interviews were transferred onto the computer, using password-protected files.

2.4.6 Transcription

Braun and Clarke (2006) argue that thematic analysis does not require the same level of detail as other qualitative methodologies and simple orthographic

transcription could produce a sufficient record. The author transcribed all interviews verbatim and the transcription process was considered part of the analytic process (Braun & Clarke, 2013). The transcription notation system followed the adapted version of Jefferson's (2004) as described by Braun & Clarke (2013).

Translations from Bulgarian to English were revised several times during transcription and analysis to ensure no specific cultural meanings were lost (Nes et al., 2010). To avoid loss of contextual meaning the researcher transcribed each interview within two days. Although the researcher/translator role offered significant opportunities for close understanding of cross-cultural meanings, the researcher also acknowledged the limitations, such as the element of interpretation that was determined by her socio-cultural positioning (Temple & Young, 2004). The researcher aimed to minimise the power relations by explaining her intentions to represent participants' views as truly as possible, which was in keeping with the choice of a critical realist paradigm. Furthermore, the researcher checked any concepts that proved difficult to translate with a Bulgarian community member, taking into account the specific context but preserving participants' anonymity (Temple & Young, 2004). At times fluid descriptions of meanings were used rather than literal translation and these were verified several times in the source language (Nes et al., 2010).

The researcher acknowledged that transcription represented a textual version of the 'interaction between the recording and the transcriber' (Braun & Clarke, 2013, p. 162), and whilst care was taken to offer an 'accurate' representation, transcription would inevitably entail the 'selective rendering of the data' (Atkinson & Heritage, 1984, p. 12). After transcription, the researcher omitted any identifiable information and gave participants pseudonyms to preserve anonymity.

2.5 Data analysis

2.5.1 Thematic analysis

Despite being widely used in qualitative research, there was a lack of clear conceptualisation and explanation of TA processes in most of the literature (Boyatzis, 1998). In order to overcome the criticism placed upon TA as being too vague in its method (Holloway & Todres, 2003), the analytical process followed the seven stages proposed by Braun and Clarke (2013) (Appendix 8). The researcher decided on a semantic-level inductive approach (Braun & Clarke, 2013), which was in keeping with the critical realist perspective and exploratory nature of the study. A rich, thematic description of the whole data set was undertaken, because the studied research area has been under-investigated.

At the first stage, the aim of the researcher was to transcribe and check transcripts both thoroughly and multiple times for accuracy. Data analysis started

after all data was collected, although this is not viewed as an essential requirement of TA (Braun & Clarke, 2013).

During the second stage, the researcher immersed herself in the data noting overall impressions, some conceptual ideas and specific issues. These were noted in an electronic file (Appendix 9) for record keeping. This was done in order to make explicit how the researcher's personal experiences could shape the analysis (Braun & Clarke, 2013). The initial noting files (and later descriptive coding) were shared with the research supervisors in order to check on possible biases.

The complete coding started with the first data item and progressed systematically until the last data item was coded in a thorough and inclusive way. At this third stage, all data relevant to the research question was coded at a semantic level (Appendix 10). Semantic codes were data driven and provided summary of the explicit data content, whilst latent codes were researcher-driven and identified implicit meanings within the data (Braun & Clarke, 2013). According to Braun and Clarke (2013), the separation between semantic and latent level of coding was not pure and occasionally codes had both elements. Codes were evident in more than one data item and captured patterns and diversity within the data set. The elements of each code were considered for consistency or overlap with other codes, which in turn provided the opportunity to start refining codes and linking these together (Appendix 11).

During the fourth stage, the researcher actively reviewed the codes and collated data in relation to each code with the aim of recognising overlap between codes that could result in forming candidate themes (Braun & Clarke, 2013). The researcher acknowledged the possibility that other researchers might have identified different themes from the data. During this fifth stage, the candidate themes were reviewed and agreed among the researcher and the supervisors involved in the project (Appendix 12).

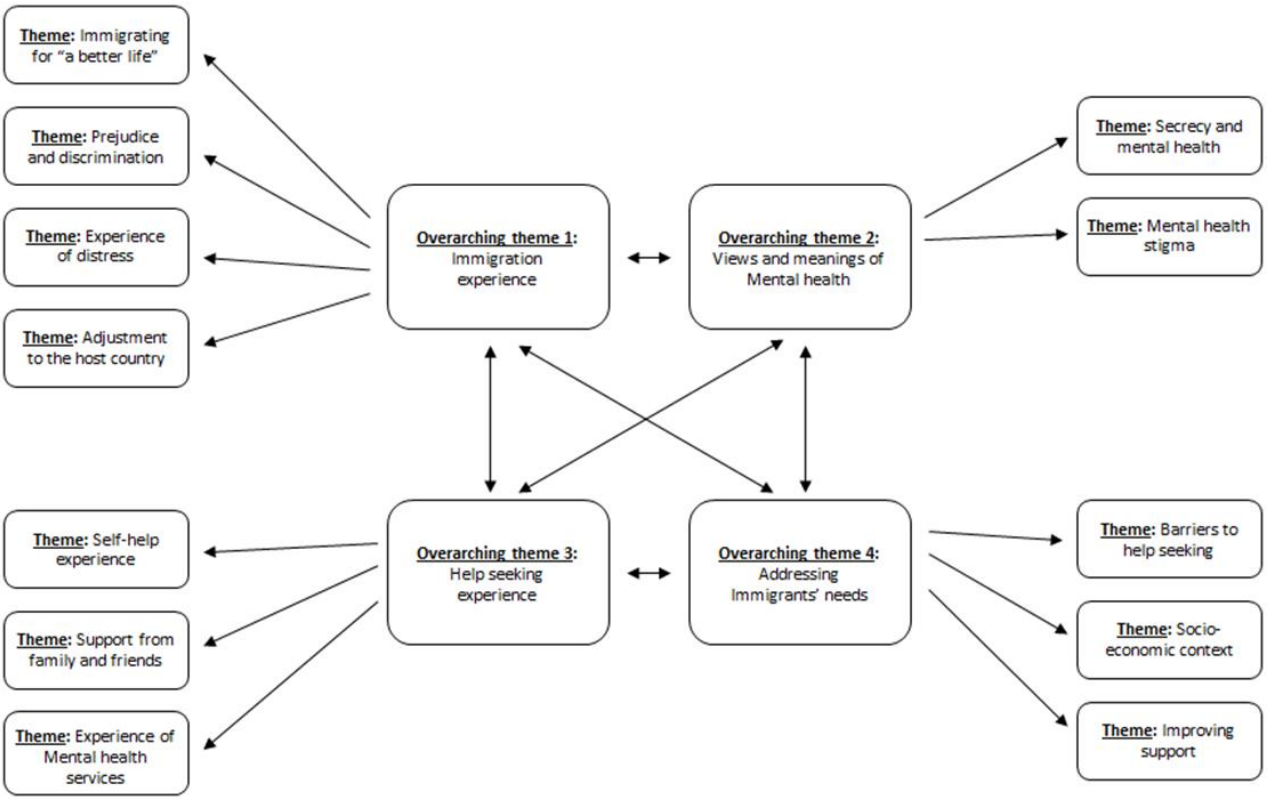
After the process of refinement of candidate themes, four overarching themes were identified and presented in a visual thematic map, showing their relationship with individual themes (sixth stage). Overview of all themes could be seen in Appendix 13. Braun and Clarke (2006, p.91) advise that 'Data within themes should cohere together meaningfully, while there should be clear and identifiable distinctions between themes.'

When working towards the final analysis, the researcher selected extracts that illustrated the themes (Appendix 14). Elliot et al. (1999) and Nikander (2008) have argued that extracts should be offered in order to increase transparency and demonstrate analytic rigour. Thus, the researchers' interpretations of data were supported by extracts from the interview transcriptions in order that those readers could make their own judgements about the quality of the analysis.

Chapter 3: Results

The analysis of the data identified twelve themes, which have been grouped into four overarching themes in accordance with the research questions. 'Immigration experience' contains themes that address the varied factors faced by some immigrants that have led to feelings of distress, anxiety and depression. 'Views and meanings of mental health' includes themes that convey the high level of stigma felt by the members of this minority group concerning mental health issues. 'Help seeking experiences' contains themes that describe the various sources of support used by the participants after immigrating to the UK. 'Addressing CEE immigrants' needs' includes themes that address some of the complex factors that can prevent CEE immigrants from seeking help, while also suggesting possible ways to support them with mental health issues. A pictorial representation of these themes can be seen below.

Figure 1. An illustration of the overall thematic analysis



An example summary description of themes with some corresponding excerpts can be found in Appendix 13. In order to aid readability, unnecessary details such as 'erm' and 'you know', and digressions from the topic (indicated with […] were removed from data excerpts when providing quotes to illustrate themes. Short pauses were indicated with (p) and longer with (pause). Emphases on word or raised voice were registered with underline. The original English has been retained and has not been edited to improve readability or correct grammatical mistakes due to English being the participants' second language. All the names used in this section are pseudonyms and were allocated by the researcher.

Overarching theme 1: Immigration experience

All participants highlighted a socio-economic motive as an important factor in the decision to leave their country of origin -that is, they were in search of a better future. Immigration was described as a complex process, which included different stages - making a decision to immigrate to the UK, the physical movement to their host country, and the post-migration experience - each influencing the wellbeing of immigrants on biological, social and psychological levels. Four main themes connected with the immigration experience were identified. These describe the participants' reasons for immigrating, experiences of prejudice and discrimination, impact of distress on immigrants' wellbeing and factors that influenced their adjustment to their host country.

Theme 1.1: 'Some people expected to be easier, but found it hard' - Immigrating for 'a better life'

Most participants had moved in the hope to escape financial hardship in their countries of origin and to improve their lives. All participants described their pre-immigration process and the first years of living in the UK as the most difficult. Their comments suggested that experiences of immigration had both positive and negative aspects, and were influenced by their expectations and goals. For example, Monika shared that it took her three years to decide finally to immigrate to the UK and to leave everything familiar behind in the hope to build *'a better life'*. Laura also reported that the lack of job opportunities and financial struggles pushed her *'to move and to start work normally'*. Similarly Sandu spoke about his struggle to make a decision to immigrate, because he did not know what to expect and had self-doubts whether he had *'enough skills and potential'* to succeed in the UK. Although Sandu had been in the UK for eighteen years he was able to reflect on the way he felt, and said that it was *'actually scary'*. He also spoke about his reasons for immigrating:

If you immigrate, you have probably a good point to do it, so something is not quite right in your country, and you are not happy. […] (p) Very often that's because the country is poor and there are not job opportunities etc. etc. but very often this is not the only thing, and some social environment probably is the problem sometimes (p) so when you go to another country you try to build your life, and this is very complex process, it is a complicated thing to do.

This quote reflects the experience of other participants and reveals that some had experienced high levels of distress in their countries of origin prior to immigration due to poverty and unemployment. It also appears that economic insecurity had an impact on some social aspects of participants' lives such as marital discords. The immigration process was viewed as challenging, complicated and requiring many resources, which in turn had a further negative impact on participants' wellbeing. Interestingly, participants reflected on their experiences in a matter of fact way and expressed few emotions. As Baker (2007) suggests, this may be because painful feelings are often dismissed or suppressed among CEE immigrants, as a way of coping with stress. Gross and John (2003) argued that the use of suppression to manage emotions had negative outcomes, such as poorer social adjustment and decreased wellbeing for immigrants.

All participants viewed the first years of immigration as most difficult. Anda said that even though she immigrated with her family the *'first year was hard'* and presented many personal challenges. Monika reflected that *'in the beginning it is hard for everyone and some people struggle a lot'* but then suggested that if one was determined to achieve their goals they could make it happen. Similarly, Indre spoke about her experience and her beliefs that if someone wanted to succeed it was their responsibility to make it happen:

It is not easy as it seems (p), like you hear people saying, could be very hard and it is hard. So I think they have to try and if they don't like their job in England, they can just always come back here (Lithuania) or you can stay, if you really want to stay in England, and you just define problems and fix them.

It appeared that participants believed in their ability to cope with hardship. They attributed this to their personal characteristics such as being strong and persistent. Having difficulties was viewed as normal, perhaps because back in their countries of origin life was even harder.

For some, such as Indre and Monika, living in the UK was seen entirely as a personal choice, while for Laura it was the only way to survive: *'I can't go like back, just have to move forward'*. That is why she talked of feeling trapped in her current situation with little chance for a change. Laura openly spoke about her depression and hopelessness and said that she was '*really pessimistic about future*'. She was deeply disappointed that despite being educated to degree level she could not find an appropriate job but had to accept a low-skilled one where the pay barely covered her outgoings. Five other participants also described working in low-paid positions, despite holding degrees. Rather than achieving the higher socio-economic status they had aspired to, they found themselves faced with more financial problems. These participants also highlighted that their initial expectations had led to disappointment. Tanja did not reflect explicitly on her experience but shared her view that:

Just to say that coming here some people expected to be easier, but found it hard, maybe not as hard as at home but not easy at all (p). Especially if you had a degree and can't find a good job. A lot of these people are very well educated, but they work in any position, just to get enough money, not easy when you are in a different country. This is something that can make you feel down. (pause)

As this quote shows, participants who had accepted a low paid job might consequently have experienced low mood and anxiety, although only Laura openly shared this experience. Most participants used words such as 'hard' and 'difficult' to reflect on their life as an immigrant, giving an indication of possible negative moods or states of mind because of migration. Again, the lack of direct emotional language here may reflect the cultural belief of many Eastern Europeans that it is not acceptable to share openly such personal issues (Selkirk, 2012; Madden, 2014).

In contrast to the difficulties already highlighted, six participants felt that they had gained a lot by immigrating to the UK. Ioana transferred her educational credentials and *'found a job'* easily. Agata also reported a similar experience and Tanja felt that she *'got better life here'*. Family reunion, safety and security, and better opportunities for their children were also highlighted as positive outcomes of immigration and advantages of living in the UK in comparison to their country of origin. Katya shared:

There are laws and following these makes me feel safer because in a way I know what to expect, and for the children, especially for them, here they have got more opportunities and for me this is the most important thing.

This quote highlights that the immigration process, although challenging, could also lead to positive experiences. Factors such as immigrating with a family member, gaining further education, finding a good job and acquiring financial security appeared to contribute to participants' feelings of fulfilment. Personal achievement was closely associated with higher self-esteem and confidence and a willingness to engage more actively in all aspects of life in the UK.

Many participants talked about additional factors influencing their wellbeing that provided a more complex picture of immigrants' experiences, and are addressed in the following three themes.

Theme 1.2: '*We just accept it*' - Prejudice and discrimination

This second theme identifies that perceived prejudice and discrimination were a significant influence on participants' wellbeing. Whilst most participants did not report the discrimination and their negative experiences to anyone, two did address such instances and reported having had a positive outcome from this. One participant also highlighted the role of the media in stereotyping negatively immigrants from CEE.

Six participants reported explicit negative attitudes towards them on institutional, structural and individual levels. Piotr and Emilia recollected their memories from their first years of living in the UK and remembered how other pupils at school perceived them as different, and abused them physically or verbally. Piotr was pushed towards a wall and felt deeply upset by this particular situation: *'he didn't know what I went through but just judged me. I felt bad to be judged by another person'.* He said he felt sad, worthless, and this had resulted in *'huge major headache over a long time'.* Emilia's tone of voice was very quiet and sad when she reflected on her experience:

*Oh some I guess, were really racist to me because I do not speak English, I was just ignoring what they were saying, but I could actually get the idea what they were saying horrible things to me by their face expression. (p) So when they were really angry, and their eyes were shining and when I heard the word f*** I obviously knew they were saying something nasty to me. So it was not really nice […] I was really upset about it (pause).*

These accounts clearly demonstrated the negative effects of individual prejudice and racism on participants' emotional state. Piotr's internal distress manifested itself in psychosomatic symptoms that lasted over several months and made him feel withdrawn and worthless. Similarly, Emilia experienced marginalisation from some pupils at her school for two years, which made her feel

lonely and upset. Greater anxiety, hopelessness and low mood were some of the effects caused by the discrimination experienced by some of these participants.

Anda also reported instances of prejudice and feeling like a stranger, not being *'welcomed'*. Ioana and Marek reflected on how their friends, or people they knew, had been affected by prejudice and discrimination and highlighted that these experiences decreased their sense of personal ability, self-worth and self-esteem. On some occasions, this made individuals unwilling to integrate more fully in the UK.

Krisi, Miro and Laura shared their experience of prejudice and discrimination at structural and institutional levels. Krisi spoke with sadness but also acceptance of discriminating practices at work because of a fear of being sacked. Her husband had been redundant for more than a year until he found a new job, but his salary was below minimum wage. They did not report this for fear of losing the job and being in a worse financial position. In contrast, Miro and Laura felt angry and openly expressed their feelings:

For a Bulgarian it is not the <u>same</u> even when someone is working they can come and say- go away. […] Just not to discriminate us, to have the same rights and payment and should not ask for all these documents, we are also in the EU as Polish. (Miro)

I am disappointed and I am like upset, it's really the manager, you are came to England from Latvia, and some Polish and some other countries, and take the job from

English people, and you need to work, then I found it just like a dog- working working and you are only earning little money for extremely high hours, extremely not respect (p). (Laura)

Anda felt that the media was a mechanism that generated stereotypes about immigrants, which contributed to the feelings of marginalisation and increased initial difficulties:

It is reflected even in Media –foreigners use benefits and don't contribute to the economy. And this creates more emotional problems, they are not just mine or yours, but we think they are, don't we?!

These quotes highlight three important issues. One is related to the institutional discrimination that is reflected through the governments' policies, which have created opportunities for inequalities based on participant's country of origin (e.g. different policies for A8 and A2 immigrants). The second issue refers to structural discrimination that is reflected in managers' attitudes. And finally, it appears that negative portrayals in the media may have a powerful role in shaping how members of the public have understood immigration, which influences attitudes towards CEE immigrants. These issues indicate that perhaps migration of CEE individuals was not well received and the presumed benefit of being white and Christian had not prevented participants from experiencing discrimination and exploitation. All of these factors seemed to disadvantage participants and

create significant distress. This had a profound negative effect on participant's wellbeing, such as feeling disrespected, abused and humiliated. Overall, it appeared that such experiences made it more difficult for immigrants to benefit from immigration and to have a sense of belonging to society in the UK.

However, Piotr and Emilia managed to address instances of discrimination with the help of their parents, who brought the discrimination to the attention of teachers at their school. As a result, Piotr and Emilia received a lot of support, which had made a significant difference to the way they felt. The supportive family environment and their adopted coping strategies of being friendly helped them to counteract the detrimental effects of discrimination. Both of them spoke of their sense of feeling accepted and appreciated. Piotr found being able to talk about the discrimination resulted in better support from friends, increased empathy and social integration:

From there on I had more friends cos they felt sorry for me, and they tried to help me, and they were all right, they were friendly. Because my whole group saw it and they were quite with me about it, cos they saw how I went down like a brick. […] I was lucky enough to be here in the UK and within a year, they were not racist, and they were nice, and they were told to be nice even the one I mentioned.

However it was only Emilia and Piotr who were able to bring changes in attitudes towards them, and were able to buffer themselves from negative

interactions. Anda preferred to dismiss instances when she felt discriminated against, perhaps because that was perceived as less threatening. Her coping strategy was to focus on the positive aspects of interacting with friendly people. In contrast, Marek felt he was strong enough not to be affected by these attitudes. His position of not taking abuse personally, but attributing it to individuals' ignorance helped him to deal with the discrimination in a constructive way. Five participants did not mention discrimination, thus it is unclear whether they did not encounter any prejudice or preferred to dismiss it like Marek. What became apparent is that participants responded in different ways to instances of prejudice and discrimination. Their reactions seemed to depend on their personality, their social status and the support they received from others. Only one participant felt that she had '*been very lucky, I haven't any problems, I haven't been discriminated against' (Ioana)*. Overall, it can be concluded that prejudice and discrimination were commonly experienced by participants of this study.

Theme 1.3: '*Everything is getting on your nerves*'- Experience of distress

This theme captures additional important factors that had an impact on participants' wellbeing. All the participants reported that dealing with everyday stress was hard. They mainly attributed their distress to difficulties finding accommodation, learning how the system works in the UK and having financial problems. Perceived stress was also significantly related to participants' sense of not belonging to a community.

Six participants cited problems related to finding accommodation as contributing to their distress. These individuals reported that finding money for deposits, references, and agents willing to assist them was challenging. Knowing little about procedures made them feel confused, anxious and insecure. For Miro, *'the accommodation is the most important'* issue, which he had to face at the same time as he was trying to secure an employment. Similarly, Katya reported that housing security was dependent upon being employed, which was often in low wage jobs where the pay did not always cover the housing cost. Anda viewed her situation as privileged because her husband earned a good wage, but she was still stunned at how expensive their accommodation was:

Finding accommodation, getting referents to assure you can pay, and dealing with agents was hard. Renting was not easy. I was shocked how much money went for a rent, so expensive.

Similar to other minority groups in the UK, the participants in this study cited affordable and adequate housing as important in order to feel emotionally well. In some cases, it appeared that housing issues negatively affected participants' social interactions, which further intensified their distress. Katya and her husband had been living in the UK for three years but still had to share a house with other immigrants from their country of origin:

When you have to share a house with other people is stressful because you have to be careful not to upset anyone, or have to shut up even if you don't agree but because of money, (p) it is harder in this situation.

This quote clearly demonstrated the link between the problems of post immigration living and participants' wellbeing. The lack of privacy in the home put more strain on their coping resources. It also appeared that living and working conditions, limitations on resources, and the subsequent effect on social relationships could have a cumulative effect. Miro was particularly upset about his situation and commented on how it affected him:

On my nervous system, because to find a house is hard, when you go to work and see that for the same job you get half of which other people get everything is getting on your nerves and is affecting you.

For Miro and three other participants these accumulated experiences of distress resulted in anxiety and depression. Agata shared that she had observed that other immigrants were unable to cope with stress:

When I am talking to friends, some of them are always feeling down […] My neighbour came across someone who felt distressed and not knowing what to do with life, and thinking of killing herself.

What seems significant in this data is the importance of considering the wider circumstances of participants' lives in making sense of patterns of their mental health problems. It was not a single factor that made a stressful experience unbearable, but a combination of a variety of determinants. The economic and closely linked social circumstances seemed to interact with additional factors, such as feeling socially excluded, which increased vulnerability to emotional distress.

Perceived life stress was also significantly associated with a sense of not belonging to a community. Tanja shared that she felt '*lonely sometimes, all my family and friends are left there so it is a bit difficult*'. Similarly, Piotr spoke about his feelings: *'you are alone, you can't talk to anyone, you feel lonely, you feel sad, there is no one for you'*. Sonja also reflected on her emotional state: *'I felt alone in this country I felt depressed'*. Laura said she could not integrate into the host culture and felt that *'this coldness and what I met here maybe I am not just in the right place'*. Krisi felt that in her interaction with British people, they were often overly polite but she was not sure *'what it is behind words, smiles and respects'*. These comments indicate that some participants had a sense of disconnection, isolation and lack of closeness in their relationships with the majority population. This appeared in part to be due to perceived differences in social conventions and the concept of friendship.

Being able to establish meaningful relationships with people in the local community reduced feelings of homesickness and stress: '*because I met some people*

that were also open to me and shared more with me (Anda). Many participants highlighted factors such as having support from both minority social networks and making new networks with British people as important to their integration in the host country. Barbara said: *'So it's good to live in a society of Polish people who can help you'.* The ability to participate actively in relationships was appreciated by most participants. Piotr talked about how important it was for him to make his first friendship with an English person:

I could talk to him, actually I have a friend, I made a bond with that person. They don't know how you feel but they tried to understand, just the bond (p) really strong friendship bond.

This quote highlights the importance of the relational aspects in participants' experiences and the importance of family and community context in shaping their sense of exclusion or inclusion at an individual level. Social exclusion was found to be reinforced by mental health problems and to present barriers to help-seeking among adults with mental health, and particularly affect young males, single parents, adults with complex needs and ethnic minorities (Social Exclusion Unit Report, 2004; Butterworth, et al. 2009; Jenkins et al., 2008). Social exclusion also could be experienced when people have restricted access to economic resources; an issue that underpins Miro's earlier quote on him being treated differently.

Overall, these experiences appeared to represent an identity threat in the form of challenging participants' sense of belonging to the new community.

Theme 1.4: *'Everything was hard'*- Adjustment to the host country

Participants talked about their efforts to adapt and fit into their host society. Dealing with bureaucracies and learning new rules was seen as challenging but essential in order to succeed in the UK. The participants' social and cultural patterns of adjustment varied due to their personal characteristics, specific environment and their choice of strategies used.

Most participants reported that adjusting to life in the UK took a long time. Marek explained that *'you kind of settle down […] you can have a job that people appreciate here'*. The challenges faced seemed to give a sense of greater personal achievement, which in turn made some participants more active and increased their self-confidence. In contrast to this however, Katya found that the adjustment was hard *'because you are in the dark, you know nothing*', and this adjustment was made harder because Katya's English was not fluent. It seems that the loss of her familiar environment made her feel anxious, vulnerable and less confident in herself, and she distanced herself from British people. Barbara appeared overwhelmed because she had to manage studying, working and looking after her children, which strained her resources. However, she seemed to accept this situation as normal and commented about pragmatic things and giving herself space to adjust:

There is a lot of information you need to know, I mean so many things to know and to learn when you come here, and everything is new, not easy to know where to find things, takes time to adapt.

Laura said she felt alone in her struggles and had *'lost all interest about this country, to adapt because I tried and nobody like cared'*, which suggested that the adjustment process depended also on participants' interaction with and support from people in their environment.

Participants employed various strategies to reduce uncertainty, some being more active, other giving up, and becoming passive. Individual factors such as age, language fluency, educational level, occupational background and family set-up had an influence on participants' adaptation. For example, Krisi felt that her age and living in rural area strongly affected her ability to adjust to her new environment and caused her emotional problems. Her view highlighted that individuals' circumstances may affect differently their adjustment to the host country.

I am middle aged and thus adaptation is more difficult. When a young person comes here and starts without anything is different from someone who is older. I had many emotional difficulties (p).

This quote shows that older immigrants might be at increased risk for mental health problems (Stepleman et al., 2009).

Most participants engaged in an ongoing learning process in order to acquire new knowledge that could enable them to succeed and 'fit' better into their new environment. Sandu talked about his efforts to understand and adapt to the new social and economic system. He said that he did not *'know how to comply with a lot of rules and procedures'*. Marek shared his opinion that most people struggled emotionally and felt stressed and down because they tried to abide by *'new traditions, new rules, new laws, new rights'*. Opinions about whether there was any support available varied from none to *'at the moment there are so many help around for us'* (Agata). Miro's perception was that finding support was expensive and not everybody could afford it:

Whoever is fed up of dealing with these issues goes to London, pays to solicitors and they pay quite a lot of money to have these documents in order to stay here and work. Without documents and an insurance number you cannot do anything.

The participants' accounts illustrated that most experienced difficulties in order to adapt to their new environment. Krisi shared that *'administrative things you have to know and to deal with*' in order to reside legally in the UK were her *'biggest worry'*. The perceived ambiguity and uncertainty that characterised the bureaucracy was frustrating and anxiety inducing:

I have the impression that the UK has strict laws but it seems that as everywhere else there are also some gaps in the system here. You can go round too and enter through another door but it it's not for everyone. (Krisi)

Another aspect of participants' adjustment was negotiating differences between their own and their host culture. Tanja retained aspects of her cultural identity but also valued her encounter with British culture. She clearly differentiated herself from some immigrants who segregated themselves, and might not even speak English. Many participants appreciated British politeness, charitableness, liberality and said that *'people are respectful' (Krisi)* and *'are trying to be very tolerant, and very like person's rights' (Indre).* However, some also viewed the host culture as more materialistic and individualistic rather than the community based culture of their home country: *'people here are not tuned to this way of living' (Sonja).* Krisi and Marek talked about the importance of preserving their cultural identity and transmitting it to their children. Their major concern was how to support their children in their adaptation process, maintaining a balance between their own childrearing views and the ones belonging to the host country culture. Krisi thought that '*there are a limited number of Bulgarian schools*' and it would have been beneficial:

…to meet other Bulgarians, to celebrate national Bulgarian days, to communicate with other will help someone to carry on and to be more positive. I think you feel closer to your roots and that helps here in England.

Overall, it appeared that financial and social problems were the main factors, which caused psychological distress among participants. Experiences of prejudice and discrimination provoked anxiety, hopelessness and low mood, reduced participants' sense of self-worth and in some instances hindered significantly their adjustment. Further factors, such as institutional policies that allowed discriminating practices at organisational level, also impacted on participants' wellbeing. Feeling socially included and supported enabled a better adjustment to life in the UK.

Overarching Theme 2: Views and meanings of mental health

This cluster consists of two main themes that examine how participants' culture influenced the way they identified, expressed and understood mental health conditions. Their views suggested people in their communities attach a high level of stigma to mental health. Mental illness was thought to bring shame and embarrassment to individuals and their families and therefore was kept secret. Ignorance was seen as a contributing factor to stigmatisation of people suffering from emotional pain. Negative views about mental health institutions in the country of origin increased participants' sense of fear and distrust in formal

mental health services. A common view among participants was that help should be sought only when someone is seriously mentally unwell.

Theme 2.1: *'Everything stays in the family'*- Secrecy and mental health

Mental health problems were predominantly contained within the family. Most participants believed that if a person was aware of their difficulties they should resolve their problems by relying on their personal strength. In addition, there was also a belief that if someone remained in this state she/he was weak. Cultural beliefs about the origin and nature of mental illness varied, including being seen as a personal fault or weakness, a genetic problem, or caused by environmental factors. In their countries of origin, individuals who suffered from mental health problems were likely to be treated in specialised mental health facilities due to the lack of community based services.

Despite their different ethnic and cultural backgrounds, participants shared a common view that family matters should be kept private. They talked of family cultural scripts, such as not sharing one's emotional problems and concerns with people outside the family. Indre viewed Lithuanians as *'quite reserved nation'* where people *'don't like to speak a lot about personal problems'*. Most of the participants talked about their resilience, being strong and able to deal with problems alone. Agata wondered *'how can you just feel down and cannot get on with your life?'* which reflected a common cultural expectation that individuals should cope better. There was a notion that one should conform to cultural norms of not

displaying openly their distress: *'you are not supposed to talk about your problems to anybody '(Laura).* Similarly, Monika viewed individuals from Poland as mostly relying on themselves to resolve such issues because they *'learnt to be strong'*. She explained that if they could not resolve their emotional problems alone *'they just would live by themselves and stay at home, and feel bad'* with the conviction that their problem was entirely their own fault. Others like Emilia said that the burden of care usually fell on families. She shared her view that: *'mental is someone who needs to take like a medicine and should have someone who looks after them, cos can't look after themselves'.* Tanya also felt that people suffering from emotional distress relied on *'their families to sort it'.* Although most participants thought that everyone could suffer from some type of emotional pain, many believed that the ones who remained in this state *'are just weak' (Anda).* From these quotes, it can be concluded that mental health issues were viewed as a personal responsibility or primarily a family concern. These views suggested considerable social pressures on individuals to conform to cultural expectations. Mental illness was seen as a condition of weakness, which made it more difficult for sufferers to disclose.

Mental illness was also assumed to bring shame to the family and this contributed to an inclination to suffer in secrecy. Katya explained that the reasons for keeping it a secret would be that: *'if your relative is ill you might have it as well and people might abuse you or just avoid you'* and *'have to be locked in isolation away from normal people'*. It appeared that a perception of genetic inheritance as a cause of mental illness could create fear of disclosing such issues. Lack of understanding

had led to abuse or caused others to stay away from the person suffering from mental illness. However, distress attributed to everyday life stressors and social factors, such as marital discord, problems at work, and financial difficulties, was more openly discussed and accepted.

Mental health was often understood holistically by some participants. Indre, Sonya, Ioana, Anda and Tanya believed that mental health depended on an individual's physical, emotional and spiritual state. Ioana felt that these *'are interlinked in many ways'* and *'mental health is one part of your wellbeing'*. Krisi stated strongly her belief that health and mental health were closely connected and *'when you have inner struggles then all problems with health come. Then you have psychological problems, being tense, nervous'*. Extending beyond the body, wellness was seen as a state of health that involved many dimensions, which together made up the whole person; these included environment and financial factors. The following excerpt illustrates this holistic view:

Psychological health means that everything is all right with you. I mean to do well at work, to work what you want, to work not what you are pressured to do because if you are pressured it also has a negative impact on you, you feel depressed. To have a loving family because if there is no love between the people, only hate each other that will lead to depression. We have to feel all right in each of these areas […] if one of these things is not all right, it leads to lack of balance in the whole organism. (Sonya)

CEE immigrants in the study shared that they did not have the benefit of organised social services in their countries of origin. Serious mental health problems were often treated by forced institutionalisation: '*you have to stay in the hospital locked so you don't harm people' (Katya).* Tanya highlighted the difference between the services in Lithuania and the UK:

Who really has serious mental health problems in my country they are in special hospitals, in locked rooms and they are just taking these very strong tablets and again they are getting worst and worst, and here in England as I see they work with every individual and they extend that to their family and they get all support and family get all support, so it is a big difference.

This quote suggests that there was frustration of over-medicalisation in the countries of origin. Unlike in the UK, there was no support provided to the family of a mentally unwell person. The quotes from Katya and Tanya also indicated that individuals with mental health problems might keep their condition a secret in order to avoid being hospitalised, often in very poor conditions, where the professionals' choice of treatment was heavily medicalised. Despite these preconceptions, it seems that some participants held a more positive view of mental health services in the UK. This suggests that highlighting the differences between mental health services in the UK and those in their countries of origin may encourage more CEE immigrants to access support.

Overall, it can be assumed that individuals with mental health problems from CEE countries might be less visible and less likely to access support services due to their fear of being marginalised or treated forcibly. Their families might also be reluctant to access help due to their cultural beliefs or because of negative experiences in their countries of origin.

Theme 2.2: '*Crazy, mad and dangerous* ' - Mental health stigma

The range of cultural beliefs highlighted in the previous section appeared to influence the way people understood, expressed and associated with mental health conditions and their subsequent treatment. The consequence of these beliefs was that mental health conditions were often stigmatised. Social stigma seemed to endorse stereotypes about mental illness and the participants often acted based on these stereotypes. Ioana talked how the common perception of mentally ill people was that *'they are bad people, scary or almost like they are violent'*, and that *'people do generalise'*. Barbara thought that immigrants brought with them these stereotypes:

Yes, there is stigma (p). You just can't forget it and become different, absolutely different person with different culture and different background. You still have this background, this culture stays with you.

Marek, like many other participants, highlighted that the stigma attached to mental health issues *'was huge'*. Many participants reported labels such as '*psycho*', '*mental*' or '*crazy*'. Katya explained that people dreaded being labelled *'as insane,*

people are scared of being diagnosed with this kind of illness, scared to be labelled'. Most participants stated a view that nobody would disclose mental illness due to fear of being negatively judged. Social and self-stigma appeared to lead to mental illness being hidden, and this may contribute to high levels of social stress and strained social interactions. As Monika said, they were *'people from the outside, they just don't talk to them, they talk about them but not to them'* indicating that people avoided mentally unwell people and talked negatively about them behind their backs, which gives a clear picture of the extent of the stigma . In support of this, Katya shared:

I don't think they would seek help because of our upbringing, if you seek help for emotional problems means that you are not OK, almost if you go there you are not all right. You are crazy, mad and dangerous (laughs) and people would avoid you, and your family would be ashamed.

It was noticeable that five of the participants often laughed when talking about difficult feelings or describing mental health problems. This may have been due to a reluctance to express their real emotions, due to fear of being seen as vulnerable or being judged negatively (Selkirk et al., 2012). Only Emilia expressed her sadness on this issue, and openly shared that she had several members of her family diagnosed with schizophrenia, depression and other mental health conditions. She had seen the effects and felt that it was important for people to learn more about mental health rather than allowing ignorance to maintain

negative views. Similarly, Marek also spoke strongly that the lack of knowledge about mental illness created these negative beliefs and that *'education was the biggest way to teach people'* about the *'mental health issues'*. Barbara, like Marek and Emilia, acknowledged that ignorance contributed to stigmatisation of people suffering from emotional pain. As a result, many individuals were not aware of signs of illness and the need for treatment, but suffered alone, since they did not understand their condition. Thus, the lack of knowledge about mental health created a false belief that being mentally unwell was the individual's fault.

I think it's the Polish culture to be honest with you. It's lack of knowledge, I would say, where people don't know much about the emotional difficulties and mental illness so they just don't understand that is kind of illness and it needs to be treated. And obviously people who committed suicide, I don't think that anyone understood them and anyone is aware of they actually were ill or something they thought they it's something wrong with them, it was their fault and things like that. It's their fault for being ill. (Barbara)

It was Katya's opinion that people would try to ignore their mental health problems. She went on to say that even their families *'would not speak to anybody about it, they'll try to ignore as long as possible almost as this does not exist'*, attributing this avoidant behaviour to stigma and shame. This indicates that people with mental health issues can be rendered invisible by stigma internalised by the family. Barbara spoke with great sadness about a young mother who ended her

life because her husband did not know how to support her, while her mother discouraged her to access professional help:

She wasn't looking after herself, she wasn't looking after the children, she was aware of that, she was crying, asking her mum for help. Asking if she just could come and teach her how to love her children and stuff like that, so she phoned me a couple of times, because my brother told her I've got children so I could give her advice, how to look after them and stuff. So obviously she didn't know me very well, so because of the stigma she didn't tell me that she feels depressed.

This quote clearly illustrates how mental health stigma among CEE immigrants could have severe consequences, such as extreme depression, social isolation and even loss of human life. It suggests that many people's problems were made worse by the stigma they experienced, not only within society but also in their families. In order to avoid labelling, individuals chose not to seek help for mental health problems, but suffered silently or shared their problems only with their families, whom were unlikely to have had the skills or training to support adequately them.

Overarching theme 3: Help-seeking experience

This cluster of themes describes participants' patterns of coping with distress. Psychological distress was seen as part of normal life and was managed

alone or with the help of family and friends. Significant factors such as culture, gender and previous experience all had an impact on the ways of seeking or not seeking help.

Theme 3.1: '*I have been trying to deal on my own*' - Self-help experience

The participants' cultural beliefs and views presented in the previous sections suggest that they might be less likely to disclose emotional distress as this was seen as being weak. Therefore, it is not surprising that both male and female participants in this study expressed self-help as the most preferable strategy when faced with emotional difficulties. It was noticeable that the self-help strategies employed by participants revealed that there were gender differences in handling distress.

Sonja, like many others, spoke strongly about managing emotional difficulties herself initially, rather than seeking support from others. She appeared very resourceful and shared that she applied meditation and complementary health practices such as *'aromatherapy* ', and had *'started to talk to myself, to think in a positive way'* in order to cope with emotional distress. Similarly, Anda chose *'to focus on positive things in life'*, seeing emotional pain as a normal part of life. Although positive thinking appears to be a helpful coping strategy for some participants, it could also be seen as conforming to the cultural pressure of needing to be strong. This was hinted at by Tanja's comments when she spoke about people who hide their emotions and *'pretend to be happy'*; this she thought

was counterproductive and *'they should not fake it'*. A similar point was made by Agata, who highlighted that someone could deny their mental health problems *'getting worse and down down down"* even to the extent of considering suicide.

In order to handle distress, female participants engaged in recreational activities, whilst male participants were less likely to utilise these coping strategies. For example, female participants talked about walking, going to a gym, dancing, joining a choir, and being creative. It was apparent that participants used these activities to distract themselves from negative thoughts, increase their self-esteem and relieve emotional distress. Indre reflected on biomedical explanations of why someone may feel depressed, but preferred non-pharmacologic approaches of alleviating distress. She felt that by playing *'badminton or aerobic'* or engaging in other physical activities the *'serotonin levels in the brain'* were boosted and she clearly felt better. Ioana said that she would first try herbal remedies instead of medication, and would combine these with physical activities. These comments suggest that many of the female participants were resourceful and able to draw upon many useful strategies and could combine scientific and alternative ways of dealing with emotional distress.

Some days the gym will do but some actually not, it is not good enough (p), I would come back home, have a shower, listen to music really loud and start do other things and do (p) cleaning that's really a good one and get stress out. I like cleaning, ironing, just <u>do</u> something else to exhaust yourself and then the problems gone.

Female participants also said, if it was 'bad enough', they would eventually talk about their emotional difficulties with close friends and families. In contract, the male participants said they used other strategies such as smoking cigarettes, drinking alcohol and withdrawing into themselves. For example, Miro stated firmly and proudly that '*I will struggle myself, I will be alone'*. Marek said that males could try to *'self-medicate and usually it is with alcohol, and sometimes it's with drugs'*, which he attributed to the pressure to get better without any support. It would therefore appear that there were gender differences around coping strategies, which also influenced the decision to seek help. This was alluded to directly by some:

Especially females they actually talk to each other but like males, they don't want actually to talk about it. They wouldn't disclose any of these problems to GPs to their friends to anybody. They just prefer to keep it inside. (Marek)

…especially for men, maybe women are different, but we don't really culturally we don't talk between ourselves how to deal with your emotional problems. You don't seek empathy, you don't seek understanding. (Sandu)

Sandu recognised that this was a learnt behaviour and reflected on the cultural belief that a male *'should be rational and not emotional, and don't have to do anything about your problems'*. He went on to say that he recognised that the

difficulty in identifying and expressing his own emotions could lead him to feeling down and to suppressing and discounting negative emotions.

The previous quotes illustrate that female participants were more likely to be in touch with their own emotional state whilst male participants seem less aware. However, this gender difference was not thought to be universal, and Barbara indicated that she knew a woman who had been reluctant to share her feelings: *'she became depressed and obviously nobody from her family and from the environment that she used to live, was aware of that she had a depression'. (*Barbara). Despite the usefulness of coping strategies, some participants seemed to recognise that there were limits to self-help. For example, Agata felt that *'I would not go if I was only depressed, but would eventually go if there was something very serious'.* Katya also said that '*You search for help when there is a serious issue which you can't deal with on your own'.* This was also acknowledged by four participants who said that the way immigrants were coping with emotional difficulties was not always helpful. They indicated that negative emotions can build up over time and then overflow uncontrollably, causing increased distress and feelings of helplessness:

But you don't think at the time because you try to cope with the stress and there are not too many things you could do, frustration or anger or helplessness feel so overwhelming and you just burst out and don't care but of course you do later on you think and realise what your reaction was and what caused it and how simple things

sometime built into something huge because you are stressed most of the time, and you don't know what to do and you just become emotional. (Katya)

So, although some participants put in substantial efforts to regulate their emotions, the strategy to contain these within oneself, and to remain 'strong' was not considered useful in the long term. However, there was only the occasional realisation that by seeking help and support they might discover different ways of coping that would be better for their wellbeing.

Theme 3.2: '*You seek help from your partner or friends*' - Support from family and friends

Friends and family were the first point of call for all of the participants who had found they could not resolve their difficulties alone. This informal support network provided the participants with a sense of emotional connection, shared values and inter-dependence, which was viewed positively by most. Seeking out someone for support who had the common experience of being foreign was also viewed as helpful.

Friends and family were considered the most important support network when dealing with practical, financial and emotional problems: '*First you seek help from your partner, or friends even from friends back in Bulgaria' (Katya).* Most participants felt that the majority of problems could be contained and resolved easier within this network. For Miro, his extended family was very important, and

he firmly stated that he would turn for help to his parents first, even though they lived back in his country of origin:

…my parents, if I am nervous or have problems I can rely on them. You can talk and share with them. While here you are alone (p). There is nobody here you can share with.

Similarly, Krisi cited her extended family as the most important social support unit and spoke about cultural values that kept these ties close:

Well, the thing is that I used to live in a very strong family, I include my parents although I have been married for so many years, I also include my cousins, nephews, nieces. These people make my family. We live with the problems of every single one of the family although we are living here. They know ours and we know theirs. This is our family. For me the distance does not matter.

Most participants said that this social network provided them with a sense of safety, helping them to keep shameful experiences private, thus avoiding gossip in their communities. As discussed before, family life and close connections with friends were part of a communal way of living in ex-communist countries, where people were encouraged to be altruistic and to help others in society (Robila, 2004). Anda spoke of this interconnectedness, which was even more important than finding a solution: *'sometimes they don't know either, but we support each other'.* Furthermore, it was felt that friends and family '*exchanged energy*' *(Krisi),* relieved

stress and helped to deal with emotional problems. Barbara believed that families and friends would detect mental health issues earlier, which in turn could help individuals to accept and deal with them better. She also talked about how family members felt compelled to help.

Friends and families, they are all aware […] I mean they can talk about it, because they say if you accept it and do something about it you are halfway there.

These quotes described the positive effect of having close relationships with family members, and showed how these could buffer participants from emotional distress. However, on occasion families and friends also encouraged participants to reach out beyond this buffer and contact local services and social institutions.

Individuals immigrating by themselves experienced more emotional strain, as was the case with four participants. Sandu shared that it *'was difficult to come alone, and you don't have really support from your closest people',* and that immigration-related separation had negative effects on family dynamics. He tried to overcome his feelings of homesickness and loneliness by speaking frequently to his family; however, this only relieved his distress temporarily. Therefore, it can be assumed that separation from family might be a serious factor affecting adversely on participants' emotional wellbeing.

Despite the majority viewing family and friends as their primary support network, a few participants did not want to seek support from family members. Their reasons included stigma, causing unnecessary worry for the family and fear of misunderstanding.

You don't want to burden them, you don't want them to think something of you, to let them know that there is something wrong with you. (Agata)

It's no good to worry her, she cannot help me anyway, she does not live here, she does not understand my problems […] I feel worst after speaking to her. So I say I am all right. (Anda)

It appeared that these participants kept emotional struggles quiet for as long as possible so as not to burden the family system. It was thought that voicing one's difficulties could cause negative reactions from family members who might view their emotional distress as a weakness. As already discussed, the high degree of stigma around mental health issues can result in more shame-based interactions within the family, leading to further isolation and an unwillingness to seek help.

There was also a noticeable difference with the younger participants who, in times of emotional difficulties, preferred to seek support from friends and other significant people in their lives rather than from family. Piotr felt that he could ask for support from his family only if nobody else was available. The following quote

from him highlighted how participants' patterns for seeking help varied across generations:

And then at the end will be your parents cos they don't see how you look how you feel at Uni. So they wouldn't be able to help you as much, so friends and tutors can help you the most. Even your brother cannot help you so much because they don't know. Unless they are there as well although they may have different experience than yours, so they will not be the best one who can help.

Although most participants talked about seeking help from friends from their own communities, a few also valued diversity and having close friends from other cultures. With friends from other cultures who were also immigrants, they said they felt close to them through their common experience of being a foreigner. Piotr said that his friend was the *'biggest booster as to me being driven higher and higher'*, and Anda was introduced to British people and this led her to say that she *'didn't feel absolutely alone here'*. It appears that these new relationships helped to build a sense of belonging and self-worth, shielding individuals from feeling socially isolated.

Theme 3.3: *'Ticking the boxes was not going to solve my problems'* - Experiences of mental health services

This theme describes participants' mixed experiences with mental health services in the UK. Reluctance to use such services was attributed to dissatisfaction, mistrust and cultural attitudes.

Only three participants reported seeking formal support for emotional problems. However, the majority of participants had knowledge in this area as they had friends or relatives suffering from mental health conditions (and a few had committed suicide). Sandu had received some private therapy and talked about his positive experience in resolving family issues and working on his self-development. He deemed the therapy *'very helpful'*, which he attributed to his therapist being able to show empathy because of cultural similarities in their background: *'She had an access to another culture and that particular culture was similar to my own culture, so she could help me better'*. It appears that the similarity in culture helped to establish rapport, provided a sense of trust and understanding, and facilitated the positive outcome of therapy. However, most participants said that they could not afford the cost of private therapy. Tanya pointed out that *'this help is very expensive, they know cos in England all this is so expensive'*. She suggested that if it was made clear that some services were *'for free'* people might use them, indicating that a lack of accessible information about mental health services may be a barrier to seeking help for CEE immigrants to the UK.

Sonja was referred to NHS mental health services, but felt that the service provided was inadequate and did not address her needs. The quality of communication and the perceived lack of care and commitment of the therapist had resulted in feelings of frustration, anger, and dissatisfaction with the service:

She worked like using a specific programme 'one size fits all' and did not invest anything more from herself. I went to the psychologist but nothing changed a lot because I am still jobless. Just to sit and talk about what happened in our lives is not making any difference quite the opposite I feel even more depressed.

This quote clearly shows that Sonja needed her problems to be seen more contextually and for the therapist to go a step further than just listening in order to provide effective long-term interventions. Her comments indicate that the traditional individual-based approaches did not help her to recover but caused further despair. The excerpts below highlight again participants' perceptions that services were not adequate:

She went and asked and was referred and all she was asked to do was to fill in some questionnaires, how was that supposed to help her I don't know. She had real problems and they asked her to think more positively. If you can think positively why would you go to seek help?! I think you go to a professional as a final step when you can't resolve it yourself, you need some real help. (Katya)

And there are this IAPT like counselling services, however, you have to wait for ages there. Six months if not longer to actually see somebody and get this help. I think it is a problem because sometime people try to go and they are very down and even don't want to live, so to wait for more than 6 months what's the point?! (Marek)

Although these experiences might be similar to those of British people, there might be some differences. Indre deemed therapy a *'waste of time'* saying that therapists *'don't know me, they'll not be interested'*, and felt that *'your problems are like private ones […] so why should I say for a random person and I am not sure maybe like that person would reference me somewhere.'* Similarly, Miro felt that *'I can't trust them, as I said there are consequences, I would not risk losing my job'*. Tanja spoke of her friend who found therapy *'very mechanical'*, was given *'papers to fill in and some to read at home but [therapist] even didn't ask if she understand it, so she didn't go again at the end'*. These quotes highlight issues of mistrust and dissatisfaction of services provided.

Participants' comparison of services in the country of origin and the UK also led to disappointment '*I thought it must be much better than in Poland, the health system etc., but unfortunately it's not'* (Monika). Monika reported that the assessment was not thorough and long waiting times were the cause of her disappointment. Marek was very concerned about the lack of investment in mental health needs and prevention that led people to be afraid to seek therapy or go in to hospital and stay on an inpatient ward when at crisis point. He pointed to

how an early discharge could inhibit recovery because *'there is a pressure on beds, and a Polish person was admitted being quite psychotic, and a couple of days later they send him to his mother'*.

Most participants recognised that people needed help at one time or another, but they would not seek help from professionals. Therapy was seen as a *'western'* notion (Agata) that can be overused by people from the majority population. Indre felt that she did not have any mental health problems but her emotional struggles derived from being an immigrant and hence she would not seek formal support for these:

I would not go unless I have very serious problem, I know that maybe it's not good, but I think that they have a lot of quite I mean people who has much more bigger problems than like we are having cultural differences problems (laughs) I think. We should not put more pressure just with our problems.

This suggests that participants were not sure of their entitlement to use mental health services. The realisation that if not addressed their problems might exacerbate made little difference to their attitudes. The latter view reflects a problem that is not unique to immigrants but has been shown to be a common one amongst non-immigrants (Baker, 2007), which can act as a barrier for seeking help.

However, many participants stated that they would seek help eventually if a family member urged them, but only when problems prevented them to function properly or when other attempts to resolve their problems failed. In these circumstances, most participants reported that they would seek help first from their GPs. Two participants reported a positive experience of doing this: Emilia felt 'safe' approaching her GP following bereavement, and Ioana reflected on her positive experience, highlighting the importance of building a trusting relationship:

My GP is a really nice lady so I do, when I am there, I just feel that I can talk to her, we just start talking about everything and anything so it does help also if you are having a GP or somebody to trust, to be able to talk to about problems, cos that is one big step isn't it, it's hard otherwise to go.

In contrast, Miro said that he would not go to his GP because *'they don't have time and I don't feel like telling them*' as he felt that GPs were disinterested, less competent than his doctor in Bulgaria and GPs in the UK usually suggested paracetamol. Similarly, Sonya disclosed that she *'was not happy with her'* GP because of her lack of empathy. This apparent lack of confidence and mistrust might explain why most participants were reluctant to seek help, except as a final option for support. This highlights the possible need for the NHS and GP services to recognise this as problematic and to provide better information on treatment options targeted at immigrants.

In summary, greater satisfaction and possible utilisation of services may depend on better mental health promotion aimed at overcoming distrust, and also therapeutic interventions that meet immigrants' needs. GP practices were participants' primary formal service for accessing help in times of distress. There appears to be the need for an alternative to IAPT for immigrants who cannot afford private therapy, and whose recovery may not be achieved through the type of therapy offered by current IAPT services. The perceived inadequacy of services, lack of trust, and a lack of professionals understanding their culture were all highlighted as major factors for not accessing help.

Overarching theme 4: Addressing immigrants' needs

This section of the qualitative findings focuses on participants' suggestions of how support for CEE immigrants might be improved. Three main themes that were identified here were around barriers to help-seeking, the influence of socioeconomic factors, and participants' own views of what kind of support they would utilise most.

Theme 4.1: 'It is difficult to find the right words and to express what's inside me' - Barriers to help-seeking

This theme highlights some structural and personal determinants of help-seeking reported by participants in the study. It is apparent that structural factors,

which included the health system itself, i.e. accessibility of services and the type of support provided, interacted with individual factors, such as personal beliefs, cultural stigma, and fear of possible consequences.

Difficulties with language and literacy were highlighted by all participants as the main barrier to accessing services, undermining their understanding of how the NHS functions. Barbara, a very active member of her community who often provided support to others, said that *'it is hard to explain what's not all right with you if you can't speak the language'*. Katya returned to this theme several times saying that going to *'a hospital'* required high English proficiency. Krisi drew attention to another aspect, expressing her fear of professionals not being able to understand her *'in the right way'*. Although many participants were fluent in English, they still reported difficulty of explaining emotional issues:

I think language is a big barrier, someone who could translate things to people who don't know English could be good (p), I mean if they have emotional issues and go to the GP it is kind of difficult to explain the way they feel, don't have the vocabulary. (Anda)

Anda's account demonstrated that language difficulties were closely linked to the lack of interpreting services; this was an important institutional barrier that was also highlighted by Marek, Barbara, Krisi, Katya and Monika. Miro reflected resentfully that '*a state organisation should at least out of respect to provide at least one interpreter*'. Marek said he assumed that the lack of interpreter services was due to

financial issues *'perhaps because it is expensive, about 40 pounds*'. These comments suggest that equality of access issues are a problem in mental health services. Although interpreter's services were perceived to enhance expression and understanding and to facilitate a positive outcome, there were issues of trust and confidentiality expressed about having to involve a third person due to fear of *'gossiping'* and *'stigma'*. Agata was evidently concerned about using interpreter's services: *'there were three people sitting in an office and are talking about your problems'.* Trust issues were also highlighted by Katya:

A very small part [would access services] because of fear that someone may learn about their issues (pause) people would not believe that it is confidential. People would not go to these places out of fear to be discovered, someone to know about them, especially in this small community here.

Issues of distrust, fear and lack of confidence in mental health services were discussed by most participants. Miro laughed nervously when he was asked whether he would seek help from professional services. He believed that disclosing emotional problems might have serious consequences: *'the worst is to sack you and you have to go back home or back to your country even'.* Agata expressed apprehensively her reluctance to use such services*: 'I wouldn't, why I should?! I don't feel like I should?'* Anda viewed immigrants' problems as too specific, and doubted that therapy *'could help, she [the therapist] hasn't lived in Latvia*'.

These accounts were not the only ones that pointed to barriers such as mistrust and a perceived lack of cultural sensitivity. These perceptions extended beyond the NHS to include non-profit mental health organisations. Sandu was suspicious, expecting that there would be a lack of consistency and quality of services provided:

With the charity I would've expected they change their staff very often because there are a lot of financial issues with any charity right now, even if one of the therapists is good, the next one could be terrible and you never know. And the worst that could happen is that you go there when you are the most vulnerable and they make mess of it.

In contrast, Krisi reported that she would seek help from charitable organisations if they provided support in her '*mother tongue*' but she has *'not come across any of these'*. Sonya felt that *'it is good that these organisations exist'* although she did not know of any. In regard to charities, Katya said that *'Information is not easily available at least for us. Local people may know but we don't. None of my friends know I am sure about it'*. Piotr thought that if such organisations were made *'more visible'*, it could encourage immigrants to use them. Marek shared this view:

I think, like 99% would not know any of these services. They may hear about them maybe NHS services but not any of them. They might see a poster or something but I don't think they will pay any attention.

It is clear that most of the participants were not aware of local non-profitable support organisations. However, many disclosed that even if they did know, they would not approach them. Anda shared: *'it's not likely that I am going to contact these agencies'* and Ioana said: *'I don't know the person, need to know first, not knowing enough about is scary*'. Emilia stated that these were *'for people who did not have anybody to talk to'*. Therefore, it seems that lack of awareness of services was linked to lack of understanding of what non-profit organisations could offer or who could access them. This lack of awareness is likely to contribute to people waiting for extended periods before they reach out for help. Although it can be argued that a lot of information has been produced to help people access non-profitable support organisations, it seems that, for at least the participants in this study, it has not being displayed in the appropriate locations and in an accessible way.

Another important barrier to help-seeking was a lack of awareness of mental health issues: '*Maybe I would not understand if I had a mental health problem'. (Tanja).* Ioana also felt that *'it is a massive step'* to recognise that one had a mental problem. For example, most participants responded that they could recognise signs of depression but were not familiar with conditions such as anxiety. Marek's opinion was that '*people don't know anything about it'* and don't talk about it. It appears that acknowledging mental health problems in oneself or close others is obstructed by a range of additional barriers such as lack of discussion and consequent lack of prioritisation of mental health problems in the immigrant communities.

Theme 4.2: 'They just don't live, they struggle for money each day' - Socioeconomic context

This theme highlights socioeconomic factors that influenced participants' experience of living in the UK, and affected their help-seeking behaviour.

Many participants found it difficult to deal with shifting economic and political realities. Factors such as complex government policies, employment and working conditions affected their wellbeing. Laura and Krisi explained that being on low income led to a lack of financial security and a perceived bleak future. Monika attributed impaired wellbeing to individual's economic disadvantage:

I heard many stories people feel depression cos just work all the time, they send all these money cos they have to pay for flats or support families abroad.

This quote highlights the obligation to send money abroad to family members was found to be an additional factor that put more strain on immigrants. Monika also described that people sometimes sent more than they could afford just to preserve their pride and a sense of having a higher social status. Social economic status appeared to be linked to participants' occupation and educational level. Monika highlighted that low incomes led to longer working hours, which resulted in less time for personal development. A similar opinion was also expressed by Barbara, who felt that some immigrant's financial situation could not improve without *'the support at least from your family'*:

She went to the college but she didn't last long, I think probably six months or something obviously it cost money and she said that she doesn't have the time because she works and she was on a farm so in a busy time she even works like twelve hours a day so.

Barbara's comments indicated that some immigrants might have little chance to change their socioeconomic status in these circumstances. It has been noted that lower socioeconomic status combined with additional factors such as discrimination can result in feelings of inferiority and a negative social identity (Karlsen & Nazroo, 2002). It was suggested by Laura that discriminative attitudes can lead to internalising problems such as anxiety and depression, and can cause people to feel that there was something *'wrong' (Laura)* with them.

However, participants noted that the detrimental effects of low socioeconomic status could be moderated through support from family members and employment agencies, and study opportunities. Finding a well-paid and respected job and/or the ability to continue education were perceived as important factors for constructing a positive social identity by participants. Six participants reported that their good socioeconomic status allowed them to have fulfilling lives. Emilia shared how having a well-paid job improved her family's living standard and resulted in a positive experience:

I think, but for example my parents now they got good jobs, they are paid so they do not need to worry like how are they going to pay for the bills, for the mortgage and stuff, they I kind of think they are happy now.

Working environment was an important context in which the majority of economic and social relations took place. Social environment and a good salary to afford certain commodities all affected immigrants' emotional wellbeing and influenced their help-seeking. People who earned more reported that they would access eventually private therapists for self-development*: 'I am not rich but I can afford to go to a good therapist' (Sandu)*. In contrast, participants suggested that immigrants who were in low wage jobs would not have time to find support services and would not spend money for therapy:

So if you are coming to this country, live in a small flat, go to work and don't have a computer or Internet you can't find it. (Piotr)

If you don't have enough money for food and basic things how to give money for something that you can do yourself and why? They are not going to spend them to feel better or to pay for someone just to listen to them (Indre)

These quotes highlight additional barriers such as lack of time, money, the perceived high cost of therapy and unawareness of low cost therapy options. Some participants talked about Western values prevailing in psychological services, as most of these located the causes of pathologies on individuals rather

than on external factors, such as employment opportunities or structural discrimination. Socioeconomic problems that affected both majority and minority groups were believed to be ignored in therapy. Sandu expressed his concern that therapists often overlooked these because of pressure to abide to the *'medical model'* focusing on individual explanations of distress:

These [economic] problems are real, and I am not really sure that these emotions should be silenced, […] because people should stand up and fight for their rights and fight against the system, and the system creates this sort of fears. Otherwise we become another brick in the wall. (Sandu)

In summary, it appears that low income, poor employment conditions and a lack of socioeconomic support were significant factors influencing participants' wellbeing, which also influenced their help-seeking behaviour. Opportunities for further education and better employment increased socioeconomic status and acted as protective factors. This finding is supported by research that shows psychological interventions that take into account individual's socioeconomic circumstances help people to address their needs and to instil a sense of control and resilience (Chung & Bemak, 2012).

Theme 4.3: 'People try and seek contact through these communities' – Improving support

This theme presents some of participants' views on what they considered useful support. Strong emphases were placed on working within communities, mental health promotion and education, and cultural sensitivity.

Many participants reported that working with local communities would be most valuable in improving an individual's wellbeing. Building on immigrants' strengths and resilience was seen as a way forward. As well as investing in stronger communities so that people could manage hardships themselves rather than drawing on formal sources of support. Anda explained:

… if there is a community, for example, Polish people, they have a lot of community based things, even schools for their children on Sundays, a big community of Lithuanians and for young people it's nice to get together, to share ideas.

Marek also felt that working with the community would enable people to build their knowledge and eventually seek help, rather than rely on, for example, informational leaflets:

So there is a lot of work to do like to go to small groups or clubs, and to place people where actually people meet, when they feel comfortable and then to explain them about it and talk to them because I don't think that leaflets or any other things would change too much. They may touch very minor percentage of Eastern European people, but actually

explaining them like meeting them and explaining in the face or giving them opportunity to ask some questions would make it more reasonable.

The quotes by Anda and Marek clearly show that the promotion of good mental health can be improved when community members themselves inform service delivery and development. Furthermore, employing community psychologists to engage with community groups and provide support in the community can be also helpful.

Many participants reported that cultural barriers, such as mental health stigma, were deeply ingrained and had to be addressed first. Marek felt *'that education will be the biggest thing'* in tackling fear of mental health services. He pointed out that the methods employed in the UK were very different from the more intrusive hospitalisation practices in his country of origin: '*in Poland we still use restricting jackets and methods that maybe were used here like 50 years ago'*. Raising awareness and normalising mental health illness, educating individuals about services, and how to access these therefore are of key importance. Establishing a *'kind of support group' (Ioana)* and *'a short course telling people what actual mental illness is' (Barbara)* were seen as potentially helpful. This highlights the need for a larger effort to promote positive views of mental health services and to demystify the interventions that are provided.

Participants suggested that interpreting and counselling services *'in their mother-tongue' (Marek),* which *'are run from somebody, who understands Eastern Europeans, someone from this background' (Anda)* could encourage immigrants to seek support. Similarly, Katya reported that interpreter services were essential in order to facilitate this process:

If there was an interpreter when I needed could be very helpful, someone who could explain to you, to say how the healthcare system here works.

Issues of *'trust, confidentiality' (Ioana)* were highlighted by many participants as important factors to access services because, *'you can't trust easily everyone' (Anda).* The following excerpts demonstrated this point:

If you are going to speak to someone who can understand you, speaks your language and maybe because you are Polish or Bulgarian, lived in the same countries because for the person is hard to say their problem, this person can kind of understand you. Because of the same kind of background, the same kind of culture, and you know why they can't deal with that. (Agata)

…when you speak to a person with whom you grew up in the same environment, the same kind of worldview, I think they will understand you better rather than someone who lives in a totally different way here in England. (Katya)

These quotes indicate the need of culturally sensitive support provided either by professionals from their cultural background or at least from someone who understands their views of psychological wellbeing, different forms of distress presentations, idioms of distress and explanatory health beliefs and world views. Increased awareness of norms, traditions, historical barriers and the need of a relational approach in therapy were highlighted. Sandu felt that *'Therapist is like a part of your family it's important to have a relationship with the therapist'*. Agata spoke that the person to whom one turns up for support should be '*like you've got friends round you'* and *'you can tell them everything, and you can go to that together'.*

As described earlier, a more holistic way of seeing individuals' problems was cited as being beneficial. Sonya suggested a holistic centre for wellbeing that could provide mental health promotion and prevention, in which people could receive physical health services, mental health services, attend activity groups and voluntary sector services:

Something has to be done to make the person to do something for pleasure or to deliver relief in the family. This team should have connection with employers or new job positions to be designed something like to do art, something creative, to go to a centre where you will have the opportunity to see a psychologist but also to learn something new, but also something that will be financially rewarding. Only in this way you can get out of this situation.

Support with practical issues such as filling in documents, joining English language courses, advice about human rights and state benefits, and support in finding work and housing was also deemed useful. Miro felt that obtaining a legal status in the UK was most important, because it gave access to better jobs and could increase socioeconomic status. He added that he could deal with his emotions if practical help was available:

To help with documents not for other things. Some help to explain how to send forms, what kind of forms are needed to be downloaded from the website, for absolutely everything. For practical help, because emotional problems we can resolve on our own or with friends and relatives.

All of these comments suggest that people may seek informal help or go to community 'centres' rather than approach mental health services which have the stigmatised label of a 'mental health institution' around them.

Mental health promotion and education strategies were seen by participants as a way to modify cultural beliefs and attitudes. Participants' comments point to the apparent need for community promotion, prevention and education around mental health in order to deal with decades of negative stereotypes. De-mystifying services has to be a key priority if this minority group can feel confident to engage in them. Mental health services may need to change their approaches, offering a wider range of interventions that reflect individuals' cultures. Participants'

multiple needs may also require support from various agencies that will need to work in partnership.

Overall, risk and protective factors appeared to act on several levels, including individual, family, community, and structural levels. It can be concluded that immigrants' wellbeing might be improved by addressing existing structural and personal barriers, considering culturally sensitive interventions and immigrants' socioeconomic circumstances in therapy, and providing opportunities for personal development that can enhance their resilience. This could be done through an active engagement with immigrant communities.

Summary of the findings

The aim of this study was to explore the experiences, beliefs and views of CEE immigrants about mental health, highlighting some of their needs for support. Specifically, five research questions guided the research process, which could be grouped into three main ones: How has the experience of immigration impacted on Central and Eastern European immigrants' wellbeing? Would immigrants seek help for psychological distress providing their cultural views, beliefs and understandings in relation to mental health? What are the factors that hinder or facilitate help-seeking highlighting the specific needs of CEE immigrants?

Four clusters of themes were identified through the analyses of the data. The first cluster highlighted that CEE immigrants moved to live in the UK for economic betterment, but their experiences were not entirely positive. The immigration process was described as hard and challenging. The primary factors that seem to influence negatively immigrants' wellbeing were experiences of prejudice and discrimination, housing and job issues, distress and difficulties caused by language issues and socio-economic circumstances. The second cluster of themes indicated that most participants held a holistic view of individual's wellbeing. It also showed that participants would contain emotional distress within their families, highlighting the perception of a high level of mental health stigma. The third cluster of themes noted a reluctance to seek out mental health services. Gender, culture and previous experience were significant factors influencing the decision whether to seek help for emotional difficulties. This cluster also highlighted personal, institutional and structural barriers to help seeking. Participants in the study proposed that working within and alongside communities to co-produce services (such as support groups that could provide advice about human rights, available services, finding employment, and housing) would be a good way forward. Each of the themes provided insights into how CEE immigrants dealt with emotional difficulties and viewed mental health services in the UK. These findings are discussed in depth in the following chapter.

Chapter 4 Discussion

This study set out to explore how the immigration process had impacted on CEE immigrants' wellbeing and any subsequent decisions to seek help for emotional difficulties. The following sections consider the core findings of the research project in the context of the literature discussed in Chapter 1. Following this, reflections on the significance and implications of the findings are provided. Finally, limitations of the study are addressed and future directions proposed. The discussion chapter ends with the overall conclusions.

4.1 Consideration of the results

4.1.1 Immigration experience

The first aim of the study was to explore how the immigration experience affected participants' wellbeing. The analyses identified both risk and protective factors influencing participants' wellbeing, which in the main corresponded with findings in the existing literature. The following discussion explores some of these factors in order to aid understanding in this area.

Most participants stated they had immigrated to the UK for 'a better life'. Socioeconomic changes that led to high levels of unemployment and ongoing financial problems in their home countries had been recognised as 'push' factors (Bhugra & Gupta, 2011), and immigrating to the UK appeared to provide a solution to escape economic struggle. This pre-migration stage seemed to be

marked by experiences of distress. The results suggested that these individuals also experienced hardships after coming to the UK. For example, most participants initially only managed to attain low wage occupations, despite most having high levels of education, which supports Rienzo's (2013) claim that in her study those individuals in the CEE group were well educated, in contrast to other immigrant groups in the UK. The resulting disappointment with the job market caused distress amongst participants, which was also highlighted by Bhugra (2004a), and found in Kozlovska et al.'s (2008) study of Polish immigrants. The results from the current study also add to Bhugra and Gupta's (2011) argument that immigration process might be a considerable risk factor for reduced wellbeing.

Some participants felt that their limited career opportunities affected their finances and led to problems finding adequate housing. In particular, participants reported that issues with shared accommodation put a strain on their resources, affected their social relationships and often caused family discords. These post-migrating factors seemed to increase feelings of anxiety, low mood and distress as also argued by Bhugra and Gupta (2011) and Villatoro et al. (2014). These results add to Loue's (2009) argument that overcrowded and inadequate housing can increase the risk of mental illness.

Participants felt there were additional stressors specific to their experiences as immigrants, such as loss of familial support, social networks and culture. These results are in line with a study done by Kouroukian (2009) and Hall (2001), who

identified similar factors. The findings of the current study also correspond to broader immigrant literature indicating that lack of family support can increase social isolation and in turn lead to a higher risk of mental illness (Bhugra & Gupta, 2011; Font et al., 2012; Loue & Sajatovic, 2009). Social alienation affected some participants and resulted in feelings of loneliness and sadness. Through limited familial and social interactions, participants experienced a loss of contact with their culture, customs and traditions. These findings agree with Bhugra and Gupta's descriptions of cultural bereavement (2011) and add to Monteiro and Serra's (2011) claim that separation from family had a negative impact on Eastern European immigrants' mental health in Portugal.

The results found in this study suggest that experiences of prejudice and discrimination, on institutional, structural and personal levels, had a negative impact on the participants' wellbeing. They also reported similar effects on other immigrants around them. These results add to Yakushko and Consoli's (2014) argument that anti-immigrant sentiment had a negative impact on the mental health of immigrants in the USA. Adding to this, discrimination in the UK came as a surprise to some participants of this study, as they identified themselves as ethnically similar to the host population. Similar findings were reported by Moore (2013) and Dawney (2008). This unexpected discrimination caused feelings of anxiety and depression, and loss of self-worth amongst these individuals in the study. The present research backs Finch et al. (2000) who found a direct link between discrimination and depression.

The results indicated that adjustment to the host country might be affected negatively by prejudice. The research also suggested that experiences of isolation, humiliation and marginalisation could have a relational nature, providing evidence for Relational Cultural Theory (Comstock et al., 2008), which argues that contextual and sociocultural challenges inhibit individuals' abilities to develop growth-fostering relationships in life. Results from the current study point out the complexity of the experience of discrimination and highlight factors such as being older, lower socioeconomic status and living in a rural area that might increase feelings of isolation and consequent psychological distress. This supports Stepleman et al. (2009) and Karlsen and Nazroo (2002), who argued that these factors increased the risk of developing poor mental health among immigrants. Furthermore, the findings suggested that experiences of discrimination might lead to disempowerment and highlight the existence of economic inequalities at structural and organisational levels that might maintain unfair practices. Similarly, Birell and Freyd (2006) argued that the oppressive relationships institutionalised within society have a profound impact on the interpersonal relationships between its members. A common coping strategy among the participants was avoidance, which could lessen social contact and hinder integration.

Multiple negative experiences appear to have had a cumulative effect, which was also noted by Buchwald et al. (1993), and Lakinska and Bornarova (2004). The accumulation of distress seemed to lead to participants' feelings of anxiety and

depression. These findings correspond well to Abebe et al's (2014) conclusion that post-migration factors might influence significantly the wellbeing of immigrants.

The immigration process had presented challenges but also opportunities to participants in the study. Some participants took the opportunity to further their education in the UK, while others managed to transfer their educational credentials from their country of origin. In contrast, studies from outside the EU, such as Robila and Sandberg (2011), highlighted Eastern European immigrants' difficulties in transferring educational credentials in the USA. Similarly, previous studies in the UK highlighted that diploma recognition was problematic for some CEE immigrants searching better employment (Csedı 2007; Currie, 2007; Kofman 2000). According to Trevena (2013, p.6) 'the European Union has developed a system of mutual recognition of qualifications' but 'even the recognition of professional qualifications proves to be problematic in the UK', arguing that British employers preferred nationally recognised qualifications instead of Eastern European credentials. In the present study, educational opportunities seemed to lead to improved financial situations and increased self-confidence, contributing to a positive immigration experience.

Protective factors such as having a strong family and community support, educational attainment, employment and economic opportunities appeared to enhance wellbeing, which is also found by Stepleman et al. (2009). This, in part, explains why some participants indicated that they had adjusted well to the UK

and reported having good mental health. These fortunate participants had found adequate work and accommodation, had not felt discriminated against and were satisfied with their life in the UK. Prejudice and discrimination was experienced by many but when instances of prejudice and discriminative practices were adequately addressed, they had resulted in improved wellbeing. These findings are in line with Constantine and Sue (2006) who argued that addressing prejudice and discrimination had positive effects on the wellbeing of minorities.

Hence, findings in the study have so far suggested that a variety of factors had an impact on participants' wellbeing; these being socioeconomic, psychological and cultural. These same factors also appeared to influence the participants' adjustment and integration in the UK. However, their experience also depended largely on their personal expectations, goals and circumstances. These results are in line with the broader literature, and support Bhugra and Gupta's (2011) and Sue's (2004) argument that mental health professionals need to be aware that a number of factors might combine and be specific to immigrants, and to take these into account when providing support for people from ethnic minorities. Dovidio and Esses, (2001) argued that successfully managing the immigration process can bring about a positive sense of achievement and enhance wellbeing, and this was reported by participants in the current study.

In summary, it appears that negative experiences were linked to unemployment, financial difficulties and housing and caused psychological

distress. Loss of familiar social network and culture were identified as important post-migrating factors leading to low mood and anxiety. Experiences of prejudice and discrimination seemed to add to initial distress and hinder adjustment to the host country. Better adjustment depended on socioeconomic factors such as good social support, economic opportunities and better education.

4.1.2 Views and meanings of mental health

This theme explored some of the factors that may influence CEE immigrants' decisions whether to seek help by considering the sociocultural context. Their conceptualisation of mental health was influenced by participants' cultural and historical background. It was found that families play a significant role in responding to mental illness in CEE culture. Secrecy, about mental health, and a high level of mental health stigma were identified as major patterns within the data.

According to the participants in the study, the topic of mental health is taboo among CEE immigrants, and individuals with mental health conditions are likely to suffer in silence. These results add to Madden et al.'s (2014) claim that mental health was not discussed among Eastern Europeans. However, the current study identified a perceived differentiation between emotional difficulties and mental illness, where the former designation seemed to allow a degree of recognition and expression of emotional struggle. Thus, emotional difficulties were viewed as a normal part of life, whilst mental illness meant that a person was 'mad',

dangerous and should be avoided. Interestingly, Selkirk (2012) also found that the conceptualisation of mental illness because of genetic make-up did not necessarily lessen the perceived negative effect of being diagnosed. This is also in line with Read et al. (2006) who found that biomedical model of psychiatric disorders can lead to the belief that people with such diagnoses are dangerous and unpredictable, resulting in fear and social exclusion. The consequent of this is a possible increased risk of hiding mental illness, an argument also raised by Bhui et al. (2005) and supported by this study.

It appeared that this secrecy about mental health was linked to cultural norms and obligations, which influenced significantly participants' behaviour, thus highlighting a high level of conformity to cultural expectations. Cultural scripts of resourcefulness, resilience and determination to overcome distress on one's own were reported by most participants. An inability to deal with emotional difficulties oneself was viewed as a weakness or a personal fault. This belief may have led to a denial of problems and increased the unwillingness to seek support. These results appear similar to Keynejad's (2008) findings on South Asian and Jewish communities, which showed that certain cultural beliefs (e.g. acknowledging a mental health as a sign of personal failure) might be a significant barrier to accessing professional help.

Despite frequently assigning individual responsibility, most participants nonetheless valued family interdependence as a means of support. This backs

Viazzo's (2010) argument that after the fall of the communist regimes in Eastern Europe, families were more interdependent than those in more individualistic societies such as Scandinavia and North-West Europe. The current study suggests this 'familialistic' tendency extends to coping with mental health issues. Problems related to mental health were not shared openly but contained within participants' close circle of family and friends because of embarrassment. These results add to Beiser's et al.'s (2003) claim that feelings of shame and concerns about others' judgements prevented ethnic minorities from seeking help. They also fit well with Selkirk et al. (2012), who found that Polish immigrants depended mainly on close family and friends due to fear of gossip. Therefore, the family would appear to be both a mechanism for supporting immigrants through mental health difficulties, while also acting to hide mental health issues in this population, and thereby working to maintain the stigma attached to mental health conditions.

The secrecy around mental health problems may be explained by participants' cultural beliefs and experiences, which seem to be also influenced by historical practices in communist regimes. As discussed in the literature review, there was a greater stigmatisation of mental illness during the Soviet period, which impeded the reporting of symptoms (Bloomstedt et al., 2007). The biomedical model was the primary model of treatment by psychiatric services in the Soviet Block (Marks & Savelli, 2015; van Voren, 2013) with no other therapy options available. Fear and stigmatisation was therefore present in the accounts of the most of the participants. They also reported that mental illness in their

countries of origin was treated in specialised hospitals where individuals were locked up and heavily medicated. The findings suggested that immigrants brought these mental health stereotypes and cultural memories with them to the UK.

Mental health stigma is found to affect the majority population in the UK (Anderson et al., 2009; Brohan et al., 2013; Time to Change project, 2008; ScotCen Social Research, 2013; Sherwood et l., 2007; Vogel &Wade, 2009) and its causes and effects can be multifaceted - Holman (2014) argued that studying the relationship between social class, mental illness stigma, mental health literacy and the effect on help-seeking is complex. The present study argues stigma is also evident among CEE immigrants. Participants reported that lack of knowledge about mental health further worked to increase stigma. This can, in part, be explained by the underdeveloped mental health policies and services in the participants' countries of origin, where stigma and mental health promotion still remain to be addressed adequately (Germanavicius et al., 2005; Tomov, 2001). Furthermore, the results also suggested that some individuals might experience a double dose of stigma due to both minority status in the UK and mental illness; this was also recognised in a study by Gary (2005). Therefore, it might be expected that immigrants might be more vulnerable to psychological distress but due to the high levels of associated stigma be consequently less likely to seek support.

Overall, it appeared that mental health was not openly discussed by participants. Mental illness seemed to be stigmatised due to cultural beliefs and historical practices in their countries of origins. Stigma was identified as an important factor that may influence negatively an individual's help-seeking behaviour. Mental health problems were seen as a private or a family matter by participants, and may not be addressed until a crisis point.

4.1.3 Help-seeking experience

This overarching theme related to the second aim of the study: exploring participants behaviour when experiencing emotional difficulties. As already noted, the participants seemed to deal with distress alone or with the help of close friends and family. The research also identified a gender specific difference in the coping strategies employed by participants. GP practices appeared to be the last resort for support, yet the first formal service for accessing help.

Most participants felt that they were in good mental health and could manage their difficulties without any professional support. While they recognised that everyone could experience emotional distress at one time or another, such as depression or anxiety, they seemed to consider seeking support only when the problems had become significant. One explanation participants gave was that they might not recognise the symptoms of a mental illness. These results back Jorm's argument (2000), that individuals often could not recognise different types of psychological distress, which in turn hinder help-seeking. Another reason

participants gave for not seeking support was a fear of being diagnosed and what this would mean in terms of stigma and shame; this fear of disclosing a mental condition was also found by Savage et al. (2015) and Selkirk (2012).

This study found that male participants were less likely to seek professional help than female participants, and this is also corroborated by the existing broader literature as indicated below. The differing gender attitudes amongst CEE immigrants identified in this study draw parallels with Anderson et al.'s (2009) findings that women were more at ease discussing their emotions than men, and with Courtenay's (2000) argument that gender roles in British society lead to internalisation of the ideological position that men should be strong, competitive and emotionally inexpressive (see also Clement et al. 2009; Holman, 2014; Thornicroft, 2009). Due to the transition of CEE countries from communism to a new democratic society, these societies seemed to reject the communist egalitarian family roles and to return to traditional family models, where women were responsible for housework and childrearing, whilst men were predominantly breadwinners (Adler, 2004; Robila, 2004). This may also explain, in part, the gendered differences described in the current study.

Comparable to Addis and Mahalik's (2003) claims, male participants in this study were also less likely than female participants to recognise nonspecific feelings of distress as emotional problems. Gender-specific differences were also apparent in participants' coping strategies: women stated that they dealt with

emotional pain through involvement in varied activities, whilst men were more likely to drink alcohol, smoke cigarettes, take drugs or withdraw from others. Combined with the trend of men being less likely to seek help, it might be assumed that male CEE immigrants are at a higher risk of developing mental health problems to a point of crisis. Men's unhelpful coping strategies were also noted by Selkirk et al. (2012) within the Polish community. The results of this study suggest that even though some female participants also hesitated to share emotional difficulties, this was more an exception than a trend, and that stigma influenced the secretive behaviour in both genders (see also Corrigan & Calabrese 2005; Selkirk et al., 2012).

The present study suggests that cultural rules limit the sharing of emotional difficulties to reciprocal helping relationships (e.g. family and close friends). This seems in contrast to Furedi's (2004) claim of 'therapy culture' and Time to Change report (2014) that British people held more positive attitudes towards help-seeking, suggesting that culture changed over the last fifty years **.** Nevertheless, Anderson et al.'s (2009) noted that there were gendered and generational differences that affected help-seeking attitudes and stated that mental illness stigma still widely existed in the UK. He pointed out that therapeutic practices were not broadly accepted and understood. A review of the literature suggested that stigma led to social exclusion and perpetuated mental health problems (Economic & Social Research Council, 2011; Jenkins et al., 2008). Researchers concluded that the interaction between class, gender, age and other socio-

demographics must be considered (Andersen et al., 2009; Butterworth et al., 2009; Holman, 2014). However, a preference to exclude the family was also occasionally expressed in the current study. It was also noticeable that younger participants in the study showed a stronger preference to discuss emotional difficulties with friends first and family second. This suggests that there may be generational differences influenced by immigration and the adoption of cultural behaviours from the UK, as noted by O'Brien and Tribe (2014). Furthermore, socio-demographic characteristics such as age, sex, ethnic group and local area deprivation could also affect help-seeking behaviour (British Social Attitudes Survey, 2015).

In most cases, this study identified the family as a protective factor, providing a sense of stability and connectedness. Often the family unit included close relatives who had remained in the participants' countries of origin. However, this support was not always seen as helpful such as when people with mental health problems had been encouraged by relatives to remain silent and secretive; thus hindering their recovery. Even when family or friends were not trained in mental health support, they were frequently experienced as very holding and nurturing, which adds to the findings from Keyjenad (2008), that showed that family was considered as most important support among studied minorities. Some participants in the current study believed that families and friends could detect mental health issues early, which in turn could help individuals to recognise problems and seek professional help.

The results indicated that formal mental health services would be accessed only as a final resort. Help would be sought by first contacting the GP. Experiences with GP services were mixed; some participants felt confident they could share their difficulties, whilst others were more fearful. There were perceptions that GPs did not have enough time, did not provide consistent services and would refer individuals to NHS-provided treatment that was unlikely to be culturally sensitive. Furthermore, Keynejad (2008) and Madden et al. (2014) have highlighted that immigrants may not be familiar with the concept of using their GP as a gatekeeper to NHS services and that this can be experienced as a denial of care or a cost-saving scheme and therefore not utilising these services.

These perceptions and experiences can explain why this study identified a preference by some participants for seeking private psychological treatments, whilst others had seen these as too expensive and thus inaccessible. When therapy was considered, cultural sensitivity and therapist-client matching were identified as important factors for a positive outcome. Participants felt that the therapist should have a good awareness of their culture, worldview and healing practices, findings that add to Chung and Bemak's (2012) argument for multicultural counselling. This also echoes the Guidelines for Professional Practice in Counselling Psychology (BPS, 2005), which advocates a culturally sensitive approach to practice.

In summary, with respect to the research question, it was found that participants were reluctant to seek help from formal mental health services. They employed several alternative coping strategies, which appeared to be gender specific. The family was identified as a protective factor for dealing with psychological distress. The study also identified that cultural sensitivity and multiculturalism may well be important aspects of the therapeutic encounter.

4.1.4 Addressing immigrants' needs

This final overarching theme addressed the issue of meeting some of CEE immigrants' needs by exploring what they found had hindered or enabled them to seek support. Some barriers were identified and ways of overcoming these are suggested. Socioeconomic issues and approaches to mental health were also considered when discussing the needs of CEE immigrants.

Lack of English proficiency was found to be a major barrier that affected many areas of participants' lives, but made it particularly challenging to understand the way the NHS worked. Expressing emotions demanded even better knowledge of English, thus participants felt their vocabulary lacked specific terms that might be needed when accessing support services. Fears of being misunderstood were highlighted. Perhaps because of these reasons, linguistic barriers appeared to reduce significantly the likelihood of participants to engage with mental health services. These findings are in line with the broader literature

on immigrants' help-seeking, such as Halli and Anchan (2005), Wood and Newbold (2012) and Wynaden et al. (2005). Better language support services, that provide help with interpretation, translation and cultural interpretation for those who do not speak English well, could increase the take-up of mental health services by CEE immigrants.

The lack of interpreting services was identified as a related barrier. Some participants in the current study said that interpreters would make it possible to express personal issues. In contrast, others were concerned about confidentiality if an interpreter was involved. They felt that introducing a third person into the therapeutic relationship can be anxiety provoking and can alter its dynamic significantly. These findings align with Stuart et al.'s (1996) argument that interpreters can facilitate, but also limit communication. It has been proposed that difficulties with involving interpreters in the therapeutic process can be overcome by professionals covering aspects of confidentiality and interpreters' responsibilities, and outlining ethics and boundaries with clients (Smith, 2008). The use of interpreters can communicate the professional's genuine attention to clients' needs, increase the sense of being understood and thus can improve engagement in therapy (Smith, 2008).

The results of this study suggest that mental health stigma was a major barrier to help-seeking. Some participants attributed this stigma to a general lack of understanding, discussion and prioritisation of mental health issues in their

community. Improving mental and physical help for male immigrants seems particularly important due to higher levels of perceived stigma and unhelpful coping strategies. Participants suggested that the best way to address this barrier in their communities was through education. There was a suggestion that key figures in immigrants' communities could invite speakers and arrange discussions on mental health topics, contributing important ideas for potential community intervention. Listening to recovery narratives and expressing experiences creatively can be very healing (Rethink, 2010). Similarly, Corrigan and Penn (1999) argued that stigma could be challenged through the approaches of education and contact strategy. Confronting stigma and drawing attention to injustice, while providing education about the facts of mental health conditions, could be an effective way of changing views (Corrigan et al., 2001; Chung and Bemak, 2012).

The high level of fear and suspicion towards mental health services was seen as another barrier influenced by the recent CEE historical context (Lewis, 2002; Van Voren, 2013; Tosevski et al., 2008). This suspicion is likely to reduce significantly immigrants' contact with support services, as also highlighted by Kouroukian (2009). Interestingly, the participants' mistrust towards mental health services extended beyond NHS services to non-profit mental health organisations. These findings back the argument that there is a need for greater mental health promotion to develop strategies for overcoming barriers (Kejenad, 2008; Bhui et al., 2005; Bhugra & Gupta, 2011).

Unawareness of the availability of services could also contribute to people not seeking help. This argument is in line with Hall (2001), who highlighted lack of knowledge as a significant barrier. The previously described trend amongst participants to suppress psychological problems could lead to further lack of awareness of psychological services, as also noted by Zane et al. (2004). Furthermore, individuals may not be aware of their entitlements to use certain services (Jayaweera, 2010). Thus, help-seeking required extra effort from the participants in this study to find out about mental health services. Lack of awareness of support organisations combined with institutional barriers such as limited provision of interpreters made it even more difficult to access services. Participants reported that awareness could be improved through dissemination of information (talks, leaflets, discussions) on service provision in the community. These results add to Kehjanad's (2008) argument for community support.

The findings from the present study also highlight that a lack of culturally sensitive therapies could present a problem to CEE immigrants who were seeking help for emotional difficulties; this was also found by Robila and Sandberg (2011) in the US. Some participants talked about Western values prevailing in psychological services, which backs Huygens's (2009) and Levy's (2003) argument that the discipline of psychology was still promoting mono-cultural Western traditions while invalidating others. Based on the current research, it appears that culturally sensitive support, offered by professionals either from CEE cultural background or from someone who understands their culture and specific needs,

would provide a better service to CEE immigrants. Employing community psychologists to work within minority groups could be an important step in this direction, which is in line with the suggestion of Prilletenski and Nelson (1977) and backs Chung and Bemak's (2008) argument for therapists to actively engage and consult local communities. This study adds to current research suggesting that the Multi-Phase Model of Psychotherapy, Counselling, Human Rights and Social Justice (Chung & Bemak, 2012) may be better suited to addressing immigrants' needs, as this encourages psychologists to redefine their professional roles to incorporate proactive leadership, the facilitation of social change and advocacy.

Socioeconomic issues would appear to provide an important context when thinking about how to address CEE immigrants' needs. Socioeconomic problems, which affect both majority and minority groups, may not be addressed in the most prevalent forms of therapy available in the NHS. Factors such as policies restricting participants' rights to work, low-paid employment and problems with securing accommodation seem to lead to significant distress, and for which participants rarely sought support. These findings add to Villatoro et al.'s (2014) and Pearson et al.'s (2007) arguments that low income and poor housing exacerbated negative symptoms of depression and anxiety. Therefore, the need to address these issues in therapy is of vital importance; this is also argued for by Vera and Speight (2003) and Hall (2001). Participants indicated that support with

finding affordable and adequate housing could have a positive effect on individuals' wellbeing.

Results indicated that experiences of prejudice and discrimination, both in society and the media, combined with poor socioeconomic positions may increase immigrants' psychological distress; and this is supported by Shaw's et al.'s (2006), Swantek's (2009) and Bhugra & Gupta's (2011) arguments. However, when discrimination was reported and dealt with at an organisational level, participants felt empowered and reported a high level of self-confidence, personal achievement and socialisation. Therefore, protesting against inequalities and challenging media stereotyping could be a powerful antidote to prejudice. Similarly, Swantek (2009) noted that journalists might not recognise their own biases, such as a lack of understanding immigrants' issues concerning mental health, and argued that immigrants must confront stigma.

Participants suggested additional aspects of addressing their needs besides the ones described above. Protective factors such as having a strong family and community support, good English language skills, educational attainment, employment and economic opportunities seem to enhance participants' wellbeing and therefore reduce the need for support. These findings might address Yakushko and Consoli's (2014) argument that it was better to study how immigrants can remain resilient in face of mounting negative pressures rather than focusing on pathologies experienced by them. Therefore, it is important to

focus on these protective factors when supporting CEE minority groups, such as building resilience using positive coping strategies, and recognising that families and close friends have important roles in supporting people and are sources of strength and support.

Some participants spoke in favour of comprehensive community centres that might offer holistic support. Such centres could provide mental health promotion and prevention, physical health services, voluntary services, activity groups, exercise classes and meeting points for younger members of communities. As findings suggest, participants valued creative activities and opportunities to learn new skills that could be financially rewarding. Offering alternative therapies could demonstrate that services are able to go beyond the Western psychological model and implement non-medical explanatory models of mental health as highlighted by Ridley et al. (2005) and DCoP (2005). Moreover, holistic centres could demystify and promote positive views of mental health services. These findings add to and support a BPS report that highlighted the need for integrated care plans for socially disadvantaged people, 'which need to link health and social agencies, education, the benefits and employment system and the justice system' (BPS, 2009, p. 5). These community centres could bring people together and help them connect with others to create a greater force to bring about change, as highlighted by Kagan et al. (2011).

Overall, findings from this research suggested that addressing barriers to help-seeking could be achieved through active involvement with CEE communities. Creating opportunities for individuals to voice their concerns and learning how to facilitate change can be a step towards developing a socially responsible and just society. Therapists should focus on protective factors, recognising the impact of social reality, power imbalances and contextual factors (Mio & Iwamasa, 2003; Thatcher & Manktelow, 2007; Koroukian, 2009), and facilitate opportunities for personal development that can enhance CEE immigrants' resilience (Chung & Bemak, 2012).

4.2 Contributions and implications

The findings of this study contribute to the body of literature regarding the wellbeing of immigrants from a counselling psychology perspective. Yardley (2000) argues that in order to evaluate the usefulness of a study, it is necessary to consider its theoretical and practical impact. Therefore, this section will also consider the research contribution to multicultural counselling and the social justice movement within counselling psychology. It will also consider the recognition that the construction of knowledge may need to expand beyond the medical and psychosocial distress based understanding of immigrants' wellbeing, to one that is based on context and relationality. Finally, the research suggests that national policies may need to develop different strategies in order for mental health services to become more accessible for CEE immigrants.

The findings of this research adds to existing literature on multiculturism by providing an insight into some of the experiences, views and needs of CEE immigrants living in the UK in relation to their mental health. This is highly relevant to counselling psychology practice; as Yakushko and Consoli (2014) argue, culturally relevant practice and education should be informed by research on immigrant populations. To date, there is a scarcity of research focusing specifically on CEE immigrants' mental health, and the present study has provided a comprehensive view on potential barriers and facilitators of successful adjustment and help-seeking. The suggestions made in Section 4.1 may contribute to the existing theory and practice of counselling psychology (e.g. Schwartz et al.'s model of acculturation, 2010; Chung & Bemak's MPM model, 2012). Increased recognition of culturally different perspectives has the potential to expand the repertoire of helping responses available to counsellors (Pederson, 2001).

The socio-cultural explanations of distress in this study, adds to the literature from the social justice movement in counselling psychology. Many argue that counselling psychologists have a moral responsibility to both address the significant social, cultural, economic and political challenges that have a negative impact on clients' wellbeing and development (BPS, 2009; Chung & Bemak, 2012; Priletensky et al., 2009; Cutts, 2013; Constantine & Sue, 2006), and to also redefine their professional roles and identities (Moller, 2011). This research responded to this call by giving a 'voice' to individuals from CEE communities and highlighted some existing attitudes that marginalise and disadvantage them in society. For

example, experiences of prejudice and discrimination are often not reported (Meer, 2015); hence, these issues remain problematic and to some extent hidden in society. This should encourage therapists to start discussions around these issues in therapy (Chung & Bemak, 2012; Kagan et al., 2010; Vera & Speight, 2003). Therapists' increased awareness of CEE immigrants' needs can encourage them to focus more on the economic, social, familial and cultural context that may lead to their clients experiencing distress (Priletenski & Nelson, 1997; Strawbridge & Woolfe, 2003).

The results from this study resonate with Priletnsky et al.'s (2007) and Kagan et al.'s (2011) arguments that Western psychological theories and interventions greatly presuppose individualism on an implicit level. This presents important ethical dilemmas, because adopting intrapsychic approaches may detract attention from social and cultural problems, minimising the government's responsibility to address social exclusion and inequality. Adopting a social justice approach would encourage community interventions, rather than an individualistic approach, and hence ameliorate this problem (Parker, 2007; Kagan et al., 2011; Chung & Bemak, 2012). Hopefully, this study can stimulate counselling psychologists to engage strongly in anti-oppressive practices. This could be done by taking the positions of advocates, and supporting individuals by building on their existing strengths and resilience (Yakushko & Consolli, 2014).

The results indicate that holistic and developmental views of individuals' lives, where emotional difficulties are seen as part of human condition, might be helpful, and here counselling psychologists are particularly well situated to effectively support CEE immigrants due to the emphasis on this in their training and subsequent practice. Counselling psychology has strong humanistic values and an interest in facilitating wellbeing as opposed to responding to sickness and pathology experiences (Woolfe & Strawbridge, 2009; Woolfe, 1990). The results indicated that CEE immigrants wanted to have a close relationship with a helping professional. Therefore, their needs may be better addressed by counselling psychologists, whose relational focus gives prominence to the building of a strong therapeutic relationship and who are able to use a wide variety of therapeutic approaches (Shorrock, 2011). A clear outline of boundaries, confidentiality and explanation of therapeutic process may help to overcome distrust and build a therapeutic alliance. Knowing the person's history, family system, ethnic identity, life and immigration experiences are deemed important by Chung et al. (2008), and are all essential for engaging with this group (Robila, 2004). Psychologists should also be invited to explore and recognise that they may hold attitudes and beliefs that can detrimentally influence their perceptions of and interactions with individuals who are ethnically different.

This study suggests that CEE immigrants might be different from both non-immigrants and other minority groups, because their cultures tend to be much more collectivist with a greater psychosocial reliance on family and friends.

Therefore, it is important to explore family dynamics and to consider family therapy as an option (Robila, 2004). Collectivist cultures often address problems in different ways; it is uncommon to discuss problems with nonfamily members (Selkirk et al., 2012). In addition, signs of emotional distress can sometimes be downplayed to protect family or because it is culturally inappropriate to complain. Therefore, some CEE immigrants appear to have a difficulty attending therapy due to significant stigma and shame in the CEE culture that leads to an absence of dialogue about mental health issues (Madden et al., 2014). Gaining understanding of the significant role that informal resources play could enable mental health professionals to facilitate new ways of utilising services.

This study has some implications for mental health policy changes and provisions. There is a need for different strategies that can make services more accessible, acceptable and affordable. For example, establishing community 'hubs' could help provide education about legal, employment and mental health issues, by involving volunteers from the local community, health and social services. Community outreach programmes have been found to increase help-seeking, lower dropout rates, and improve intervention outcomes, as is matching clients to therapists in terms of language and ethnicity (Leong & Lau, 2001; Snowden, 2001). A solution-focused coaching service could address practical problem-solving needs and could diminish resistance towards mental health services. Information about mental health and services should be provided in more languages, not only through leaflets, but also by creating local community websites, Facebook pages

and multimedia resources. Not only is the investment in promotion, prevention and effective mental health care of importance to individuals, it has also been recognised to be beneficial to society as a whole, saving billions of mental health cost (Centre for Mental Health, 2010). Non-referral pathways of accessing mental health services could be specifically useful in promoting service utilisation among CEE immigrants, because it is more in line with mental health service provision in their countries of origin. Training for interpreters and mental health practitioners could also be beneficial to delivering culturally sensitive therapy (Raval, 2003).

Despite the legal requirement that public authorities need to ensure that their services are responsive to the needs of all communities, there is a gap between research and practice to implement findings (Joseph Rowntree Foundation, 2004). To address this gap, the researcher disseminated the findings of the current research in psychology conferences and submitted her research paper for publishing. Perhaps this study can encourage counselling psychologists to attend more actively to the needs of their communities.

4.4 Limitations of the research

Although this research contributes to the wider immigrant literature on the studied subject, it is not without limitations.

The research has an exploratory and qualitative nature; hence, it is limited in terms of generalisability (Yardley, 2008), and may not reflect the views,

experiences and needs of all CEE immigrants in the UK. What is more, it undoubtedly was influenced by the researcher's points of views and cultural knowledge in spite of efforts to maintain a high level of reflexivity through ongoing detailed reflection and discussion with the supervision team (Braun & Clarke, 2013). The researcher recognises her active role and that 'the kind of knowledge that is produced depends on what problems we have and what questions we ask in relation to the world around us.' (Danermark et al., 2002, p. 26). Other researchers could have asked questions that could have reflected different experiences, views and meanings with regard to mental health. However, the knowledge gained might be transferable when working with individuals from CEE background, highlighting significant moral issues in multicultural counselling (Tracy, 2010).

Although the researcher's choice of thematic analysis attempted to go beyond the surface of the studied phenomena, it would have been possible to employ interpretative phenomenological approach for a greater depth of analysis (Smith et al., 2009). Nevertheless, this study provides extended descriptions of CEE immigrants' experiences and views in order to fill the identified research gap. Furthermore, the critical realist approach enabled the participants' descriptions to be understood in terms of their reality, shaped within their social context (Danermark et al. 2002; Houston, 2001).

Information leaflets were written in English and given to the community development workers and some key members of the community. Although

interpreter services were offered, most participants communicated in English, thus people less proficient in English could have been discouraged to participate. Participants in the study held mixed views about the involvement of interpreters; from seeing them as helpful to having concerns about them 'being a third person in the room'. This confirmed previous research that has shown that working with interpreters is a complex process, where individuals need to build trust and clear boundaries have to be well defined (Tribe & Raval, 2003; Smith, 2008). Future research may benefit from an additional fieldwork, involving interpreters and building trustful relationships with communities, which can attract a different sample.

Some of the participants were recruited with the help of the community development workers (CDWs) and key members of CEE communities, which might have created a power dynamic. Therefore, before the start of each interview, participants were invited to discuss any concerns regarding the study. Montero (2009) suggests researchers have to be vigilant to the needs of the community members during the research processes and to facilitate an opportunity for expression of concerns. Participants did not report any imbalance in power and said they valued the role of the CDWs.

Six people declined to participate in the research, which might be explained by their unwillingness to speak about mental health issues, lack of time to participate or lack of confidence in the researcher. As a result, more individuals were recruited through snowball sampling. There may therefore be a bias in the

data as it only represents the experiences and views of individuals who volunteered to take part in the study. However, the studied individuals were purposively chosen from different cultural, social and educational backgrounds and hence presented various views and experiences about the studied topic.

The sample was not balanced across the genders, as only four of the 16 participants were male. This is in line with the findings of this study, which indicates that CEE immigrant males are more reluctant to talk about mental health or possibly, they were discouraged to participate because of the researcher's gender. Although male participants appeared assertive and determined to present their views, their responses might be influenced by researcher's gender because of their need not to show weakness. They might have different responses if the interviewer was a male. It could be helpful for future research in this area to employ male co-researchers from within the community to facilitate discussion and openness concerning the studied topic, and in this way could lead to greater participation and awareness from both genders (Rogers, 2009). Involving community members as co-researchers can have a broader impact, empowering members to become experts in the research process and to initiate change (Boylorn, 2006; Chung & Bemak, 2012).

4.5 Proposed further directions

The study highlighted issues that can inform counselling psychology practice when working with CEE minorities. However, it explored broader issues rather

than detailing specific strategies of providing support. Following on, more work is needed to address and understand which therapeutic practices may be suitable to meet the needs of CEE groups, and to apply findings to the training and practice of culturally sensitive therapy (Sue, 2004; Sue & Sue, 2013). Interviewing CEE therapists could provide an additional perspective in gaining such knowledge.

Future research might facilitate processes of community consciousness raising and empowerment (Watkins and Shulman, 2008), which could better address CEE immigrants' needs. Counselling psychologists should be encouraged to research and explore the sources of emotional distress at cultural and institutional levels (Chung & Bemak, 2012). This could be done through formulating joint community-based, action-oriented research that seeks to empower participants as co-researchers, as suggested by Kagan et al. (2011).

Psychological research has been critiqued for its lack of response to political struggles and thus maintaining the status quo of political powers and cultural prejudices (Fox, Prilleltensky & Austin, 2009; Cutts, 2013). Future social action can address inequalities in society through a democratic, equitable, liberating and life-enhancing process (Stringer, 1999; Chung & Bemak, 2012). For example, representatives of CEE communities, mental health organisations, employment services and research teams could participate jointly in developing and implementing research methodology and protocol. This could be liberating for CEE immigrants, and instil hope that limiting circumstances could be challenged

and changed. Establishing support initiatives, such as psychoeducational days, advocacy services and workfares that address these issues could be a way forward.

4.6 Conclusions

Participants in the study shared that immigrating to the UK was a stressful process that was affected by cultural and socioeconomic factors. Generally, they reported having good mental health and being able to deal with difficulties themselves. Protective factors such as a good social network, English proficiency and equal economic opportunities contributed to positive experiences, whilst prejudice, discrimination and a lack of culturally sensitive service provision had negative implications. Promotion of strength-based narratives about the CEE communities could help to create an understanding of the resilience of these communities. This may encourage prioritisation and discussion of mental health issues that could potentially reduce the stigma around seeking help. Therapeutic interventions that ignore the socioeconomic factors that affect peoples' lives are likely to be ineffective. Addressing CEE immigrants' needs requires active engagement from the community, the acknowledgement of the contextual factors that affect wellbeing, the highlighting of discriminating practices and policies, and the building indigenous forms of resilience.

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Appendixes

Appendix 1 - Demographic Questionnaire

1) How old are you?

19 – 24 ☐
25 – 35 ☐
36- 49 ☐
50-69 ☐
70+ ☐

2) What is your gender .....

3) What is your Ethnicity?

Albanian ☐
Bulgarian ☐
Czech ☐
Estonian ☐
Hungarian ☐
Latvian ☐
Lithuanian ☐
Polish ☐
Serbia ☐
Slovakian ☐
Slovenian ☐
Romanian ☐
Ukrainian ☐
Other (please specify) .....
Mixed (please specify) .....

4) Were you born in the UK?

Yes ☐
No ☐

5) If no, for how long have you been living in the UK?

1-5 ☐
6-10 ☐
11 years or more ☐

Which of the following best describes the area you live in?

Urban ☐
Suburban ☐
Rural ☐

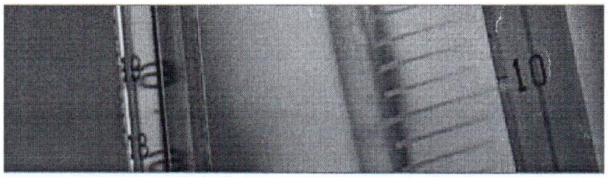
6) What is your first language? .....

7) What is your religion? .....

Demographic data Table 2.

Participant	Gender	Age group	Ethnicity	Born in the UK	Immigration group	Area of living	First language	Religion
Miro	Male	25-35	Bulgarian	No	1-5	Rural	Bulgarian	Orthodox
Krisi	Female	36-49	Bulgarian	No	1-5	Rural	Bulgarian	Christian
Sonja	Female	50-69	Bulgarian	No	6-10	Suburban	Bulgarian	Orthodox
Katya	Female	25-35	Bulgarian	No	1-5	Rural	Bulgarian	None
Ioana	Female	25-35	Romanian	No	6-10	Urban	Romanian	Orthodox
Emilia	Female	19-24	Polish	No	6-10	Suburban	Polish	None
Agata	Female	25-35	Polish	No	6-10	Suburban	Polish	Christian
Marek	Male	25-35	Polish	No	6-10	Suburban	Polish	Protestant
Piotr	Male	19-24	Polish	No	6-10	Suburban	Polish	Catholic
Tanja	Female	25-35	Lithuanian	No	1-5	Suburban	Lithuanian	Catholic
Barbara	Female	25-35	Polish	No	6-10	Suburban	Polish	Christian
P12 Monika	Female	25-35	Polish	No	1-5	Suburban	Polish	Catholic
Anda	Female	36-49	Latvian	No	11+	Suburban	Latvian	Orthodox
Indre	Female	19-24	Lithuanian	No	1-5	Urban	Lithuanian	Christian
Laura	Female	36-49	Latvian	No	1-5	Suburban	Latvian	Orthodox
Sandu	Male	50-69	Romanian	No	11+	Suburban	Romanian	None

Appendix 2 - Ethical approval



University of the West of England, Bristol
Faculty of Health & Life Sciences
Research Governance
Project Certificate

Project Details Overall approval status for HLS10-2488 is ***APPROVED***

Project Title:	Acculturation and attitudes to help-seeking: An exploratory study of Eastern European immigrants in the United Kingdom
Project Area/Level:	Psychology / Doctorate
Proposed Start/End Dates:	30-04-2012 / 30-07-2014
Chief Investigator:	Mrs Elena Chtereva
Supervisor/Manager:	Dr Tony Ward
Section Status:	Review Complete <-Approval Lock should be checked
	Approved

Appendix 3 – Recruiting leaflet

Calling all Central and Eastern Europeans – we need to talk!

Participate in an exciting research study. Come and share your experiences of living in the UK in a friendly mind-stimulating 60 minute interview session.

Adults from Eastern Europe living in Great Britain needed for study *'Attitudes to help-seeking: An exploratory study of Eastern European immigrants in the United Kingdom'* conducted by Elena Chtereva MBPsS – doctoral student of counselling psychology at the University of the West of England.

Get in touch now to arrange a session at a convenient location and time for you.

Call 07927 359 180

or email elenapsychology@gmail.com

Appendix 4 – Information leaflet

University of the West of England
BRISTOL

ID No:

1. Study Title

Attitudes to help-seeking: An exploratory study of Eastern European immigrants in the United Kingdom

2. Invitation Paragraph

You are being invited to take part in a research study. Before you decide whether or not to take part it is important that you understand why the research is being done and what it will involve. Please take time to read the following information carefully and ask me if there is anything that is not clear or if you would like more information.

3. What is the purpose of the study?

My aims are to explore your experience of moving to live in the UK. I am interested in your views about mental health and mental health services in the UK as an Eastern European. It will be helpful if you could share your opinion about what someone could do if they are experiencing emotional difficulties.

4. Why have I been chosen?

You are being invited to participate in this research because you are an Eastern European who has migrated to the UK and I would be interested in hearing about your experiences of this process. I intend to interview up to thirty Eastern European migrants in this study.

5. Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be asked to sign a consent form. Your participation is very valuable. However, you are still free to withdraw from the study at any time and without giving a reason.

6. What will happen to me if I take part and what do I have to do?

Taking part in this project is entirely your choice: if you do take part, you may stop at any time or withdraw the given information later without any consequence to you. If you do not want to answer any of the questions your choice will be fully respected. However, your participation in the project will be highly appreciated.
As a participant in this study you will be asked to participate in one individual

interview lasting approximately 30-60 minutes. The interview session will be recorded on a Dictaphone and transcribed.

7. What are the possible disadvantages and risks of taking part?

Anything you say might be shared only with my research supervisor who is bound by the Ethical Code of British Psychological Society. However, if you tell me something that suggests that either you or someone else is at risk of serious harm I would have to break confidentiality. You may also find talking about your experience brings up some distressing memories and feelings. I will be providing you with sources of support should this being the case.

8. What are the possible benefits of taking part?

Taking part in the research may provide you with a chance to reflect on your experience of migration and acculturation to the UK. You may find useful asking questions regarding mental health and places for support.

9. What if something goes wrong?

If you have any concerns about this study either before or after participation you may contact the director of the research study Dr Tony Ward on: tony.ward@ac.uk or the research supervisor Christine Ramsey-Wade on christine.ramsey-wade@ac.uk. However, do feel free to discuss your concerns with me and I will try my best to resolve any problems.

10. Will my taking part in this study be kept confidential?

As a participant in this study, your privacy will be fully respected. Your identity will be kept anonymous at all times by using coded identifiers on your written documentation and file. A different name will be used in reporting the results of this study instead of your real name. All information will be kept securely for a period of 6 years in accordance with University policy after which time it will be destroyed.

11. What will happen to the results of the research study?

The information you give me will be used to write a research paper which may be presented to the Division of Counselling Psychology. Nothing in the presentation will enable any individual who has participated to be identified.

12. Contact for further information

If you need any further information you may contact me on elena2.chtereva@live.uwe.ac.uk or my supervisor Christine Ramsey-Wade on: christine.ramsey-wade@ac.uk or alternatively write to:

Christine Ramsey-Wade (Elena Chtereva)
The University of the West of England
Faculty of Health and Life Sciences
The Department of Psychology
Frenchay,
Bristol,

BS16 1QY

You may want to contact me by telephoning on **07927 359 180**.

If you would like to take part in the study then please email me on: elenapsychology@gmail.com or contact me by telephoning the above number to arrange a suitable time for the interview.

Thank you for taking part in the study. I highly appreciate your help and cooperation.

Appendix 5 – Consent form

University of the West of England
BRISTOL

ID No:

Title:

Attitudes to help-seeking: An exploratory study of Eastern European immigrants in the United Kingdom

Name, position and contact address of Researcher:

Elena Chtereva - Trainee Counselling Psychologist

Christine Ramsey-Wade (Elena Chtereva), The University of the West of England,
Faculty of Life sciences, Department of Psychology, Frenchay
Bristol, BS16 1QY
Mob: 07927 359 180
or: elenapsychology@gmail.com or elena2.chtereva@live.uwe.ac.uk

A

Please tick box

1. I confirm that I have read and understand the information sheet for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving reason. ☐
3. I agree to take part in the above study. ☐

	Yes	No
4. I agree to the interview consultation being audio recorded	☐	☐
5. I agree to the use of anonymised quotes in publications	☐	☐

Name of Participant Date
Signature

Name of Researcher Date
Signature

Appendix 6 – Debrief

University of the West of England
BRISTOL

Title of study: Attitudes to help-seeking: An exploratory study of Eastern European immigrants in the United Kingdom

Thank you for taking part in this study. If you have any questions about the study or you would like to say anything about your experience of participating then please feel free to discuss this with me or send me an e-mail, and I will come back to you as soon as possible.

Please remember that you have the right to withdraw the information collected about you at any time during or after the study. All you have to do is email me giving your ID number (which can be found at the top of your Participant Information Sheet) and your data will be removed from the study. However, after the final report is written I will not be able to withdraw your information. Nevertheless, pseudonyms will be used in order to anonymize the data and nobody will be able to recognise you personally.

It is possible that you may have experienced some distress as a result of talking about your experiences of moving to and settling down in the UK. If this is the case, then you may wish to contact the following support services:

Mind Info Line
(open 9.15 a.m. to 4.45 p.m.) Tel.: 0845 7660163
www.mind.org.uk

Samaritans National
Tel.: 08457 909090
(24 hours a day, 365 days a year)

Sane Line
(Mon to Fri 12.00 noon to 11.00 p.m.; Weekends 12.00 noon to 6.00 p.m.)
Tel.: 0845 7678000
www.sane.org.uk

Depression Alliance
Information line Tel.: 0845 1232320
www.depressionalliance.org

Rethink National Advice Line
Helpline: 020 89746814
(Monday to Friday 10.00 a.m. to 3.00 p.m.)
www.rethink.org/services

Anxiety UK
Helpline: 08444 775 774
(Monday to Friday 9.30 a.m. to 5.30 p.m.)
http://www.anxietyuk.org.uk

If you have any comments or concerns about the study, please call me on **07927 359 180** or email me at: elenapsychology@gmail.com or elena2.chtereva@live.uwe.ac.uk . You may wish to contact my Director of Study: tony.ward@live.uwe.ac.uk; or my supervisor: christine.ramsey-wade@uwe.ac.uk
or write to them on:

The University of the West of England,
Faculty of Life sciences
Department of Psychology
Frenchay
Bristol
BS16 1QY

Thank you once again for participating in this study.

Appendix 7 – Interview schedule

1) What are the issues for an Eastern European when immigrated to the United Kingdom?

2) What do you understand by emotional difficulties?

3) How do you think the experience of feeling fed up may have an effect on people from your ethnic background?

4) What an Eastern European might do if he/she is feeling that everything is too difficult?

5) What help is available in the United Kingdom if someone needed support and wanted to give up?

6) Have you come across the following agencies/organisations?

Mind Info Line
Samaritans National
Sane Line
Depression Alliance
Rethink National Advice Line
Anxiety UK
Carers Direct

7) How do you feel contacting some of these agencies?
a) What might be the reasons for not contacting these services?
b) What other help you might seek?

8) What set of services might people use?

9) Is there anything else you wish to highlight?

10) Is there anything else you would like to ask before we finish?

Appendix 8 Seven Stages of Thematic Analysis

Stage	Thematic analysis	Description
1	Transcription of interview data	Turning audio data into written text (or transcripts) by writing down what was said and how it was said so the data can be systematically coded and analysed.
2	Reading and familiarizing with data	Reading and re-reading the data to become intimately familiar with the content (i.e., immersion); analysis begins with noticing things of interest that might be relevant to the research questions.
3	Coding data	Identifying aspects of the data that relate to the research questions; can involve selective coding, where only material of interest is coded or complete coding where the entire dataset is coded.
4	Searching and identifying themes	Identifying salient features that capture something important about the data in relation to the research question; may represent some level of patterned response or meaning within the dataset.
5	Reviewing themes (visual map of provisional themes and subthemes, that can show relationships between them)	Determining whether candidate themes fit well with the coded data; themes should tell a story (not necessarily the story) that 'rings true' with the data; essentially represents quality control in relation to the analysis
6	Defining and giving names to themes	Defining themes by stating what is unique and specifi about each one; useful because it forces researchers to define the focus and boundaries of the themes by distilling to a few short sentences what each theme is about.
7	Writing and finalising analysis	Writing the report by selecting compelling, vivid examples of data extracts, and relating them back to the research question and literature

Based on Braun and Clarke (2013), pp. 202–203.

Appendix 9 – An example of noting overall impressions

100	Interviewer: Hmm, so you replied with very		
101	short answers and didn't engage very much		
102	Interviewer: No, I was too shy erm I didn't want		
103	to look like a fool.		Stress caused by bullying at school
104	Interviewer: Hmm, okay. Yeah, so did you have		Many of the children who are affected by traumatic stressors such as bullying can have their developmental processes and parts of their brains affected by the traumatic events (Ziegler, 2002).
105	any emotional difficulties at the time?		
106	Interviewee: I can't remember anything to be		
107	honest, the difficulty was the stress to be honest,		
109	because some people at school were mean to		
110	me. This was in year X (p) but over time we got		
111	over it. I just said to myself: 'Don't worry about		
112	that'. That's it, that's the only (p) emotional bit,		
113	but I was abused by this other person.		Effect of bullying on wellbeing Impact on one's integrity and sense of security, diminished sense of Self- worthless, anxiety, depression
114	Interviewer: Hmm		
115	Interviewee: So actually I was walking along the		
116	corridor at school and he pushed me to the wall		
117	then (pause) that felt really really mean. And I		
118	was feeling down emotionally. But as I said		
119	manage to go over it.		Wolk (2010) Bullies are about power and control
120	Interviewer: Do you know why did it happen?		
121	Interviewee: They didn't like me.		
122	Interviewer: Hmm		
123	Interviewee: I am not sure why erm I was not so		
124	scared but (p) they wanted to put me in trouble.		
125	So I just decided to stay away erm and not to be		

126	involved.		
127	Interviewer: Did you tell somebody?		Wolk (2010) states, 'Most bystanders do not like witnessing another person being bullied. It puts one into an uncomfortable psychological state known as cognitive dissonance to witness a bullying incident and do nothing about it. Cognitive dissonance occurs when our actions do not match our internal code of ethics and morality.
128	Interviewee: Yea, eventually I told my teacher,		
129	and he got I think this boy got suspended for a		
130	week, because other people also saw it, and he		
131	got like shouted quite a lot. Erm when it		
132	happened I was a bit (p) erm (p) I don't know		
133	how to say it erm (pause) I was a bit surprised		
134	how (p) a person didn't see how I was in the		
135	beginning, he didn't know what I went through		
136	but just judged me. I felt bad to be judged by		
137	another person. I think he thought that I was		
138	really bad, like so bad that he couldn't be with		It seems that the school responded well and supported him Emotional pain of being judged, pushed away etc. was difficult to describe.
139	like as friend, and I think that might be erm when		
140	we talk about it later.		
141	Interviewer: Hmm, so you were surprised		
142	Interviewee: Yea, it is difficult to describe that		
143	time, cos you just walk around and someone		How others see you could influence someone's self-confidence, especially in young age
144	pushes you for no reasons. I've been shocked,		
145	I've been so surprised how mean that person		
146	was and could not understand why. So I was		
147	looking on corridor not to see him, that's sort of		Avoiding encounter with the person as a coping strategy
148	thing.		
149	Interviewer: Yea, OK so apart of that did you		
150	have any other difficulties?		
151	Interviewee: Hmm (pause) no, I don't think so.		
152	From there on I had more friends cos they felt		Bullying at school – hard enough for every child to cope with. Being

153	sorry for me, and they tried to help me, and they		a foreigner is just one more reason: being different, vulnerable
154	were all right, they were friendly. Because my		
155	whole class saw it and they were quite with me		
156	about it, cos they saw how I went down like a		
157	brick, so		
158	Interviewer: So this was in the beginning.		Feeling understood from someone with the same culture, sounds familiar: you don't need to search for words- there is a mutual understanding.
159	Interviewee: Yea, and my friend from Poland, he		
160	came almost the same time as me to the UK and		
161	he knew how it feels to be alone if you		
162	understand what I mean		
163	Interviewer: (overlapping) Yea		
164	Interviewee: (overlapping) like not having any		I can feel how important it was for him to have a friend, a sense of a wound that has deep years ago
165	friends and (pause) just when we met first time,		
166	just had a small chat for about 10-15 minutes,		
167	and they we met for lunch and chatted all time		
168	there.		
169	Interviewer: Hmm		His face lit when he spoke of his friendship
170	Interviewee: Then on a bus to get home, then we		
171	started to meet up going to his place and to		
172	mine. We came down hill at the end of the		
173	school and we are not friends any more but I've		Indeed, it is important to have a social network
174	got other friends with whom I walked and I am		
175	still with some of them even now.		
176	Interviewer: Yea, I understand.		

Appendix 10 – An example of coding data

100	Interviewer: Hmm, so you replied with very		
101	short answers and didn't engage very much		
102	Interviewer: No, I was too shy erm I didn't want	Avoiding embarrassment	
103	to look like a fool.		Stress caused by bullying at school Many of the children who are affected by traumatic stressors such as bullying can have their developmental processes and parts of their brains affected by the traumatic events (Ziegler, 2002).
104	Interviewer: Hmm, okay. Yeah, so did you have		
105	any emotional difficulties at the time?		
106	Interviewee: I can't remember anything to be		
107	honest, the difficulty was the stress to be honest,	Stress caused by bullying	
109	because some people at school were mean to	Overcoming difficulties	
110	me. This was in year X (p) but over time we got		
111	over it. I just said to myself: 'Don't worry about		
112	that'. That's it, that's the only (p) emotional bit,		
113	but I was abused by this other person.	Abuse at school	
114	Interviewer: Hmm		Effect of bullying on wellbeing Impact on one's integrity and sense of security, diminished sense of Self- worthless, anxiety, depression
115	Interviewee: So actually I was walking along the		
116	corridor at school and he pushed me to the wall	Physical abuse	
117	then (pause) that felt really really mean. And I		
118	was feeling down emotionally. But as I said	Feeling down Overcoming difficulties	
119	manage to go over it.		
120	Interviewer: Do you know why did it happen?		Wolk (2010) Bullies are about power and control
121	Interviewee: They didn't like me.	Feeling disliked	
122	Interviewer: Hmm		
123	Interviewee: I am not sure why erm I was not so		
124	scared but (p) they wanted to put me in trouble.		
125	So I just decided to stay away erm and not to be	Avoiding trouble	

126	involved.		
127	Interviewer: Did you tell somebody?		Wolk (2010) states, 'Most bystanders do not like witnessing another person being bullied. It puts one into an uncomfortable psychological state known as cognitive dissonance to witness a bullying incident and do nothing about it. Cognitive dissonance occurs when our actions do not match our internal code of ethics and morality. It seems that the school responded well and supported him Emotional pain of being judged, pushed away etc. was difficult to describe. How others see you could influence someone's self-confidence, especially in young age Avoiding encounter with the person as a coping strategy Bullying at school – hard enough for every child to cope with. Being
128	Interviewee: Yea, eventually I told my teacher,	Disclosing problems to a teacher	
129	and he got I think this boy got suspended for a		
130	week, because other people also saw it, and he	People witnessed abuse	
131	got like shouted quite a lot. Erm when it	School's support	
132	happened I was a bit (p) erm (p) I don't know	Hard to describe feelings	
133	how to say it erm (pause) I was a bit surprised		
134	how (p) a person didn't see how I was in the		
135	beginning, he didn't know what I went through	'felt bad to be judged'	
136	but just judged me. I felt bad to be judged by		
137	another person. I think he thought that I was		
138	really bad, like so bad that he couldn't be with		
139	like as friend, and I think that might be erm when		
140	we talk about it later.		
141	Interviewer: Hmm, so you were surprised		
142	Interviewee: Yea, it is difficult to describe that	Hard to make sense of abuse	
143	time, cos you just walk around and someone		
144	pushes you for no reasons. I've been shocked,	Feeling shocked	
145	I've been so surprised how mean that person	Increased vulnerability	
146	was and could not understand why. So I was	Anxiety about confrontation	
147	looking on corridor not to see him, that's sort of		
148	thing.		
149	Interviewer: Yea, OK so apart of that did you		
150	have any other difficulties?		
151	Interviewee: Hmm (pause) no, I don't think so.	Support from school children	
152	From there on I had more friends cos they felt		

153	sorry for me, and they tried to help me, and they		a foreigner is just one more reason: being different, vulnerable
154	were all right, they were friendly. Because my	Witnessing abuse	
155	whole class saw it and they were quite with me		
156	about it, cos they saw how I went down like a		
157	brick, so		
158	Interviewer: So this was in the beginning.	Shared experience-loneliness	Feeling understood from someone with the same culture, sounds familiar: you don't need to search for words- there is a mutual understanding.
159	Interviewee: Yea, and my friend from Poland, he		
160	came almost the same time as me to the UK and		
161	he knew how it feels to be alone if you		
162	understand what I mean		
163	Interviewer: (overlapping) Yea	Social isolation	
164	Interviewee: (overlapping) like not having any		
165	friends and (pause) just when we met first time,	Making friends	I can feel how important it was for him to have a friend, a sense of a wound that has deep years ago
166	just had a small chat for about 10-15 minutes,		
167	and they we met for lunch and chatted all time		
168	there.		
169	Interviewer: Hmm		
170	Interviewee: Then on a bus to get home, then we	Making friends	His face lit when he spoke of his friendship
171	started to meet up going to his place and to		
172	mine. We came down hill at the end of the		
173	school and we are not friends any more but I've		
174	got other friends with whom I walked and I am		Indeed, it is important to have a social network
175	still with some of them even now.		
	Interviewer: Yea, I understand.		

Appendix 11 – An example of Collating Data

Code 8 Help-seeking attitudes

8.1 Seeking help from family and friends

P1 (263-267) my parents, if I am nervous or have problems I can rely on them. You can talk and share with them. While here, you are alone. You have friends but you cannot share everything with friends.

P1 (272-274) I cannot really, there is not a Bulgarian who does not have problems. Everyone has problems

P1 (284-285) With friends' help. Whatever way to help each other, there is no other way (p) (287-289) but also emotional, financial ... everyone tries to help whatever way is possible for them.

P2 (317-322) Maybe we developed like that over the years. I believe that we have to communicate, we have to talk rather than bottling it in whatever it is, when with your partner or with a friend. Because if it is bottled it is not good for you psychologically.

P2 (336-340) I think it is important to talk, to emphasize how important it is to share, to comment. But you have to fight, that is what I say to my children, they should not despair (p) not give up.

P2 (524-532) This is something I try to resolve myself or in my family. I would not share with people outside my circle, my family, my husband. There is a limit what I could share with others, emotional difficulties erm maybe with a very good friend, here it is hard. And children need more support here, so I have to be strong for them too, like a pillar.

P2 (701-704)*(Family is)* it is the support, giving advice, helping each other when there are difficult moments but also to share joyful moments, to be together.

P2 (704-709) For me for me not material things are of any help, (p) for me personally it is like that: someone to listen to you, to be able to speak to someone is very important. A person should not be materialistic, just to try and seek material things.

P2 (715-723) Well, the thing is that used to live in a very strong family, I include my parents although I have been married for so many years, I also include my cousins, nephews, nieces. These people make my family. We live with the problems of every single one of the family, although we are living here. They know ours and we know theirs. This is our family. For me the distance does not matter.

P4 (190-195) I would talk if there was something we were not able to resolve within our family. Something that is more difficult, more stressful for which you cannot find a solution at home, I would. I would talk to someone else if I can't do it at home, especially if the person is from my background.

P4 (204-210) it should be something in regard to health or mental health, you cannot resolve such problem at home. Maybe if there was a serious health problem I would go and seek help from someone who could give me

explanation, advice where to find a specialist in this specific area I needed help.

P4 (346-347) First you seek help from your partner or friends, even from friends back in BG.

P4 (478-481) You may know some of their problems but I am not sure you'll know erm I mean there are personal things that you don't share even with friends.

P4 (749-753)Then you may ask for help but your friends that are close to you, or your family to help you until your situation is improved. Some people go back home if life is too difficult here.

P5 (377-380) I try something else you know, call a friend, I am lucky enough to have them, but you know, just do something to get out of that.

P5 (564-568) It is hard, it is hard, if they have not got the support of the family and their friends then it is very hard. I can repeat myself, if they can't do it erm it is a very hard to do it, isn't it.

P5 (570- 576) Mental health is quite linked with I think emotional, so because you've got a problem if you are depressed about it, you know, all these things, it is a whole erm if you don't feel confident how would you find that strength to go without people being behind you?

P5 (578-560) maybe some people just find it within them but, you know, not everybody, only a few .

P5 (762-765) If all these don't help I can again friends family, I will try to keep up with the Gym, I will do my things which I usually do, you know (778-783) if somebody are: 'all right, sit down, we need to talk about it', you know, so probably then you need to go, you know, and see specialist or whatever, then I obviously be oh actually, yes but depends on how how I am told and how erm (p)

P5 (785-791)straight forward (p) I don't like going around, no. Just straight forward for any health problems in general, but not just about mental just any problem I like to be told there and then (p) yea, no go no around no way around it erm no just tell me about the problem. I don't like guessing (793-795) because then (p) that makes me almost like anxious, you know. I guess it will make anyone anxious (801-802) Yes, to be told directly.

P5 (804-808) And then maybe I would have some ideas and they tell me: 'Ok you shall seek help or you should do that' then definitely, you know, that will be helpful as well.

P5 (828-829)I went with a problem and then again they they helped me (834)I found them very helpful

P5 (1022-1025) you trust your friends don't you?! You think if my friend goes there obviously it means that this place is good.

P5 (1032-1036)I need to know before I try but if a friend comes to you and says 'Oh actually, there is and so', you know, to help you, and then I will go. Ok you just will go there. (1036-1039) As if you go somewhere else you've got so many other choices to choose from so you don't know which one to call to, you know. But I am quite reserved person (pause) it would be hard to seek help (p).

P6 (356-364)When I always have got like problem, I normally phone my godmother, she is in Poland, I treat her more like my biological mother, and my biological mother I treat like my aunty, yes I know it's sounds really weird, but it is just because I am really close to my auntie ok. So when I go to Poland, what I do is to call her straight away, and I am telling her everything (p).

P6 (370-372) I was actually crying on the phone, I was really really worried about my results (374-376) I got my initial offer from here I really needed to get high marks, I knew it was going to be really difficult (376-378) So I phoned her up crying about my like stupid problem, because I was pretty lazy to do more work at college. (394-395)I found her as a person I can trust, and so when I got problem I always phone her up

P6 (395-401)But when I know she's got problems as well and I don't want her just to have my problem and I go to my best friends, and I just talk to them. And normally when I go to my best friend we just like talk about our problems, try to solve them and at the end we got drunk to get relaxed.

P6 (725-726) If not friends and family, maybe help lines, I don't know, I am not sure that someone will go actually (pause).

P7 (236-239). As like I said, they might talk to friends, talk to someone in the chemist and ask them, there are some specialists.

P7 (242-245)You don't want to burden them, you don't want them to think something of you, to let them know that there is something wrong with you.

P7 (383-388)Some people seek help and some people don't. I don't know. It depends who you are and what kind of problem you've got, and if you are on your own and you don't have friends, then you can look for help somewhere else.

P7 (398-403) If I was depressed (p) when I was a student and there was a lot going on, what I've done was I took my staff and went back home. And I spent time with my mum in the house and she was cooking for me, and I was just watching telly, and did not think about it. I would not think of going to special help.

P8 (444-447)When you spend some years here, you hear there are mental health services, so there will be always someone like in a small group in a social network that will help. (*Longer stay in the UK, social network could increase knowledge about MHS)*

P8 (447-454)So if the issues are really big, then people will try to find help, they'll be someone who actually speaks English very well, and have got a few other friends that speak English very well as well. Because it is usually about the social group, you know. Someone speaks English very well and is part of this group. (*Help is sought from minority community; People seek help for serious issues ; Help is sought from friends speaking good English)*

P8 (467-474) people are suspicious, they are more happy to trust their family or friends more likely, cos in families people a bit more because people wouldn't disclose this type of problems. Probably they wouldn't see it as such a big barrier, especially if it is a best friend, who they really trust, and then they maybe more happy to disclose

their problems. (*Mistrust; Trust family/ friends; People disclose MHP with close friends)*

P9 ()At Uni you have friends, which is the best, if you find one good friend you can talk to that will help you the most.

P9 (415-423)And then at the end will be your parents cos they might cos they don't see how you look how you feel at Uni. So they wouldn't be able to help you as much, so friends and tutors can help you the most. Even your brother cannot help you so much because they don't know. Unless they are there as well although they may have different experience than yours so they will not be the best one who can help. *(Parents don't understand children's' issues; Parents wouldn't be able to help; Siblings are perceived as less helpful)*

P9 ()I think that the biggest help will be from their friends. It takes time to get erm to bond with the person, but once you made the first bond with this person you can (p) you might think that it's annoying them, but if they really like you they'll tell you that you are annoying them. That will be a bit tough but they will not go, they will try to understand you and will just try to help you. So friends are important. *('biggest help from friends'; Importance of bonding and trust)*

P9 (488-492) if they have that like a minor mental problem than I think I am not sure but it might help (p) the mental problem could be resolved if you have a friend, someone who knows you and you talk.

P9 (622-625)I would say just friends, teachers, tutors people at work if you are close to some, and your own family. I think these are the only ones I can think *of. (Sources for support)*

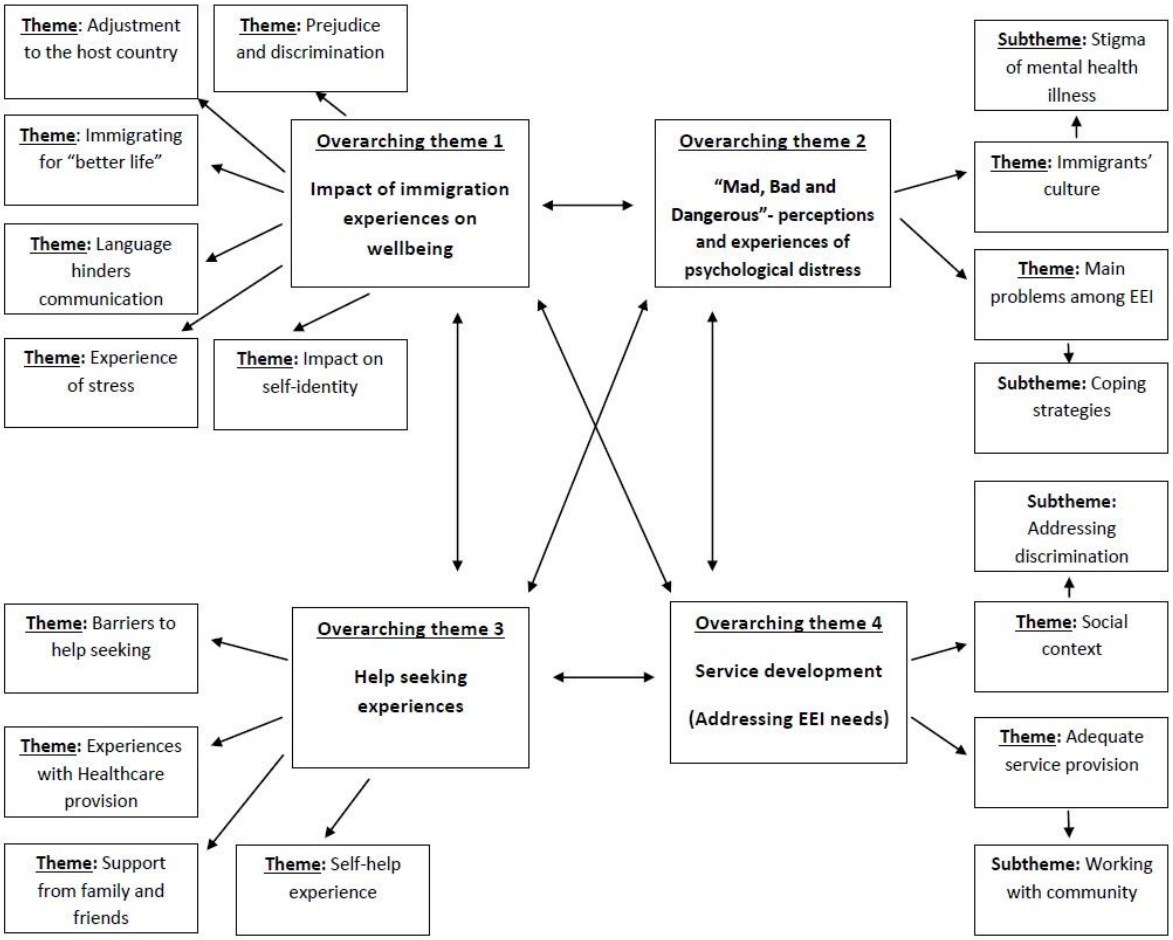
P10 (64-67)…talk to my friend, that's it, probably ask for advice cos I don't know cos if I was in my country I would go to my parents to my friends, I know what to call I know what and how but I would just go to my friend. (*Seeking help from family and friends)*

P10 (97-103)…cos usually like thinking what happens even when you don't understand like you have psychological problems or you have somebody to talk to and you realise that you really really do and this even have mental health problems, that someone from your I mean from your family or friends has to notice that and do something with you. Not this person, I don't think so. (*Family and friends might notice first and seek help; Individual is not likely to seek help)*

P10 (106-109)Yea, yea and to seek for help. They could see that something is wrong, they could tell the person to seek but they are the ones to seek for help. *(Seeking help is encouraged by family/friends; Help is sought from family/friends)*

P10 (178-179)I don't know, in my opinion these people would just go home (181-182) to their families to sort it, or if they had families here of course they would seek… (*Help from family in the country of origin or in the host country).*

Appendix 12 – Visual map of candidate themes



Appendix 13 – Overview of overarching themes and themes

Overarching themes	Themes	Examples of data
1. Immigration experience *It is not so easy as it seems, like you hear people saying, could be very hard and it is hard. (Indre)*	**1.1 Immigrating for a 'better life'**	**1.1** *Some people expected to be easier, but found hard, maybe not as hard as at home but not easy at all. Especially if you had a degree and can't find a good job. This is something that can make you feel down. (Tanja)*
	1.2 Prejudice and discrimination	**2.1** *Foreign people, they have this kind of erm approach that they are worse, when they come over here well we are worse we are not from here so we just accept it. So they don't complain they don't report it, and erm so I think there is a lot of erm discrimination that is not detected. (Marek)*
	1.3 Experience of distress	**1.3** *On my nervous system, because to find a house is hard, when you go to work and see that for the same job you get half of which other people get (p) everything is getting on your nerves and is affecting you. (Miro)*
	1.4 Adjustment to the host country	**1.4** *So many things to know and learn when you come here […] everything is new, not easy to know where to find things, takes time to adapt.(Tanja)*
2. Views and meanings of mental health *This is the balance between your desires and psychological makeup, your energy, your aims and everything (Krisi)*	**2.1 Secrecy and mental health**	**2.1** *Everything stays in the family, in Latvia you talk about your problems but at practical level and you don't show that you are down (Anda)*
	2.2 Mental health stigma	**2.2***They usually say he's just a mad person and you know, these kind of says it is a huge stigma (Marek)*

3. Help seeking experience *Because everybody is used to take care of themselves without asking for help(Miro)*	**3.1 Self-help experience** **3.2 Support from family and friends** **3.3 Experience from mental health services**	**3.1** *I have not searched for help (p) I did not have a need, I have been trying to deal on my own and that is. (Katya)* **3.2** *If I was depressed (p) […] what I've done was I took my staff and went back home. (Agata)* *You seek help from your partner or friends, even from friends back in BG. (Katya)* **3.3** *While we were filling in these tests with the interpreter I was thinking that ticking the boxes was not going to solve my problems (Sonja)*
4. Addressing immigrants' needs *I don't know anything, where I can even ask for my rights. (Laura)*	**4.1 Barriers to help seeking** **4.2 Socioeconomic context** **4.3 Improving support**	***4.1*** *Sometimes it is difficult to find the right words and to express what's inside me, what bothers me. You see, it's easier when it's in your language, the understanding is greater. (Krisi)* **4.2** *That creates a lot of problems and mental issues as well, and these issues are real, they are not imaginary. (Sandu)* **4.3** *For people having similar problems, to learn and hear a different point of view […] kind of a support group in our community. (Ioana)*

Appendix 14 – An example of defining themes and illustrating with excerpts

Theme	Examples from the data
1. Impact of immigrants' experience on wellbeing Refers to the subjective experience of what is like to be an immigrant in the UK. In what ways immigration process has an impact on wellbeing. (motivations to leave home country, the manner of exit, the context of reception by host country; support provided)	**Pre-migration experience** **P16** (9-17) First of all it is very difficult to decide to go to the other country, because you don/t know what to expect and you don't know if you have enough skills and potential to be able to work, and it is actually scary. (p) So it is a big step, something you don't just go for but you think about it and it's something that you consider (p) and think about for a long long time and then you either do it or don't. **P16** (89-101) …you don't really prioritize these things (p) if you immigrate you have probably a good point to do it, so something is not quite right in your country, and you are not happy. In general you are not happy and that forces you to do something about it, (p) very often that's because the country is poor and there are not job opportunities etc. etc. but very often this is not the only thing, and some social environment probably is the problem sometimes (p) so when you go to another country you try to build your life, and this is very complex process, it is a complicated thing to do. **P3** (28-34) I felt stressed even before I came here, not because I was leaving the country but erm I was very stressed for a while, but when I came here things became worst because I felt lonely, nobody gave me enough attention and that was not good for me. I would not say that I am used to it, although six years passed so far. **Feeling down- expectations** **P10** (516-520)Just to say that coming here erm some people expected to be easier, but found hard, maybe not as hard as at home but erm not easy at all. Especially if you had a degree and can't find a good job. This is something that can make you feel down. (522-523)…but people from EE can be strong, they can manage. **P15** (376-378) I imagine maybe I am (inaudible) too high to expect that at all (laughing) and that's I am down. *(Higher expectations led to disappointment/ depression)* **P12** (66) And looking for a job took me a lot of time (68-77) I was thinking about even when I tried to come here, but I was like in a big doubt that I could find something, big doubt in myself, and I felt a bit lost as well and I did not have a job so I was thinking: 'Oh my God, what have I done!' I was not sure that it was the right decision to come here so I had some worries in my mind, It was difficult at that time. It was difficult to justify whether I made the right decision. **P16** (101-107) First of all you have to survive physically and find a job and work for some money to be able to support yourself and your family, then to find your place in the society and feel valuable and appreciated and then to feel happy. So all these things in a new country are very very difficult.

Impact on personal identity Highlights challenges to personal identity and how these are talked about in terms of experience. A possible factors that influences decisions whether to seek help or not.	**P15** () I was for a whole month without job, without work, because I have to finish there XX (place of work) and thanks to God I got back at XX (other place of work) , but I was really really down before (146-151) I sent my CV and everybody in England has a CV, so there was no answer no anything (pause) I was really depressed I think, I did not know what to do, no pay for my flat, the bills were such high… **P1** (72-73) Because I worried for being sacked I developed a first stage of diabetes. **P1** (33-37) On my nervous system, because to find a house is hard, when you go to work and see that for the same job you get half of which other people get (p) everything is getting on your nerves and is affecting you. **P13** (501-505) I mean there are sometimes real problems like finding a job, money **Impact on self-identity** **P2** (461-465) I feel that I am less able, less valued, with a low self-esteem. (pause) That's it. I changed a lot since I am here. Maybe because of the language barrier, this is made me less communicative. **P9** (96-99) I was doing my work but I wouldn't answer the question, I didn't feel confident enough, and if someone asked me I was like 'erm, choose someone else please'. (*lack of confidence)* **P9** (102-103)No, I was too shy erm I didn't want to look like a fool. (*Avoiding embarrassment)* **P9** (471-476) Cos if you don't have a friend for 4 year time and then erm even longer that you think 'I don't want anyone because I don't worth, they are too good and I don't worth, I am not for them'. That's how it could affect. **P15 (121-125)** Sorry, sorry this is just (still laughing) me maybe. I was asking like ask for help, oh my God but I am here and nobody helps, is there something wrong with me or what and I just don't know… *(Perceiving this is only her experience; Needs for help are not fulfilled; Negative self-perception)* **P15** (128) crying (more serious now) then (laughing) (131-132) Rubbish (laughing) it is just I am nothing, I don't know. *(Feeling like 'rubbish' and crying; Negative self-perception)* **P15** (225-229)…that's make yourself, what's going on around, you are make feel very bad in yourself. Because maybe I am these problems with me, nothing is coming, it's maybe problems with me… *(Feeling confused and bad person; Personal fault/ responsibility)* **P8** (254-259)but you may have sort of like erm kind of a positive I think emotions about you know different things which would be like happiness when you can find, you kind of settle down you can have, find a good job, you can have a job that people appreciate here. (*Positive emotions result from settling down in the country, having a good job that is appreciated by others)* **P8** *(259-261)*Erm you can feel more important, you can feel like you are actually doing something good. *(Increased self-esteem and self-confidence if you are valued)*

Appendix 15 – Excerpts from Reflective Diary

Reflections- Collecting data

10.10.12

I have been recruiting participants for two weeks and have potential interviewees but feel scared to get started. In particular, after the previous project, I am aware that mental health topic is not easily discussed, at least among Bulgarians. I feel anxious how to balance the interviewing process: initiating deeper discussions to gather rich data while allowing space for interviewees to decide how much they wish to disclose. I am aware that being in a researcher's role is very different to being in a therapist role. More specifically, some aspects of being a therapist (e.g. noticing transference, counter-transference and working on the relationship) although important to note as influencing factors upon the data collection cannot be attended to as explicitly during the interview. This enables me to feel more relaxed, since I can only actively listen to the stories.

15.09.12

I met with my personal therapist and explored how I felt about my research project. I addressed my resistance towards the whole research process and my regrets that I picked up this particular subject. We discussed the importance of managing my feelings and taking care of myself during and after interviews, because these might trigger my own issues of being an immigrant. We noted that reflecting on the process using a reflective diary, and thinking about what may have affected the data, could also help in later stages of the research process. I have been processing feelings of loss over last years; hence, I assumed that at least some of participants may also experience similar feelings. Continuing with my personal therapy could help me to manage my own feelings and to bracket those during the research process.

5.10.12

I just got back home from my first interview. This interviewee (xx) was recruited through a member of the Bulgarian community. I made sure that I explained fully confidentiality, right to withdraw, and allowed enough time for questions. He and his family moved to the UK two years ago and settled down in a small town in Dorset. XX and his wife found a job in a factory, but he worked longer hours than his wife. He had little time for attending English classes although he wanted to improve his knowledge. Miro is somewhat 14 years younger than me, did not have any particular qualifications and considered himself being 'working class'. He did not seem concern that I was a female, neither did he perceive me as an 'outsider'. However, I am aware that potentially it has an impact on information he gives through the interview. (men do not show emotions, so he did not want to be seen as weak/ vulnerable). He appeared relaxed when I explained the aim of the research and all information on the Information leaflet, and did not have any questions. Initially XX seemed nervous when I switched on the Dictaphone, but after my first question, he relaxed and continued his narrative. XX took the leading role during the interview and it was hard for me to navigate the conversation close to the interview schedule. I noted his anger (e.g. being treated unfairly at work) but remained calm and just nodded to express my understanding and tried to stay neutral. There was a sense of insecurity and anxiety, which he tried to cover by talking about other people, but not about

himself. At the end, I managed gently to steer the conversation back to his experiences. However, every time we spoke about mental health he tended to get back to his physical health and dissatisfaction with his GP. I found it hard to get back to the topic. I noted how frustrated I felt, because of my submissiveness (gender roles in Bulgarian culture) that prevented me to ask further questions. On reflection, perhaps it would have been better if I allowed more time for interviewing, making sure that I listened to participant's story first, which could have allowed him to feel understood, and lead to better rapport and consequently greater openness about the studied topic. I need to remind myself, that the research has to be beneficial for participants, not to serve my interests.

12.10.2012

The topic I chose to investigate could be emotionally draining as researching into the impact of immigration on wellbeing prompted me to reflect continuously on my own experience of being an immigrant. I had to acknowledge my own coping strategies (e.g. focusing on the wellbeing of my family; blocking feelings of loss by being 'rational') and needs (having close friends in both countries to feel safe and emotionally balanced; increasing my self-awareness through therapy). This allows me to be more authentic and empathic during interviewing process.

17.10.2012

I met up with Krisi a couple of hours ago. Initially she immigrated to the UK to help her daughter by looking after her grandchildren, but after a few months, she decided to stay. Krisi is in her late fifties, neatly dressed, quiet and polite woman. I was taken aback by her selflessness and desire to help her children. I assumed that she would not talk easily about her feelings, but to my surprise, she was very open.

Krisi appeared very helpful, clearly trying to please me during our conversation. I noticed how much I focused on developing trusting relationship, hence more equal power position, so Krisi would not feel the need to say the 'right thing'. She was keen to explore aspects of her culture and tried to stay objective. This provided a useful context, which enabled me to understand her experiences in more depth.

My initial anxiety how to approach mental health topic seemed to diminish with the progression of the interview. My assumption that Krisi would not talk about this sensitive topic was not correct. Quite the opposite, she openly shared her experiences. Perhaps I don't need to be so sensitive and protective. I feel better knowing that I have explained clearly that the interviews might be emotionally evocative, so by choosing to take part she is taking responsibility for her own emotional process. Allowing more time for the interview also helped.

27.11.2012

After the exchange of 11 e-mails we finally managed to meet up for an interview with Emilia. It was difficult to coordinate free time for conducting the research. Finally, we had to compromise and met in the interview room at the XXX University, which was free just for an hour. Unfortunately, the person who had to use the room before us did not finish in time and we had only 50 minutes. That put a lot of stress on me because I had to make sure I left in time for the next person using the room. Coming out of four counselling sessions was not ideal either because it was difficult to switch from one role to another. Therefore, I could not elaborate on some of the questions, which I needed to clarify. I did not have the

chance to ask the last question. However, after leaving the room we found a quiet place in the library and managed to talk/debrief for another 20 minutes. I need to find alternative places for interviews- hotels have such rooms that I can hire for 2 hours.

I noticed that Emilia carefully chose which parts of her experience she wanted to share and some, more personal were spared/unspoken. I wondered how she experienced me: did she feel I might be judgmental and critical towards her, did we built a good rapport.

When she talked about her relative, her face appeared sad. Talking about her decision to stay and study here or back in Poland her body language suggested that it was not an easy time for her. Most of the time the participant kept eye contact but talking about her relative was more emotional. It appears that some Polish people have very strong connections with their grandparents/aunties who looked after them when younger, because 'parents worked hard for 12 hours per day 7 days a week to make ends meet'. For this particular family coming to the UK was a positive experience because both parents found good jobs, did not worry about money so much, which reflected in a better family dynamic/experience as a whole.

Reflections on transcription

9.04.13

I am transcribing and noticing how easily I can fall into interpreting data or comparing participant's experience with mine. For example, Laura talked about not having choice (despite having a valuable degree), which made me think how privileged I am, to have such opportunities to continue developing both personally and professionally, whilst some struggled to make ends meet. I could not help but felt concerned about her, how difficult it must be to immigrate alone. I listened to the interview five times and still felt sad. I need to bracket my personal experience and feelings and explore these further in private therapy.

I also need to bracket my interpretations and theoretical assumptions in order to stay as close as possible to Laura's experience. Although Laura appeared vulnerable, she also managed to support herself over the last six years. I noticed the coping strategies she used, and her needs for support. If she knew where to go in order to obtain advice about her rights, it would have been much easier for her. She requested information (CAB, advocacy services in Dorset etc.), which I could send to her later via e-mail.

Listening back to the interviews has been really helpful for immersing myself in the data. I feel interested and stimulated to continue with the research process. It is important to be aware of my existing frames of reference for making sense of the information.

21.04.2013

I transcribed several interviews and noticed that the same themes reoccurred repeatedly. This provided me with a confidence that the number of participants in the study was adequate and the data gathered is sufficient to identify meaningful patterns in order to answer the research question. The meeting with my supervisors also confirmed my assumptions. I felt relieved that I would not need to continue with data collection. It has been an anxiety-provoking process, and I am aware that this feeling will stay with me during the analysis stage. I need to learn how to relax and Christine's book suggestion about mindfulness is really good.

Reflections on coding

14.10.14

I found coding a challenging process because it was very new to me, appeared to be very subjective and I felt lacking in self-confidence. I have decided to take a 'complete coding' approach (Braun & Clarke, 2013). This decision was based on the fact that I was using an inductive bottom-up approach (my study is explorative), hence my coding needed to be rooted in the participants' own words (Elliot et al., 1999) and the content, rather than guided by a theory or pre-existing hypotheses. I think this decision reduced the possibility for data misinterpretation and kept the codes grounded rather than presenting my own assumptions, which is important in keeping with a critical realist approach. However, I felt anxious and sent my first interviews with initial coding to my supervisors. It was a relief to learn that my analysis was all right.

17.12. 2014

I am still anxious whether I am coding well. I feel that it can be helpful to aim for a rich thematic description, which Braun and Clarke (2006) state 'might be a particularly useful method when you are investigating an under-researched area, or you are working with participants whose views on the topic are not known. They also talk about deciding between 'a rich description of the data set or a detailed account of one particular aspect.' I made a decision to focus on providing a rich description to keep with the exploratory nature of the project. I also decided to identify semantic themes with a view to analysis.

24.03.2015

There are different levels at which I can code, but I am aiming to keep it simple. I wrote down: what are participants talking about?, so I can constantly remind myself during the coding process. This is in order to keep within topic coding rather than falling into social constructionist analysis.

Then I progressed from simple description level to more interpretative in order to theorise the significance of the patterns I identified during analyses, and their broader meanings and implications (Patton, 1990). This is in contrast with the latent theme analysis (identifying the underlying ideas, assumptions, and conceptualisations, which are theorised as shaping the semantic content of the data) which tends to come from a more constructionist approach (Braun & Clarke, 2013).

Reflections on analysis

17.05. 2015

I felt overwhelmed with all data that I need to analyse. I reviewed the codes several times. All of them had been collated, but there was some degree of overlapping of codes. It took me a lot of time, and I realised that my planning was not realistic. I took a day off to distance myself from the data, but analysing still felt messy. I worked from coded data and tried to identify broader patterns that could enable me to identify central organising

concepts that could form the themes. For example, it seemed that immigration process itself had a significant impact on participants' wellbeing, which I identified as an overarching theme (immigration experience). The major themes seemed to catch different aspects of the overarching theme (immigrating for economic or personal reasons; difficulties with adjustment, experience of prejudice; communication difficulties). Then I focused upon identifying the features of each theme. For example, participants' reported having both negative and positive experience with immigration and I aimed to understand what factors contributed to their perceptions.

16.05.2015

I tried to organise all of the themes on paper. This process seemed very messy and I needed to take many breaks to keep my mind clear. I was concerned with keeping close to answering the research question (and aims). At times, I felt stuck and at times, I was frustrated with my progress being so slow. I noticed that I wanted to 'get it right' and asked for my supervisors' feedback. I also reminded myself that Braun and Clarke (2013; p.230) highlighted that 'qualitative research is not about the right answer' but 'the best fit of analysis to answer the research question'.

I made a table to define each theme and although I struggled, the process seemed useful. I have also organised the provisional themes in a visual 'mind map' to facilitate my thinking about links between themes. Although I still feel overwhelmed, there is also a sense that I can manage it.

22.10.2015

Writing the research is considered the final stage of the project (Braun &Clarke, 2013). I thought naively that if I reached that phase I would feel so relieved. I found it hard to write the story in a coherent and informative way. I wrote what seemed endless drafts and had to re-start several times, because everything seemed messy and chaotic, I was repeating points and interpretations all over again. I felt so frustrated with myself. At this point, I wanted to admit defeat, and if it was not the support offered by Christine and my family I would have given up. This process brought forth my feelings of not 'being good enough', a schema which was reinforced for several years during my academic studies (Young, 2003). Writing in my second language proved to be even more challenging. I could only imagine how much more difficult it was for some of the participants in the research, at least I had the opportunity to attend English classes. There is also a parallel process. Being conscious of not making mistakes and hence being misunderstood was a concern for some participants. I am also concerned about my grammar, but also about being able to present participants' stories truthfully, thus checking constantly claims I made against the data. Writing requires responsibility, and I feel anxious that I might fail participants.

When I checked the grammar I forgot all about the content or found myself in a doubt, whether I included most of participants' views. Editing includes re-framing, re-ordering and moving parts around, tightening and tidying up the grammar and so on (Woods, 1999). I felt anxious whether I made my overall argument clear: peer review would have been so helpful at this stage. I felt exhausted with the amount of work that still remained. I decided upon proofreading, and felt grateful for proof -reader's enormous help. Communicating research has been a very difficult task. It requires a different set of skills, but perhaps with practice I can develop these.

Appendix 16 - Journal article

Becoming 'another brick in the wall': a thematic analysis of Central and Eastern European immigrants' experience of psychological distress and help-seeking

Aims: This study aimed to explore how the experience of immigration had influenced Central and Eastern European immigrants' wellbeing, whether immigrants had sought help for any psychological distress, and to investigate if there is a particular need for support for this distinct immigrant population.

Methods: A qualitative design was employed. Semi-structured interviews were conducted with four male and twelve female immigrants from Central and Eastern Europe living in the UK. Interview transcripts were analysed using inductive thematic analysis.

Results: Four overarching themes were identified in the analysis: immigration experience; views and meanings of mental health; help-seeking experience and addressing immigrants' needs. Participants in the study reported having good mental health and the ability to deal with distress, but highlighted that a lack of English proficiency, low job attainment and experiences of prejudice and discrimination negatively affected their wellbeing.

Discussions: The results offered a thorough description and understanding of some immigrants' experiences, meanings and needs concerning their wellbeing.

Practical implications for working with this minority group are discussed from a social justice perspective, including the recommendation to apply contextual approaches such as relational cultural theory.

Keywords: Central and Eastern European immigrants, wellbeing, therapy, social justice, mental health, immigration, stigma.

Central and Eastern European countries (CEE) (also commonly referred to as Eastern European countries) were all locked behind the Iron Curtain before its fall in 1989. The Iron Curtain referred to both the physical blockade and an ideological barrier that existed between 1946-1989 between CEE and Western Europe. This political boundary helped to identify a region whose development was very different from the West. Since 2004, a large number of immigrants from these countries have moved to the UK. The Office for National Statistics estimated that in 2013 there were over one and a quarter million people originally from Accession 8 (Czech Republic, Estonia, Hungary, Latvia, Lithuania, Poland, Slovakia, Slovenia) and Accession 2 countries (Bulgaria and Romania) residing in the UK, making up 1.75% of the population.

Given the recency of this wave of immigration, it is perhaps not surprising that Robilla and Sandberg (2011) found that research on mental health issues for

these minority groups was scarce. Jenkins et al. (2005) were one of the first to attempt to fill this gap and highlighted increased rates of physical morbidity, mental illness, alcohol, and tobacco abuse in post-communist countries. Mäkinen (2006) and Höfer et al. (2012), who studied the mental health of CEE nationals, also noted that changes in political regimes in CEE countries increased suicide rates.

Limited research has been conducted on the experience of distress and help-seeking of CEE migrants in the UK. Madden et al. (2014, p. 1) claimed that CEE populations have 'poorer mental health; higher mortality due to heart attacks and strokes; higher levels of obesity' when compared to the UK average. One study that has explored help-seeking patterns of Polish immigrants found that a commitment to Polish values prevented individuals from seeking support for psychological difficulties (Bassaly & Macallan, 2006). Selkirk et al. (2012) argued that responses to distress were influenced by a sense of identity, social networks and previous experience with mental health services. However, both these papers focused on immigrants from Poland, whilst other CEE immigrants remain less well studied.

Rationale

It has been recognised that psychologists need to acquire distinctive knowledge and skills in order to work with culturally diverse populations (Chung & Bemak, 2012). A culturally sensitive therapeutic approach should consider an individual's basic value structure (Sue et al., 2009) as well as the context of immigration and its impact (Levenbach & Lewak, 1995). Relational Cultural Theory

(Comstock et al., 2008) advocates expanding multicultural and social justice counselling competencies beyond the domains of self-awareness and culturally responsive helping skills, and exploring contextual and sociocultural challenges that can obstruct an individual's ability to participate fully in life.

Counselling psychologists work with diverse populations that 'experience profound issues of oppression, discrimination, social inequalities, unfair treatment and disproportional privilege, as well as unequal social, political and economic access' (Chung & Bemak, 2012, p.4). The authors noted that therapists often focused on clients' pathology or their strengths, ignoring wider socio-political issues. They argued that this individualist focus could perpetuate a discriminatory 'status quo' and further disempower already marginalised groups.

Therefore, this research will focus on illuminating the less studied of CEE immigrants to the UK, with the hope to fill a gap in existing literature. The study will adopt a social justice lens and aim to 'give voice' to CEE immigrants by exploring their experiences and challenges, as well as identifying their wellbeing needs now that they are living in the UK.

Method

The researcher' decision on a critical realist paradigm and exploration of meanings and experiences led to selection of qualitative methodology (Braun &

Clarke, 2013). Given the social justice lens for this study, it was felt that Thematic Analysis fitted best with the critical realist approach to this study.

Reflective statement (first researcher)

My interest in conducting this study arose from working with individuals from different cultural backgrounds. Being a CEE national myself enhanced my curiosity and interest in exploring the experiences of others from the region. Compared to some of the participants I interviewed, I hold several positions of privilege, such as belonging to the middle class and being educated, and so to help examine and bracket both my assumptions and experiences I kept a reflexive journal (Gearing, 2004).

Participants

In order to 'adequately capture the heterogeneity in the population' (Maxwell, 2005, p. 89), a purposive and snowball sample of females and males from different social backgrounds was recruited and interviewed. Sixteen individuals took part in the study: six from Poland, four from Bulgaria, two from Romania, two from Latvia and two from Lithuania. A desire to talk about immigration experience and help-seeking was necessary and addressed at the point of recruitment (McLean and Campbell, 2003).

Simple demographic information was obtained in order to situate the sample (Elliott, Fischer & Rennie, 1999). Twelve females and four males from two counties in the South of England, with an age range of 19 to 69 and a mean age of 34 (SD-11.5) took part.

Ethical considerations

Ethical approval for the research was obtained from the University Ethics Committee and the study was carried out according to the ethical guidelines of appropriate professional organisations. Pseudonyms were used in order to preserve anonymity and confidentiality of participants.

Procedure

Information sheets explaining the purposes of the study were given a week before conducting the interviews. After obtaining informed consent, the first researcher conducted all semi-structured face-to-face interviews. Interview duration ranged from 30 to 90 minutes. In accordance with the aims of this study, the participants were asked about the issues they faced when they immigrated to the UK in general terms, followed by open questions around meanings and experiences of emotional difficulties, ways of dealing with distress, experiences and awareness of mental health services, and views about barriers to services and unmet needs. Four of the interviews were carried out in participants' native languages, and then translated and transcribed by the first researcher. Participants were debriefed after

each interview and reminded about their right to withdraw from the research before the final data analysis. After transcription, all identifiable information was removed and participants were given pseudonyms in order to preserve anonymity.

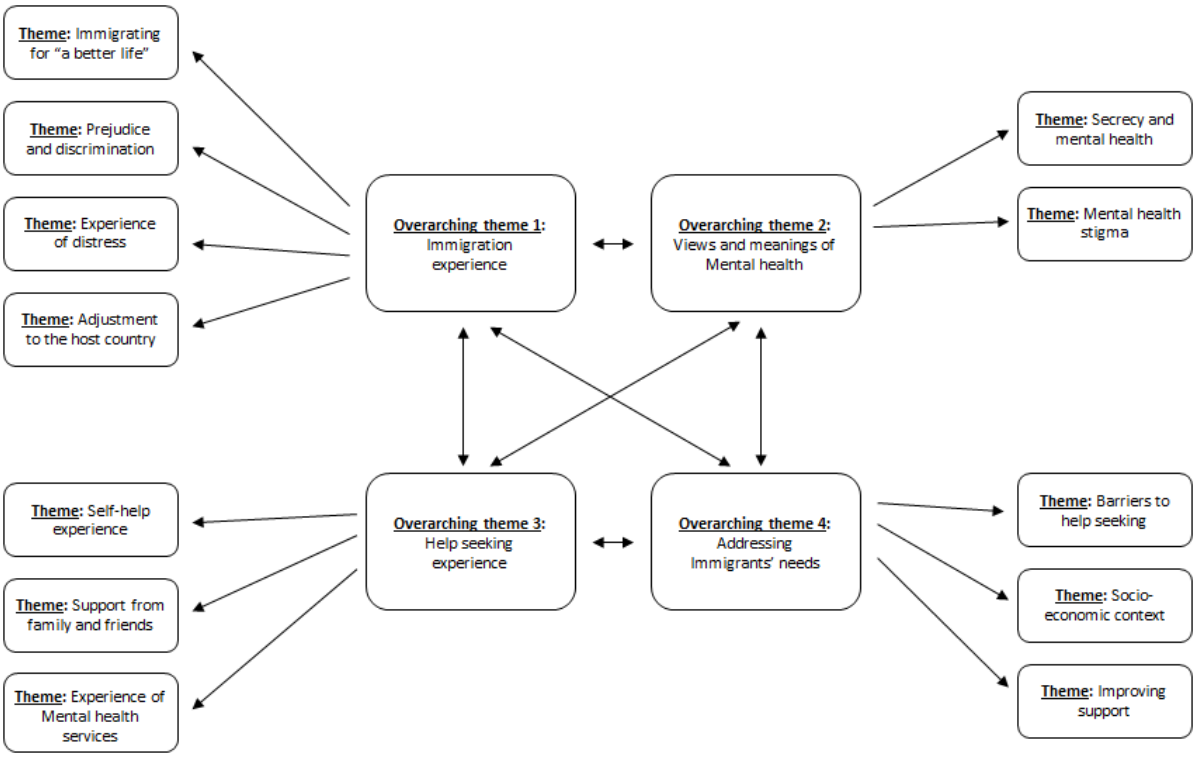
Transcription and analysis

The first author transcribed all interviews verbatim and the transcription process was considered a part of the analytic process (Braun & Clarke, 2013). Interview transcripts were analysed using inductive thematic analysis following the seven stages outlined by Braun and Clarke (2013), within a qualitative paradigm. Critical realism has been argued to be 'a perspective that combines the realist ambition to gain a better understanding of what is 'really' going on in the world with the acknowledgment that the data the researcher gathers may not provide direct access to this reality' (Willig, 2008, p.13).

Results

The analysis identified twelve themes, which can be grouped into four overarching themes in accordance with the research question, and are shown in Figure 1.

Figure 1-about here- An illustration of the overall thematic analysis



Overarching theme 1: Immigration experience

Immigrating for a 'better life'

Participants described their pre-immigration process and the first years of living in the UK as the most difficult. Most moved in the hope to escape financial hardship and to build better lives. However, finding work and affordable accommodation was identified as a challenging process. Many participants described working in low-paid positions despite being well educated. Rather than

achieving the higher socioeconomic status they aspired to, many faced financial problems. Thus, initial expectations led to disappointments:

Some people expected it to be easier, but found it hard, especially if you had a degree and can't find a good job. A lot of these people are very well educated, but they work in any position, just to get enough money, not easy when you are in a different country. This is something that can make you feel down. (Tanja)

The immigration process was viewed as complicated, requiring many resources, which in turn had a negative impact on participants' wellbeing. Interestingly, most reflected on their experiences in a matter of fact way and expressed few emotions. As Baker (2007) suggests, this may be because painful feelings are often dismissed or suppressed as a way of coping with stress.

In contrast to the difficulties already highlighted, six participants felt that they had gained a lot by immigrating to the UK. Ioana transferred her educational credentials and *'found a job'* easily. Agata also reported a similar experience and Tanja felt that she *'got better life here'.* Family reunion, safety and security, and better opportunities for children were highlighted as advantages of living in the UK compared to their countries of origin.

'We just accept it'- Prejudice and discrimination

Six participants talked about their experience of prejudice and discrimination on personal and organisational levels. As a result, they perceived themselves as inferior to British people and expressed feeling worthless, harassed, and upset:

*Oh some I guess, were really racist to me […] when I heard the word 'f***' I obviously knew they were saying something nasty to me. […] I was really upset about it. (Emilia)*

Some participants wondered whether there was *'something wrong' (Laura)* with them. Laura felt that she did not '*belong*' in the UK and that *'this coldness and what I met here maybe I am not just in the right place'*.

Others spoke about their hesitation to report these instances. Marek said: '*they don't complain they don't report it, so I think there is a lot of discrimination that is not detected*. ' Piotr felt surprised: '*he didn't know what I went through but just judged me. I felt bad to be judged by another person*'. This seems to make participants feel insecure and less communicative in order to avoid incidents, and less likely to stand up for their rights. For example, Krisi shared:

Maybe the fault is ours because we are quiet we don't say anything but his previous employer already sacked him for a similar thing and we don't want to lose this job too.

'Everything is getting on your nerves'- Experience of distress

Most participants reported that dealing with everyday stress had a negative impact on their emotional wellbeing. Although some acknowledged that British people also experienced stress, they described particular factors, such as language difficulties, separation from families and friends, and not knowing the system, that

they felt were specific to them. Miro highlighted socioeconomic factors that had impacted his wellbeing:

On my nervous system, because to find a house is hard, when you go to work and see that for the same job you get half of which other people get (p) everything is getting on your nerves and is affecting you.

Perceived life stress was also significantly associated with a sense of not belonging to a community. Many felt lonely and sad, missed their homeland, and lacked social support. Others talked about the negative impact of distress on their relationships. Katya said:

Sometimes I feel even more nervous and anxious after speaking , when we cannot agree on solution but we all know that the stress makes us like that, []arguing is not good, conflicts in family are bad, especially for the children, so we try to calm down but it is not easy.

Being able to establish meaningful relationships within the local community reduced feelings of nostalgia and stress. Many participants highlighted factors such as having support from both minority and majority social networks as important to their integration in the host country. Barbara said: *'So it's good to live in a society of Polish people who can help you'.* These experiences enhanced self-confidence and self-worth:

You kind of settle down you can have a job that people appreciate here, you can feel more important, you can feel like you are actually doing something good. (Marek)

'Everything was hard'- Adjustment to the host country

Participants talked about their struggle to fit into society. Many spoke of how hard they worked to learn the language and find their own way round without utilising formal support. Adapting was a complex process affecting individuals differently. For example, some participants felt that age strongly affected their ability to adjust:

I am middle aged and thus adaptation is more difficult. When a young person comes here and starts without anything is different from someone who is older. (Krisi)

Many reported difficulties with practical and administrative issues. Monika felt worried and anxious, but tried *'to be strong and face the challenges and that helped'.*

Participants from all five countries spoke about their problems in adapting to the new traditions, rules and laws in the UK; however returning home was also not an option. Monika spoke for many when she said that *'everything was hard but back was not any good either, so you just keep going and gradually learn what to do'.*

Overarching theme 2: Views and meanings of mental health

'Everything stays in the family'- Secrecy and mental health

Despite their different ethnic and cultural backgrounds, participants shared a common view that family matters should be kept private. They talked of family cultural scripts, such as not sharing problems and concerns with people outside the family. Mental illness was assumed to bring shame and therefore people often preferred to suffer in secrecy. Furthermore, most talked about the need for

resilience and considered that seeking external support meant *'that you are just weak' (Anda).* Monika said:

People learnt to be strong. They relied on themselves, don't think seeking help from someone else was something anybody would do.

The prevalence of secrecy seems to be rooted in historical context. CEE immigrants in the study shared that they did not have the benefit of organised social services in their countries of origin. In CEE countries, serious mental health problems were often treated by forced institutionalisation: *'you have to stay in the hospital locked so you don't harm people' (Katya).* Thus, individuals feared disclosure of mental health issues. However, distress attributed to everyday life stressors and social factors, such as marital discord, problems at work, and financial difficulties, was more openly discussed and accepted.

'Crazy, mad and dangerous' - Mental health stigma

Participants differentiated between emotional difficulties and mental health problems. The latter were assumed very serious conditions requiring hospitalisation. Without exception, all participants talked about the stigma attached to mental health issues. They cited predominant cultural beliefs that mentally ill people should be isolated to avoid harming others:

I don't think they would seek help because of our upbringing, if you seek help for emotional problems means that you are not OK, almost if you go there you are not all

right. You are crazy, mad and dangerous (laughs) and people would avoid you, and your family would be ashamed. (Katya)

Many respondents talked about the lack of knowledge about mental health conditions that shaped and promoted these beliefs. It was Katya's opinion that people from CEE countries would try to ignore their mental health problems. She went on to say that even their *'families would not speak to anybody about it, they'll try to ignore as long as possible almost as this does not exist'*, attributing this avoidant behaviour to stigma and shame. Barbara thought that immigrants brought with them these stereotypes:

Yes there is stigma. You just can't forget it and become different, absolutely different person with different culture and different background. You still have this background, this culture stays with you.

Overarching theme 3: Help-seeking experience

'I have been trying to deal on my own'- Self-help experience

Both female and male participants spoke strongly about trying to manage emotional difficulties themselves, rather than seeking support from others. In doing this, the female participants tried to be more active, whilst males were less likely to utilise helpful coping strategies. For example, female participants talked about walking, going to a gym, joining a choir, and being creative in order to alleviate distress. Meditation and complementary health practices were also identified as helpful. Sonja said:

I went to many treatments (massage) and I benefited from that. Aromatherapy for an hour is very relaxing.

However, when not able to deal with problems themselves, female participants would talk about their emotional difficulties with close friends and families, whilst males used less active and arguably less helpful means of coping such as smoking, drinking alcohol and closing down within themselves. Thus, it was apparent that gender differences were also influencing the decision to seek help and support:

Especially females they actually talk to each other but like males, they don't want actually to talk about it. They wouldn't disclose any of these problems to GPs to their friends to anybody. They just prefer to keep it inside. (Marek)

'You seek help from your partner, or friends'- Support from family and friends

Friends and family were the first point of call for all participants who failed to resolve difficulties by themselves. This informal support network provided a sense of emotional connection, shared values and inter-dependence, which was viewed positively by most. It was felt that friends and family '*exchanged energy*' *(Krisi)*, relieved stress and helped to find solutions. Barbara believed that this close social circle would be best placed to recognise emotional problems:

Friends and families, they are all aware, I mean they can talk about it, because they say if you accept it and do something about it you are halfway there.

Although the majority of participants viewed family and friends as their primary support network, a few participants did not want to seek support from family members. Their reasons included stigma, causing unnecessary worry to the family and fear of misunderstanding.

'Ticking the boxes was not going to solve my problems'- Experiences of mental health services

Only two respondents reported seeking formal mental health support. However, most disclosed that they had friends or relatives suffering from a mental health condition. Sandu had engaged in private therapy and talked about his positive experiences in both resolving family issues and being able to work on his self-development. In contrast, Sonja's experience was negative. She had been referred to the NHS for therapy and shared:

She worked like using a specific programme 'one size fits all' and did not invest anything more from herself. I went to the psychologist (p) but nothing changed a lot because I am still jobless. Just to sit and talk about what happened in our lives is not making any difference quite the opposite I feel even more depressed.

Those who had not experienced UK mental health services viewed the role of a psychotherapist as a foreign, '*Western*' (Agata) notion. Others were more acquainted with therapeutic interventions, but Tanja spoke for many when she said she *'would not waste two hours talking to someone'*. However, many participants stated that they would seek help eventually from their GPs, if a family member urged

them, but only when problems prevented them to function properly or when other attempts to resolve problems had failed.

Overarching theme 4: Addressing immigrants' needs

'It is difficult to find the right words and to express what's inside me'- Barriers to help seeking

Lack of English fluency was highlighted by all participants as the main barrier to accessing services, as this affected their understanding of how the NHS worked. Some spoke about the lack of interpreters' services, whilst others said they would be reluctant to use those for reasons of trust or confidentiality: *'there were three people sitting in an office and are talking about your problems' (Agata).*

Other important barriers to help seeking were the lack of acknowledgement, discussion and prioritisation of mental health problems and a lack of awareness by the participants themselves: *Maybe I would not understand if I had a mental health problem. (Tanja)*

Mental health stigma, cultural assumptions, perceived high cost or inadequacy of services, and lack of trust were all highlighted as major factors for not accessing help.

'Just not to discriminate us'- Socioeconomic context

Many participants found it difficult to deal with shifting economic and political realities. Some talked about policies restricting their rights to work and

healthcare, which contributed to their feelings of powerlessness and marginalisation. They also reported covert experiences of prejudice and xenophobia. Laura shared: *'the attitude, I can't understand, this make you very, very down like his attitude was like that, because you are foreigner'.*

Opinions were voiced about Western values prevailing in psychological services that locate the causes of mental distress within the individual rather than on external factors such as structural discrimination. Sandu went further to express his concern that psychologists might support a system that aimed to produce compliant individuals in society, to maintain the status quo:

These problems are real, and I am not really sure that these emotions should be silenced, because people should stand up and fight for their rights and fight against the system, and the system creates this sort of fears. Otherwise we become another brick in the wall. (Sandu)

'People try and seek contact through these communities'- Improving support

Participants reported that finding support from within their communities would be most valuable. Raising awareness and normalising mental health illness, educating individuals about availability of services and how to access these were also of key importance. Katya shared:

If there was an interpreter when I needed could be very helpful, someone who could explain to you, to say how the healthcare system here works. Because you are in

the dark, you know nothing and you try to figure out but this is not easy, especially in the beginning.

Providing culturally sensitive support with awareness about cultural beliefs, traditions, historical barriers and the need for a relational approach in therapy was highlighted. Sandu felt that *'Therapist is like a part of your family it's important to have a relationship with the therapist'*. Support with practical issues such as bureaucracy, language courses, and advice about personal rights and employment were also deemed important.

Discussion

The aim of this study was to represent the experiences, views and needs of some CEE immigrants in relation to their wellbeing. The findings have the potential to guide therapists and services who are attempting to work with recent CEE immigrants. The specific challenges faced by participants in this study supported Robila and Sandberg's (2011) research findings that an initial period of adjustment to the host country was the most difficult and presented many financial, linguistic and practical challenges that have a negative impact on immigrants' wellbeing. However, contrary to the above research, some participants in the present study did not report difficulties in transferring their educational credentials or continuing their education, perhaps because they immigrated within the European Union. Some had taken the opportunity to further their education in the UK, which in their view improved their financial situation and increased their self-esteem. Many

participants adjusted well to their new host country and reported good mental health. Protective factors such as having a strong family and community support, good English, educational attainment and economic opportunities appeared to enable this process. These findings correspond to those of Stepleman et al. (2009), who outlined such factors as having positive effects on the wellbeing of minorities.

Participants highlighted that prejudice and discrimination on personal and structural levels had significant impact on their wellbeing. In line with Finch et al. (2000), the findings suggest that these attitudes resulted in experiences of anxiety, isolation, low self-esteem and depression among CEE immigrants. It appears that experiences of marginalisation were made worse by immigrants' lack of social networks and isolation from society. These same issues were also highlighted by Yakushko and Consoli (2014), who argued that anti-immigrant sentiment had direct and indirect negative impact on the mental health and wellbeing of millions of immigrants in the U.S.

Despite describing experiences of significant distress, participants preferred to deal with their emotional difficulties alone or with the help of their families and friends. These findings could be understood in the light of CEE immigrants' societal values, such as group and family collectivism, need for belonging, and affiliation (Robila, 2008). Therefore, counselling psychologists working with this minority group may find it beneficial to focus on protective factors, such as building resilience through the use of positive coping strategies, recognising that families

and close friends are sources of strength and support, and empowering this minority group through involvement in education, research and policy making (Yakushko & Consoli, 2014).

In concordance with Robila and Sandberg's (2011) findings, the present research also identified that a high level of mental health stigma and distrust towards mental health services were barriers to seeking support. This could be explained through the socio-historical and cultural backgrounds of CEE immigrants. Oppressive practices during totalitarian regimes forced people into secrecy in order to avoid severe consequences such as imprisonment (Lewis, 2002). It is therefore understandable that many CEE immigrants would be reluctant to admit to feelings of depression, anxiety, distress and other mental health issues. They also might be less likely to report discrimination and social injustice due to fear of reprisals. It would therefore also be important in therapy to acknowledge feelings of suspicion and mistrust. As indicated by participants, getting out of the therapy room and supporting them in their communities, advocating for them and empowering them to seek their rights could be invaluable.

Finally, in order to ensure that CEE immigrant clients do not become 'another brick in the wall', their needs might be addressed through a framework that bridges relational, multicultural and social justice competences, such as relational cultural theory (Comstock et al.,2008). Comstock and colleagues argued that a more contextual approach towards supporting individuals, who have had experiences of

marginalisation and social injustice, could have positive implications not only on an individual level, but also in the context of community and the social world.

Limitations of the study

The study had an exploratory and qualitative nature and focused on broader experiences, views and needs of a sample of CEE immigrants to the UK in relation to mental health. Therefore, findings do not represent all CEE minority groups living in the UK. Future research might facilitate processes of raising community consciousness, envisioning of the future and self-empowerment (Watkins and Shulman, 2008), which could better address CEE immigrants' needs. This could be done through community-based, action-oriented research that seeks to involve participants as co-researchers.

Conclusion

Participants in the study described how immigrating to the UK was a stressful process influenced by their cultural and socioeconomic context. Protective factors such as a good social network, English proficiency and equal economic opportunities contributed to positive experiences, whilst prejudice, discrimination and a lack of culturally sensitive service provision had negative implications on wellbeing. Addressing immigrants' wellbeing needs requires a social justice active engagement with the ethnic community: acknowledging the contextual factors that

impact on their wellbeing, highlighting discriminating practices and policies, and building indigenous forms of resilience.

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