Mental Health, Religion & Culture
Publication details, including instructions for authors and subscription information:
http://www.tandfonline.com/loi/cmhr20

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Available online: 23 Feb 2011

To cite this article: Aneela Pilkington, Rachel Maria Msetfi & Ruth Watson (2011): Factors affecting intention to access psychological services amongst British Muslims of South Asian origin, Mental Health, Religion & Culture, DOI:10.1080/13674676.2010.545947

To link to this article: http://dx.doi.org/10.1080/13674676.2010.545947

Mental Health, Religion & Culture
2011, 1–22, iFirst

Factors affecting intention to access psychological services amongst British Muslims of South Asian origin

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(*Received 14 August 2010; final version received 4 December 2010*)

The aim of this study was to examine factors that affect intention to access psychological services in a sample of British Muslims of South Asian origin. It was hypothesised that the level of shame/izzat associated with mental health would predict intention to access services when controlling for other, more established, predictors. Ninety-four participants were recruited from community UK centres and online sources. Results indicated that shame/izzat and biological beliefs predicted lesser intent to access psychological services, whereas higher levels of acculturation and education predicted greater intention. Further analyses suggested differences between people that had migrated to Britain and those born in the United Kingdom. Higher education levels predicted greater intention for all participants. However, shame/izzat and duration of habitation in Britain were significant predictors for migrant participants, whereas acculturation predicted intent for those that were born in the country. Clinical implications and suggestions for future research are discussed.

Keywords: psychological services; intention; acculturation; shame; izzat

Over the past few decades, there has been an increase in research into the mental health of ethnic minority groups, and in particular, South Asian populations. This is largely due to the increasing number of people from this group living in the United Kingdom and other western countries. Demographic data for South Asians, and particularly South Asian Muslims, indicate that they are less likely than both the general population and other ethnic minority groups to access mental health services (Sheikh & Furnham, 2000). Contradictory explanations for this can be found within the literature. Initial research suggested that this population experiences better psychological well-being and therefore do not need to access services (Cochrane & Stopes-Roe, 1977; Nazroo, 1997). However, more recent studies found that South Asian populations, particularly women, have an elevated risk of psychological morbidity (Fazil & Cochrane, 2003; Sonuga-Barke & Mistry, 2000). Interest in this topic has been stimulated even further by government initiatives in which the mental health needs of minority ethnic groups in Britain are highlighted as a priority in the provision of appropriate mental health services (Department of Health, 2005).

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ISSN 1367–4676 print/ISSN 1469–9737 online

DOI: 10.1080/13674676.2010.545947
http://www.informaworld.com

Given this government focus on equality in mental health services and suggestions that this population may have high levels of mental health difficulties but do not access psychological services, the aim of this study is to further facilitate our understanding of why South Asians may not access support for such difficulties. Factors will be examined that predict intention to access psychological help using a theoretical framework often applied to health-related behaviours. The focus will be on one religious group, Muslims of South Asian origin, as it is this population that appears to be least likely to access formal psychological services. Furthermore, Anand and Cochrane (2005) concluded that demographic variability due to religion and the intra-group diversity within South Asians may limit our understanding of mental illness within this population. Cinnirella and Loewenthal (1999) also identified the need to conduct research that examines different religious group beliefs in addition to ethnic groups.

Theoretical framework

Research indicates that intention to access psychological services can significantly affect decisions to seek out such services if symptoms of mental health problems occur (Ajzen, 1988; Leong, Wagner, & Tata, 1995). Previous research into this area has been exploratory and mainly atheoretical (e.g., Diala et al., 2001; Mojtabai, 2007) and has been criticised for not using theory-based models of attitudes towards accessing mental health services (Phoenix & Winnie, 2009). Two fundamental conceptual frameworks relate intention to actual behaviour in this domain and these will be discussed here.

Firstly, the health service utilisation framework (Anderson, 1995; Anderson & Newman, 1973) has commonly been employed as a guiding theoretical model. This framework suggests that there are two factors that will influence the use of health services: the environment and the population characteristics will determine health service use and, subsequently, health outcomes. Population characteristics include predisposing factors, enabling resources and need (evaluated and perceived). Within the predisposing factors are demographics, social structure and health beliefs, and it is in this health beliefs section that attitudes are mentioned. However, the model has been criticised when utilised in research looking at the role of attitudes for being overly general, as attitudes are mentioned as one of a variety of factors hypothesised to affect service use (Mackenzie, Knox, Gekoski, & Macaulay, 2004). In particular, this framework does not allow for the possibility of exploring the complexity of attitudes and the different factors that may impact upon an individual's attitudes towards performing a particular behaviour.

The second framework was developed with the sole purpose of predicting behaviour, and health-related behaviour in particular. Fishbein and Ajzen's (1975) theory of reasoned action (TRA) proposes that specific behaviours are influenced by the individual's intent to perform the behaviour. That intention is influenced by the individual's attitude towards performing the behaviour and by subjective norms about that behaviour, that is, a person's beliefs about what others think is appropriate. Therefore, within this framework, a causal chain is assumed, with attitudes and norms predicting behavioural intentions, which subsequently predict behaviour. The theory of planned behaviour (TPB: Ajzen, 1985) expanded upon TRA to include the concept of perceived behavioural control as it was theorised that attitudes and subjective norms are not enough to predict a behaviour if volitional control is perceived as low.

TPB would appear to be a helpful framework for studying the intention to access psychological services. The literature supports its use in terms of understanding a variety

of health behaviours (e.g., Albarracin, Johnson, Fishbein, & Muellerleile, 2001). Moreover, TPB has been applied to accessing mental health services in the general population (Mackenzie, Gekoski, & Knox, 2006) and one study has applied TPB to help-seeking for mental health problems amongst Chinese populations (Phoenix & Winnie, 2009). Further support for the key principles of the TPB model was provided by a meta-analysis (Armitage & Conner, 2001), which looked at the effectiveness of this theory in predicting health behaviour. It was found that in 185 studies, the TPB framework accounted for 39% and 27% of the variance in intention and behaviour, respectively. It was also suggested that TPB is particularly helpful for cultural research.

Ajzen (1985) purported that TPB was a culturally appropriate model for a number of different reasons. Firstly, the model is well suited to studying diverse and multicultural populations, as attitudes and subjective norms can vary depending on both the behaviour and the population group being studied. Furthermore, the additional construct of perceived behavioural control in TPB may make it more applicable to different cultures. For example, religion or culture may prohibit a behaviour despite the presence of attitudes and subjective norms that may promote that behaviour. Moreover, non-Western collectivist cultures place a greater emphasis on group needs and the welfare and integrity of the family supersedes individual needs (Das & Kemp, 1997). Therefore, the construct of perceived behavioural control may again be a relevant framework for cultures where behaviours are influenced by such external factors. Although the cross-cultural relevance of this model has been supported (Hagger et al., 2007; Phoenix & Winnie, 2009; Walker, Courneya, & Deng, 2006), the model has not been previously been used within Muslim or South Asian populations in this particular domain.

Factors influencing attitudes towards accessing psychological services

This study will focus on the beginning of the TPB causal chain, examining the factors that affect intention to access psychological services, but not actual behaviour. The TPB model itself suggests that a number of variables affect attitudes, subjective norms and perceived behavioural control, which in turn affect intention to access services. However, although TPB may be applicable to different cultures, the relative contribution of each construct may vary across cultures (Hagger et al., 2007; Walker et al., 2006).

Such variability is often linked to differences in individualism and collectivism between cultures (e.g., Oyserman, Coon, & Kemmelmeier, 2002). South Asian cultures are less individualistic and more collectivist than Westernised societies. As previously mentioned, more emphasis is placed on social relationships rather than the "self" (Das & Kemp, 1997). This differs from individualistic Western cultures, where the rights of the individual and personal goals are emphasised and independence and autonomy are promoted (Phinney, Madden, & Ong, 2000). For South Asian populations, key factors have been identified that may influence these different areas, including beliefs about the cause of mental health problems such as biological/social-environmental views and religious beliefs, acculturation and shame/izzat. These will be discussed in turn.

Beliefs about the cause of mental health problems

Research indicates that beliefs about the cause of mental health problems will affect how mental health services are viewed and the likelihood of seeking help (Hill & Bale, 1980). Moreover, there is considerable evidence to suggest that explanatory models of illness differ profoundly across cultures, which subsequently affects the type of help that is sought

for a particular illness (Lynch & Medin, 2006). Explanatory frameworks are the sets of assumptions that an individual holds about the causes of particular phenomena. An individual may not consider explanations that are inconsistent with a preferred explanatory framework. Therefore, models of illness related to mental health can impact both upon intention to access psychological help and subsequent service utilisation. Within the TPB framework, beliefs about the cause of mental health difficulties could affect attitudes, and in turn intentions towards accessing psychological services.

It has been suggested that South Asian people tend to use an explanatory model involving the somatisation of symptoms (Tabassum, Macaskill, & Ahmad, 2000). In particular, it was found that this population are more likely than other ethnic minority groups to believe there is a biological/medical reason for their difficulties, and so report somatic complaints rather than obtaining professional psychological help. Therefore, if it is believed that medication is the only way to resolve mental health problems, behaviours to manage such difficulties will be different to individuals that adhere to more psychological models.

In addition, religion can influence the likelihood of accessing psychological services, which can also be understood in relation to explanatory models of illness. For example, it is common for Muslims to believe that mental illness is caused by Allah (God), either as a punishment for sins or a test of their faith (Al-Krenawi, Graham, & Kandah, 2000). This belief implies that individuals are more likely to use prayer as a coping mechanism, or utilise more informal resources, such as cultural and traditional healing methods (Hussain & Cochrane, 2003). Sheikh and Furnham (2000) found religion to be a significant predictor of attitudes towards help-seeking in South Asian populations. Furthermore, they found that Muslims in particular were not likely to access psychological services, with low levels of religious affiliation predicting positive attitudes to accessing services in this group. Cinnirella and Loewenthal (1999) also found that Muslims utilised religion as a coping mechanism for mental health difficulties. Thus, religious beliefs may affect explanatory models for mental health difficulties and subsequent support services that will accessed.

Acculturation

Acculturation refers to the degree to which ethnic minority individuals adapt to the dominant culture and the associated changes in their beliefs, values and behaviours that result from contact with the new culture (Berry, Trimble, & Olmedo, 1986). The influence of acculturation on intention to seek psychological support has been well documented in the literature (Kim & Omizo, 2003; Zhang & Dixon, 2003). With particular reference to South Asian samples, it has been observed that individuals are less likely to seek assistance for emotional and psychological problems if they have lower levels of acculturation (Kim & Omizo, 2003; Zhang & Dixon, 2003).

Within the TPB framework, the effect of acculturation on accessing services appears to be linked to attitudes towards a behaviour. One potential explanation is that South Asian migrant groups hold different beliefs about mental health compared to individuals born in Westernised countries. To support this, Erickson and Al-Timimi (2002) argued that one barrier to seeking psychological services for Muslims is the difference in approaches to treatment of mental illness between South Asian and Westernised countries. If this is the case, fundamental differences between the culture of origin and the culture of the host society in response to mental illness may influence the likelihood of accessing services.

The TPB framework might also suggest that higher levels of acculturation relate to a higher degree of perceived behavioural control, which is subsequently linked to factors such as language skills and familiarity with services (Ajzen, 1985). Research focusing on Muslim populations has indeed observed that these factors predict intent to seek mental health services (Al-Krenawi, 2002; Savaya, 1998).

Shame/izzat

Historically, mental illness has evoked negative responses in most cultures (Hong, 1997), which has subsequently led to high levels of stigma attached to mental health difficulties. This social stigma has been found to act as a major barrier to accessing psychological services (Gilbert, 2000). Recent qualitative research has highlighted the importance of shame and stigma in seeking mental health services within South Asian populations specifically (Gilbert, Gilbert, & Sanghera, 2004). Amongst this group, shame is related to "izzat," a term that is used to describe a complex set of rules that must be adhered to in order to protect family honour and maintain position within the community. Within the TPB framework, izzat appears to be related to subjective norms, as intention towards seeking psychological support will be affected by an individual's beliefs about what other people think is appropriate.

The role of izzat in affecting intention to access mental health services for South Asian populations has been identified qualitatively in a number of studies (Anand & Cochrane, 2005; Chew-Graham, Bashir, Chantler, Burman, & Batsleer, 2002; Gilbert et al., 2004). Furthermore, Al-Subaie and Alhamad (2000) claimed that Muslims often deny the existence of mental health problems because they think this may bring shame upon their families as well as affect their individual status within the community. Shame and izzat are therefore important constructs to explore when studying the intention to seek psychological help amongst South Asian Muslims.

Summary and aims

Although recent UK National Health Service frameworks have highlighted the importance of meeting the psychological needs of ethnic minority groups, fewer South Asians, and particularly South Asian Muslims, tend to seek psychological help than the general population. One way of studying help-seeking is by measuring intentions to access psychological services, as this has been found to significantly predict decisions to seek out such services when symptoms of mental health problems occur (Ajzen, 1988; Leong et al., 1995).

The present study will examine South Asian British Muslim's intention to access psychological services. A number of culturally and theoretically relevant variables in relation to accessing psychological services will be examined, particularly the role of shame/izzat. This has been identified in qualitative studies as a factor that may affect help-seeking. However, there have not been any quantitative studies assessing the influence of izzat in relation to other factors. It is hypothesised here that levels of izzat will be a significant predictor of intention to access psychological help when controlling for other factors that have been shown to predict the likelihood of seeking psychological services (demographic characteristics, levels of acculturation, levels of religiosity and biological/social-environmental beliefs about mental health problems).

Method

Procedure

Recruitment took place in three formats following ethical approval given by the researcher's university Ethics Committee. Firstly, seven Islamic community centres were contacted. The researcher attended the centres on agreed days to discuss the research with potential participants. Posters advertising the study were also displayed at each of the centres. Secondly, email adverts were sent to all students at a North West UK university, which contained a brief outline of the purpose and nature of the study. Finally, 15 special interest groups for Muslims were contacted through social networking sites. Administrators for each group gave permission for the study to be advertised. All potential participants were given the option of requesting hard copies of the questionnaires and posting them back to the researcher, or visiting a website to complete the questionnaires online. The hard copies included a consent form, an information sheet and the questionnaires, complete with a stamped addressed envelope. For the online questionnaires, the first page that was accessed was the information sheet and if participants agreed to take part in the research, they were then directed to a consent form and continued with the questionnaires online. Assistance with completion of the questionnaires was available to all participants throughout their completion process. However, no participants contacted the researcher for further details or assistance.

In all forms of recruitment, participation was anonymous and consent was provided via a tick-box consent form. As the questionnaires were self-administered, it was assumed that participants had an adequate understanding of the English language. It is noted that this potentially could have affected the nature of the sample. However, given the scope of this research and because some of the questionnaires had not been previously translated, it was not possible to make the questionnaires available in other languages.

In total, 600 paper questionnaire packs were distributed to the community centres. Sixty-two were fully completed and returned (a 10% response rate). For the online recruitment, 45 individuals started the questionnaires online, 32 of which were fully completed. However, accurate response rates are difficult to establish as it is not possible to ascertain the exact numbers of individuals exposed to the advertisements.

Measures

All measures were administered in English as some of the questionnaires used in this study had not previously been translated into South Asian languages. Given the scope of this research project, it was not possible to conduct validation studies to translate the measures.

Measure of intention to seek psychological help

This was measured using the *Inventory of Attitudes Toward Seeking Mental Health Services* (*IASMHS*: Mackenzie et al., 2004). The complete IASMHS is a 24-item measure, with each item rated on a five-point scale (0 = disagree to 4 = agree). The items are combined to give scores on three factors; psychological openness, help-seeking propensity and indifference to stigma. However, the third factor, indifference to stigma, measured similar constructs as the predictor variable, "izzat," so was not included in this study. Therefore, the version of the IASMHS used here consisted of 16 items, measuring psychological openness (e.g., "There are certain problems which should not be discussed outside of one's immediate family") and help-seeking propensity (e.g., "I would willingly confide intimate

matters to an appropriate person if I thought it might help me or a member of my family''). Higher scores reflect more positive attitudes towards accessing psychological services, with potential scores ranging between 0 and 64.

In relation to the TPB model, the questions within the IASMHS measure all three constructs deemed to predict intention to accessing psychological services; attitudes, subjective norms and perceived behavioural control. The overall score represents an individual's intention to access services should symptoms of mental health problems occur.

Previous studies (Mackenzie et al., 2004) have reported strong internal consistencies for the IASMHS and each subscale; psychological openness (0.82), help-seeking propensity (0.76) and overall IASMHS (0.87). In this study, the internal consistency was calculated to be 0.77, 0.67 and 0.78 for the total IASMHS, psychological openness and help-seeking propensity, respectively.

Measure of izzat

This was measured using the *Attitudes Towards Mental Health Scale (ATMHP*: Gilbert et al., 2007). This is a 35-item self-report measure and is rated on a four-point scale (0 = do not agree to 3 = completely agree). The subscales within this measure include; external shame (beliefs that others will look down on someone with mental health problems), internal shame (related to negative self-evaluations) and reflected shame (believing that one can bring shame to family/community). Higher scores reflect higher levels of shame/izzat in relation to mental health difficulties, with potential scores ranging between 0 and 105. This measure was selected as it has been normed on South Asian samples and is the only measure that looks at the construct of izzat (Gilbert et al., 2007). All of the subscales, when normed on South Asian populations, had good Cronbach's alpha of between 0.85 and 0.97 (Gilbert et al., 2007). Similar values of Cronbach's alpha were calculated in the present study (between 0.90 and 0.96).

Measure of acculturation

Acculturation was measured using a scale designed by Palmer et al. (2007). This is a 17-item questionnaire looking at three subscales; behaviours suggesting greater acculturation to the host community (e.g., use of the English language), attitudes indicative of greater or lesser acculturation (e.g., feelings of acceptance) and behaviours associated with society of origin (e.g., use of Asian media). This measure was selected as it examines acculturation as a multidimensional construct (Berry, 1980). Furthermore, the measure has been specifically designed and validated on South Asian populations in Britain.

The reliability coefficients using Cronbach's alpha for the three scales have been previously reported as 0.93, 0.75 and 0.72, respectively (Palmer et al., 2007). In the present study, acceptable Cronbach's alpha were revealed for the individual subscales; 0.60 for behaviours suggesting greater acculturation in the host community, 0.66 for attitudes indicative of greater or lesser acculturation and 0.66 for behaviours associated with society of origin. However, in the current analysis, one question, ''Do you see your future as secure?'', was removed from this measure. This was due to a concern whether the question was measuring the construct of attitudes indicative of greater or lesser acculturation to the host society. The internal consistency of the overall acculturation scale was 0.565 when this question was included and 0.619 when it was removed. The measure used in this study yielded potential scores of between 0 and 27 with higher scores reflecting higher levels of acculturation.

Measure of biological/social-environmental beliefs about the cause of mental health problems

This was measured using the *Mental Health Locus of Origin Scale* (*MHLO:* Hill & Bale, 1980). The MHLO is a questionnaire examining beliefs about aetiology of maladaptive behaviours. At one end lies beliefs about genetic and physiological factors and the other end consists of beliefs that focus on interactions between an individual and the environment. Thus, high scores are indicative of endogenous beliefs and low scores indicate interactional beliefs about the cause of mental health problems. It is a 20-item self-report measure and is rated on a seven-point scale (1 = strongly disagree and 6 = strongly agree).

The reported reliability coefficient for this scale was 0.76 (Hill & Bale, 1980). However, within this study, three questions from the MHLO were excluded in the analysis as they had an item-to-total score correlation of less than 0.2 as reported in the validation study by Hill and Bale (1980). The present study revealed acceptable Cronbach's alpha of 0.60. The range of scores for the measure utilised in this study were between 17 and 102.

Measure of religious belief

The strength of religious belief was measured using the *Moslem Attitude Towards Religion Scale* (*MARS*; Wilde & Joseph, 1997). This is a 14-item self-report measure and is rated on a five-point scale (1 = strongly disagree and 5 = strongly agree), with a potential range of scores between 14 and 70. This measure examines strength of faith in Muslims. Internal reliability using Cronbach's alpha was reported as 0.93 (Ghorbani, Watson, Ghramaleki, Morris, & Hood, 2000). A similar value of 0.96 was observed in the present study.

Demographics

Additional demographic information was collected. Gender and previous contact with services were treated as categorical variables. Age, years in Britain, country of origin, occupation, education and branch of Islam were categorised accordingly.

Analytic strategy

An initial power calculation indicated that a regression analysis including six predictor variables would require a sample size of 97 participants to achieve a power of 0.8 with a medium effect size of 0.15 (f^2: Cohen, 1992). Missing data replacement was performed in line with recommendations from the literature (e.g., Afifi & Elashoff, 1966). For the postal questionnaires, data were missing on 11 items (between 1% and 2%). These were replaced with the mean of all the values in that variable. There were no missing data for questionnaires completed online as this format enabled a "forced response," whereby questionnaires could not be submitted with missing data points.

The Shapiro-Wilk test was used to check distributional assumptions and the majority of variables were found to be normally distributed. However, the distribution of MARS scores, which examines levels of religiosity, was negatively skewed. Standard transformations were applied (e.g., square root, log, etc.), but the measure still did not approximate normality. Following guidance provided in the literature (Lumley, Diehr, Emerson, & Chen, 2002) suggesting that regression models can be used reliably with non-normally distributed data, the raw data were used in this analysis. Variables were also checked for multicollinearity, but there was no evidence that multicollinearity was present.

A hierarchical block-wise multiple regression analysis was performed to establish which variables significantly predicted intention to access psychological services. Demographic variables looking at age and educational levels were entered first as research indicates that these factors are important in predicting help-seeking behaviours (Zhang & Dixon, 2003). Research also indicates that levels of religiosity (Sheikh & Furnham, 2000), levels of acculturation (Kim & Omizo, 2001) and biological/social-environmental beliefs about the cause of mental health difficulties (Tabassum et al., 2000) are further factors that predict help-seeking in Muslim and South Asian populations, so these variables were entered into the second block of the regression. The hypothesised relationship between seeking psychological help and levels of shame/izzat related to mental health is exploratory, so this was entered into the regression model last to allow stringent assessment of the additional contribution to the variance. Finally, a further two regression analyses were performed, examining the relationship between the predictor and outcome variables for individuals that were born in Britain and those that had migrated to the country.

Results

This study examined variables that predicted intention to access psychological services. For all analyses, alpha levels of 0.05 were used unless otherwise stated.

Participants

Inclusion criteria for this study were that participants should be male or female who: (a) were over the age of 18, (b) identified themselves as Muslims, (c) were of South Asian origin. The final sample, summarised in Table 1, consisted of 48 women (51.1%) and 46 men (48.9%). The mean age of participants was 31.0 years ($SD = 10.3$). Participants were significantly more likely to be born in Britain ($n = 61$) than have migrated to the country ($n = 33$), χ^2 (1, $N = 94$) = 8.34, $p = 0.004$. Females were more likely to complete postal questionnaires than males, whilst more males completed the measures online, χ^2 (1, $N = 94$) = 3.57, $p = 0.059$. Online participants tended to be younger ($M = 26.9$, $SD = 5.6$) than participants recruited through community centres ($M = 33.1$, $SD = 11.5$) and this difference was significant, $t(90) = 2.890$, $p = 0.005$, 2-tailed.

In comparison to the general population of Muslims in Britain, measured using the 2001 census data (Office for National Statistics, 2001), this sample was more educated and more likely to be born in the United Kingdom. It was also reported in the census that Muslims in Britain were predominantly from Pakistan, which was also seen in our sample, although this was higher in our study.

Independent *t*-tests showed that there were no significant differences between males and females on both the outcome and predictor variables. The only measure that was significantly different between the community and online sample was acculturation. Significant differences were found in the sample between participants who had migrated to Britain and those that had lived in Britain all their life on a number of different measures; shame/izzat, biological/social-environmental beliefs about the cause of mental health difficulties and acculturation. Table 2 summarises the results of the *t*-tests.

Participants generally reported moderate intent to seek psychological services ($M = 32.4$, $SD = 9.6$, range = 0–64), moderate levels of shame/izzat ($M = 45.0$, $SD = 22.5$, range = 0–105) and no extreme views of biological or social beliefs about the

Table 1. Descriptive characteristics of the sample.

		Online sample (*n*)	Community sample (*n*)	Total (*N*)
Total number of participants (*N*)		32	62	94
Gender	Female	12	36	48
	Male	20	26	46
Age (years)	Mean (*SD*)	26.9 (5.6)	33.1 (11.5)	31.0 (10.3)
Country of origin	Pakistan	27	55	82
	India	1	4	5
	Bangladesh	3	1	4
	Other	1	1	2
Previous contact with services	Yes	2	8	10
	No	30	54	84
Occupation	Unemployed	1	3	4
	Retired	0	3	3
	Housewife	2	8	10
	Healthcare	12	7	19
	Finance	1	4	5
	Law	1	3	4
	Sales	1	2	3
	Business	3	10	13
	Civil service	2	5	7
	Teaching	1	10	11
	Student	7	6	13
Education	Left school before GCSE's/ O Levels (or equivalent)	3	6	9
	GCSE/GNVQ/O Levels (or equivalent)	1	8	9
	A Levels/AS Levels (or equivalent)	3	11	14
	Undergraduate degree (or equivalent)	17	16	33
	Postgraduate qualification (or equivalent)	8	21	29
Year in Britain	Born in Britain	20	41	61
	0–10	1	3	4
	11–20	4	4	8
	21–30	7	9	16
	31–40	0	3	3
	40+	0	2	2

Note: Values are frequencies unless otherwise stated.

cause of mental health difficulties ($M = 56.3$, $SD = 9.3$, range = 17–102). As might have been expected, high levels of religiosity ($M = 59.7$, $SD = 12.4$, range = 14–70) and of acculturation ($M = 18.0$, $SD = 3.2$, range = 0–27) were reported.

Correlational analyses

Correlational analyses were conducted to examine the degree and direction of the individual relationships between the predictor variables and between these variables and

Table 2. Mean scores and standard deviations (SD) and significance levels for differences within the sample.

	Gender					Years in Britain					Sample				
	Male ($n=46$)		Female ($n=48$)			All life ($n=61$)		Migrated to Britain ($n=33$)			Online ($n=32$)		Postal ($n=62$)		
	M	*SD*	*M*	*SD*	*p*	*M*	SD	*M*	SD	*p*	*M*	*SD*	*M*	*SD*	*p*
Intention to access services	31.4	9.9	33.4	9.3	0.316	33.6	8.1	30.1	11.6	0.125	31.4	9.2	32.9	9.8	0.493
Shame/Izzat	44.4	24.1	45.7	21.2	0.784	39.2	20.4	55.7	20.9	0.001	59.7	12.8	59.7	12.2	0.372
Religiosity	60.8	11.3	58.7	13.3	0.431	58.2	12.0	62.5	12.8	0.106	54.8	9.4	57.1	9.2	0.987
Cause of mental health difficulties	55.6	9.3	57.0	9.2	0.449	54.3	8.2	60.0	10.1	0.004	16.8	2.0	18.6	3.5	0.256
Acculturation	17.4	2.9	18.6	3.4	0.079	18.7	3.0	16.7	3.0	0.002	42.1	24.0	46.5	21.8	0.002

Note: For all comparisons $df=92$.

Table 3. Correlation coefficients for the relationships between predictor and outcome variables.

		1	2	3	4	5	6	7
1	Intention to access services							
2	Religiosity	0.085						
3	Cause of mental health difficulties	−0.361*	0.057					
4	Acculturation	0.403*	−0.136	−0.155				
5	Shame/izzat	−0.383*	−0.132	0.126	−0.296			
6	Age	−0.043	0.226	0.337*	−2.740	0.306		
7	Education	0.374*	−0.058	−0.277	0.248	−0.349*	−0.117	

Note: *$p < 0.002$.
For age $df = 92$; for all other measures $df = 94$.
Pearson's correlations used for all variables except education where Spearman's correlations were used as data within this variable was measured at ordinal level.

the outcome variable. The alpha levels for each individual test was adjusted to 0.002 to account for the multiple correlations (where $\alpha = 0.05/21 = 0.002$). Despite this conservative rejection criterion, a number of significant correlations between the variables were observed, as can be seen in Table 3. Age was positively correlated with biological/social-environmental beliefs about the cause of mental health difficulties, $p = 0.001$, indicating that the older a person is, the more likely they are to have biological-based beliefs about the cause of mental health difficulties. Education was negatively correlated with shame/izzat, $p = 0.001$, suggesting that lower levels of education are related to higher levels of shame/izzat regarding mental illness.

The only predictor variables that were not significantly correlated with the outcome variable were age and level of religiosity. Education, $p < 0.001$, and acculturation, $p < 0.001$, were positively related, indicating that greater intention to access services is correlated with higher levels of acculturation and education. Negative correlations were observed between the outcome variable and biological/social-environmental beliefs about the cause of mental health difficulties, $p < 0.001$, and shame/izzat, $p < 0.001$, indicating that higher levels of shame and more biological beliefs about the cause of mental health are correlated with lesser intent to access services.

Hierarchical linear regressions

A hierarchical multiple regression analysis was carried out using a forward stepwise entry method.[1] Intention to access psychological services was the outcome variable. Age and level of education were entered as a first block in the hierarchical regression. The second block included the variables that have been found to predict intention to access psychological services in previous research; acculturation, religiosity and biological/social-environmental beliefs about the cause of mental health difficulties. The final block consisted of shame/izzat in relation to mental health problems.

The overall model was significant and accounted for 32% of the variance in intention to seek psychological services, $R^2_{adj} = 0.32$, $F(4, 87) = 11.91$, $p < 0.001$. The final model indicated that four variables were significant predictors (see Table 4). Levels of education accounted for 20% of the variance, $R^2_{adj} = 0.20$, $p < 0.001$, and the addition of acculturation increased the variance explained to 27%, $R^2_{adj} = 0.27$, $p = 0.003$. Both

Table 4. The unstandardised and standardised regression coefficients for the variables included in the overall model.

	B	SE B	β	p
Step 1				
Constant	19.63	2.77		<0.001
Level of education	3.45	0.71	0.46	<0.001
Step 2				
Constant	6.19	5.09		0.227
Level of education	2.79	0.71	0.37	<0.001
Acculturation	0.89	0.29	0.29	0.003
Step 3				
Constant	21.10	8.35		0.013
Level of education	2.23	0.74	0.29	0.003
Acculturation	0.86	0.28	0.28	0.003
Cause of mental health difficulties	−0.22	0.10	−0.21	0.029
Step 4				
Constant	29.09	9.07		0.002
Level of education	1.73	0.77	0.23	0.027
Acculturation	0.75	0.28	0.25	0.009
Cause of mental health difficulties	−0.23	0.10	−0.21	0.023
Shame/izzat	−0.08	0.04	−0.20	0.043

Note: Dependent variable is intention to access services.

education and acculturation were positively related to intention to access psychological services. The other two significant predictors were biological/social-environmental beliefs about the cause of mental health difficulties, $R^2_{adj} = 0.30$, $p = 0.029$, and shame/izzat, $R^2_{adj} = 0.32$, $p = 0.043$. Both variables were negatively related to intention, suggesting that biological beliefs about the cause of mental health difficulties and higher levels of shame/izzat predict less intent to access psychological services. Level of religiosity and age were not significant predictors.

It became clear, however, from the differences in scores on the measures shown in Table 2, that there were two distinct groups within this sample – those that had migrated to Britain during their lifetime ($n = 33$) and those that had been born and lived in the United Kingdom all their lives ($n = 61$). Despite the power issues involved in splitting the sample, it was important to check whether the overall model held for these distinct groups and two further hierarchical regressions were carried out. The number of years in Britain was only included as a predictor variable in the analysis for the migrant group. The alpha level for each regression was decreased to 0.025 to ensure that the overall alpha level remained at 0.05.

Results of the two regression analyses are presented in Table 5. Both overall models were significant, for migrant individuals, $R^2_{adj} = 0.48$, $F(3, 28) = 10.42$, $p < 0.001$, and those who had lived in Britain all their lives, $R^2_{adj} = 0.18$, $F(2, 57) = 7.40$, $p = 0.001$. Education was a significant predictor of intention to access psychological services in both groups, $R^2_{adj} = 0.23$, $p = 0.004$ (migrant individuals), $R^2_{adj} = 0.10$, $p = 0.009$ (individuals born in Britain), with higher levels of education related to greater intent. However, interestingly, the additional predictors within each model were different for both groups.

For migrant individuals, the number of years they had lived in Britain was related to intention, $R^2_{adj} = 0.36$, $p = 0.011$, indicating greater intent for people that had spent more years in Britain. Shame/izzat was also a significant predictor of intention in the migrant

Table 5. The unstandardised and standardised regression coefficients for the variables included in the model for individuals that were born in Britain and those that had migrated to Britain.

	B	*SE B*	*β*	*p*
Migrated to Britain				
Step 1				
Constant	18.50	4.02		<0.001
Level of education	3.60	1.14	0.50	0.004
Step 2				
Constant	4.49	6.30		0.481
Level of education	4.82	1.12	0.67	<0.001
Years in Britain	4.21	1.54	0.43	0.011
Step 3				
Constant	18.95	7.81		0.022
Level of education	3.80	1.09	0.53	0.002
Years in Britain	4.56	1.40	0.46	0.003
Shame/izzat	−0.22	0.08	−0.39	0.011
Lived in Britain all of life				
Step 1				
Constant	22.18	4.36		<0.001
Level of education	2.90	1.07	0.33	0.009
Step 2				
Constant	7.17	7.11		0.318
Level of education	2.76	1.02	0.32	0.009
Acculturation	0.83	0.32	0.31	0.012

Note: Dependent variable is intention to access services.

group, $R^2_{adj} = 0.48$, $p = 0.011$, although this had a negative relationship, suggesting higher levels of shame/izzat predict lesser intention. However, for individuals that had lived in Britain all their life, only acculturation was a significant predictor, $R^2_{adj} = 0.18$, $p = 0.012$, and was positively related to intent, indicating that increased acculturation for British-born Muslims predicts greater intention to seek help for mental health difficulties. Age, biological/social-environmental beliefs about the cause of mental health difficulties and levels of religiosity were not significant predictors in either model.

Discussion

This study examined factors that were associated with intention to seek help for mental health difficulties in Muslims of South Asian origin. It was hypothesised that shame/izzat would explain additional variance in the intention to access psychological services over and above that explained by other, already established, predictors of intention (biological/social-environmental beliefs about the cause of mental health difficulties, levels of religiosity, levels of acculturation and demographic variables). Taking the sample as a whole, as might have been expected, education and acculturation were positively related to intention, whereas biological beliefs about the causes of mental health difficulties and shame/izzat were negatively related. However, when data from migrant individuals and those who were born in Britain were examined separately, the picture was somewhat different. Education was a significant predictor in both analyses. However, acculturation

was only a key predictor of intention in the British-born sample, whereas shame/izzat was an important negative predictor in the migrant sample. Therefore although overall findings supported the hypothesis, closer examination suggested that the relationship between acculturation, izzat and intention was more complex than originally expected and depended on whether participants had migrated to, or were born in, the host country.

One finding of this study is that higher levels of shame and izzat are related to lesser intention to access help for mental health difficulties. Izzat, which is related to family honour, had not previously been examined quantitatively in relation to the impact this has on intentions, although qualitative studies had identified it as one of the major barriers to accessing services (Anand & Cochrane, 2005; Chew-Graham et al., 2002; Gilbert et al., 2004). One explanation for the role of izzat in predicting intention may be the collectivist nature of South Asian populations. Within such cultures, group needs are placed before personal needs and individuals are expected to make sacrifices on behalf of the group (Das & Kemp, 1997). Furthermore, South Asians tend to be allocentric, that is, the self and family are integral rather than separate concepts. Therefore, the role of family honour in decision-making processes fits with the cultural beliefs of South Asian populations.

Interestingly, in the separate regressions, shame/izzat was only a significant predictor for individuals that had migrated to Britain, although these results must be interpreted with caution given the small number of participants in each group. Moreover, people who had migrated to Britain produced significantly higher scores on the measure of shame/izzat than those who were born in the country. One possible explanation for this may be that there are fundamental differences in relation to conceptualisations of mental health difficulties between South Asian countries and Britain. As previously mentioned, individuals who have migrated from South Asian countries hold different beliefs about mental health compared to individuals in Westernised countries in relation to causes and beliefs about treatment. In particular, one popular explanatory model within these cultures is that mental illness is a punishment for sins (Al-Krenawi, 2002), which may explain why there are higher levels of shame associated with mental illness for individuals that have migrated to Britain.

Of the other predictor variables, biological/social-environmental beliefs about the cause of mental health difficulties, levels of acculturation and education were associated with intention to access psychological services. This is consistent with previous research indicating that these factors are important in mental health service use (Lynch & Medin, 2006). The negative association between beliefs about the cause of mental health difficulties and intention to access psychological services indicates that people holding more biological-based beliefs about the cause of mental health difficulties are less likely to access psychological services. Explanatory models of illness would explain this relationship, as help-seeking behaviours will differ dependant on beliefs about causes (Tabassum et al., 2000). Therefore, this finding lends further support to previous research into this area. A useful resource for understanding the relationship between causal factors of mental health and seeking support are studies that have been conducted in South Asian countries (e.g., Suhail & Ajmal, 2009).

Both education and acculturation were positively related to intention, indicating that higher levels of education and acculturation tend to predict greater intent to access services. Education was a significant predictor of intention in both the overall regression analysis and in the group analyses. Suhail (2005) found that education was also related to mental health literacy in a study conducted in Pakistan. Therefore, this may indicate that education is important in relation to understanding mental health across all cultures and transcends whether individuals have migrated or stayed in their country of origin.

Acculturation predicted intention overall and in individuals that were born in Britain but not migrant people. These factors may be related to higher levels of education occurring in more acculturated populations (Hazuda, Haffner, Stern, & Eifler, 1988). This again supports previous research that more acculturated and educated people choose to access psychological services (Kim & Omizo, 2003; Zhang & Dixon, 2003). The sample demographics in the present study indicate that more individuals were born in Britain and therefore, are more likely to have been educated in Britain. Furthermore, the overall sample was more educated when compared to the general population of Muslims in Britain. Subsequently, the relationship with education and acculturation may be explained by more understanding of and familiarity with Westernised belief systems surrounding mental health.

Levels of religiosity were not found to be a significant predictor of intention. Interestingly, this variable was also not correlated with any of the predictor variables. Previous research would suggest that Muslims with high levels of religious beliefs would be more likely to access more traditional forms of support than formal psychological services (Hussain & Cochrane, 2003), with higher levels of religious affiliation predicting lesser intention. To understand the results from this study, it is important to consider the sample that was recruited. Participants were accessed through community centres for Muslim populations and online resources, which were set up for Muslims. Thus, a majority of the sample were likely to be religious and the negatively skewed distribution of scores on the measure of level of religiosity was consistent with this. Therefore, the recruitment method may have biased the sample such that there was little variability of the religiosity within the sample, which is why this was not a significant predictor.

In relation to the regressions analyses, a final, potentially important, consideration is the difference in variables that predicted intent between the overall sample and the separate samples of migrants and individuals born in Britain. As previously mentioned, the overall model indicated that biological/social-environmental beliefs about the cause of mental health difficulties, acculturation, education and shame/izzat-predicted intention. However, the separate models found that education and acculturation were significant predictors of attitudes for those who were born in Britain, whilst education and shame/izzat-predicted attitudes for those who had migrated. Interpreting these results is difficult, given the reduced power of the two separate regression analyses. However, this may suggest that intention is moderated by factors such as migration.

This study utilised only one component of the TPB model in relation to psychological service use; factors that affect intention. There has been some recent research looking at the applicability of this model for mental health service use (Mackenzie et al., 2006; Phoenix & Winnie, 2009), however, the framework, to date, has not been used within South Asian or Muslim populations for this purpose. Therefore, although the model has considerable explanatory power, only one aspect of the model has been examined in this study. The results support the idea that there are a number of different factors, which will affect intention towards performing a particular behaviour, which in this study is the use of psychological services.

Limitations and future research

Although the results reported include significant findings, there are some limitations that must be acknowledged. In particular, it is important to examine the sampling methods used to determine whether this may have introduced possible biases to the study.

A questionnaire design was used and a 10% response rate was observed. Within any questionnaire design, it is important to consider response bias and the impact this has on the findings of the study. Research has found that low education is one of the key factors associated with nonresponse (Gannon, Northern, & Carrol, 1971; Robins, 1963). Higher levels of education were observed in this sample compared to the demographics of Muslim populations in the United Kingdom. Therefore, the recruitment methods may have introduced a bias and the results of this study may be more applicable to Muslims in Britain who have higher levels of education.

A further bias related to the design of the study is that the questionnaires were only available in the English language. It was not possible to offer the questionnaires in South Asian languages as the majority of the measures had not previously been translated and a validation study was not possible. This would suggest that the sample recruited were more likely to be educated and have higher levels of acculturation. Again, it is important to recognise that the results of this study may be more applicable to this group than to all South Asian Muslim populations.

Also related to the sample, two further factors are important to consider. The majority of data was collected through sites where we would expect individuals with high levels of religiosity, such as Muslim community centres and Islamic online groups. Therefore, the participants recruited were likely to have high levels of religiosity. Subsequently, the study may not have accessed individuals who identify themselves as Muslims but may be less religious. Furthermore, non-clinical samples were accessed and measures to examine mental health were not used in this study. This makes it difficult to extrapolate the results to Muslims with mental health difficulties.

Future research should validate measures in different languages, with a view to replicating this study using translated versions. Moreover, it would also be useful to extend the sample to include individuals that may not be literate and those that may not be likely to complete paper or online questionnaires. Random sampling methods could also be used to reduce the bias in the sample. Finally, research may benefit from looking at a range of clinical and non-clinical populations.

It would also be beneficial to use a more homogenous group to examine factors that may affect intention to access psychological services. This study attempted to address some of the previous limitations to conducting research into this field by examining intention in Muslim populations only, rather than South Asian samples as a whole, thus reducing the effect of intra-group diversity (Anand & Cochrane, 2005). Although it is difficult to draw conclusions due to small sample sizes, the results of this study indicate that there may be differences between Muslims based on their migrant status in relation to the intention to access psychological services.

This study used the TPB framework for understanding factors that affect attitudes towards the use of psychological services for Muslims. However, given the previous limited research into the applicability of this model for mental health services generally, and no research looking at intention to access services for Muslims, more research into this area is necessary to fully consider the validity of this framework in this domain. In relation to the TPB framework itself, one limitation is that only one part of the TPB model was tested, examining factors that influence intention. The complete TPB model hypothesises that, whilst subjective norms, attitudes and perceived behavioural control impact upon intention to access services, there is a final dimension of actual service use, that was not tested in this study. Future research would benefit from looking at all three dimensions of the TPB framework.

Although not explicitly examined in this study, a further area that has arisen is to consider definitions of mental health and the differences between Western and other cultures in relation to what is considered to be a mental illness. This study utilised Westernised instruments to look at intent to access psychological help and thus, the constructs of psychological difficulties are based on these cultural ideas. Given some of the results of this study, and in particular the importance of explanatory models of illness, it may be important to consider whether the measures that are designed within Westernised frameworks are actually applicable to other cultures. Therefore, a potential area for future research may be to consider the validity of such measures and whether there may be a need to develop new measures, incorporating cultural ideas of different groups to ensure that the concepts being examined are actually being captured.

Clinical implications

Given government initiatives (Department of Health, 2005) to improve mental health services for ethnic minority groups, the present study served as a step towards understanding intention to seek help for mental health problems amongst Muslim populations in Britain. Specifically, barriers to accessing psychological services have been identified and a theoretical framework that may facilitate understanding of help-seeking behaviours has been used for the first time with this population. These will be considered in more detail below.

The main clinical implications of this study's findings relate to the identification of barriers that may prevent individuals from accessing psychological services when symptoms of mental health problems occur. The role of family honour and societal stigma has a number of different implications. Firstly, initiatives to improve such services need to understand and work with the importance of such a barrier. Research has indicated that by normalising help-seeking behaviours and educating the general public in the effect that therapy can have on the treatment of mental health difficulties, attitudes towards accessing services can be improved (Shin & Lukens, 2002). Therefore, possible interventions such as psychoeducation and normalisation could be considered to try and reduce the stigma and shame associated with accessing formal psychological services. Secondly, there are implications for direct therapeutic work. If an individual does access services, despite high levels of shame/izzat, this is an area that could be addressed in therapy. In particular, recognising that this may be a difficulty, thus giving individuals permission to talk about potential stigma and validating concerns regarding this issue, may help with the therapeutic alliance and reduce rates of dropout.

Further to this, the results of this study indicate that explanatory models of illness are important in predicting intention to access services. In particular, having more biological beliefs about mental health will lead to more negative views towards psychological services. Interestingly, higher levels of education and acculturation have been found to predict greater intention to access services. This may be due to more familiarity with Westernised explanatory models of mental health. Therefore, a possible implication from the results of this study may be to further consider education about mental health for Muslim populations.

This study has also highlighted groups within Muslim populations in Britain who may be the hardest access in relation to psychological support. In particular, interventions to target individuals that have migrated, are older and do not have many formal qualifications may be pertinent. Furthermore, the differences between individuals who

have been born in Britain and those that have migrated may be understood by the disparity between Westernised and Eastern cultures in relation to understanding mental health. Collectivist cultures tend to focus on approaches such as patience and acceptance of mental ill health (Abudabbeh & Hays, 2006). Given the range of therapies that clinical psychologists are trained in, this could be considered within treatment options. In particular, it may be useful to consider therapeutic approaches consistent with a more collectivist lens on mental health, such as mindfulness (Segal, Williams, & Teasdale, 2002) and acceptance and commitment therapies (Hayes & Wilson, 2003), to support and acknowledge the different perspectives by clients from such cultures.

Conclusion

This study examined factors that influence intention to access psychological services for British Muslims of South Asian origin, using the TPB framework. Findings suggest that levels of shame/izzat surrounding mental health predict intention to access such services. Furthermore, biological/social-environmental beliefs about the cause of mental health difficulties, levels of acculturation and education were also found to predict psychological service use. Results indicated potential differences between people who had migrated to Britain and individuals that had been born in the country, suggesting that there may be a possible relationship between shame/izzat, intention and migration. Awareness of such factors provides important clinical implications for government policy, attempts to access ''harder to reach'' individuals and direct therapeutic work. However, given the exploratory nature of this study, future research is essential to further replicate and expand on these results, using theoretical frameworks such as TPB to gain a greater understanding of psychological service use.

Note

1. A forward entry method searches for the best predictor with the highest correlation to the outcome variable followed by the second highest predictor and continues to do this until all significant predictors are entered into the model. Predictors are only included if they improve the model significantly. The advantage of this is that only significant predictors are included in the final model. However, as such methods involve repeated statistical testing at each step of the regression, this brings the increased risk of error. Therefore, the regression was also completed using the forced entry method, which produced the same results as the forward method. In this method, all variables are entered simultaneously and remain in the model if they are significant or not. The results reported here were not dependent on entry method.

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