




**An exploratory study of facilitators and  
barriers to mental health  
help-seeking in Indian immigrant youth in  
Gauteng, South Africa**

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## **ABSTRACT**

It has been documented in international literature that Indian immigrants underutilise mental health services to a significant extent. The purpose of this study was to identify the facilitators and barriers which prevent or prompt mental health help-seeking among Indian immigrant youth in South Africa by evaluating their personal and lived experiences. To achieve this aim, a qualitative study was done adopting a phenomenological design, which allowed for an understanding of the lived experiences of Indian immigrant youth regarding mental health help-seeking. Nine participants were recruited through purposive sampling from Gauteng, and data collection was performed through online interviews that explored the participants' lived experiences. The data was analysed using thematic analysis. Five subthemes of facilitators were identified, namely, encouragement to seek help for mental health difficulties, social media and the mass media, university and school environments, availability and awareness of resources, and open conversations about mental health. Four subthemes of barriers were also identified, namely, the individual's perspectives on mental health, a lack of access to resources, parental factors that discourage help-seeking, and community factors that discourage help-seeking. It is hoped that an improved understanding of the barriers and facilitators will also allow other Indian immigrant youth to manage their help-seeking processes while increasing awareness about others in the community with similar experiences.

**Keywords:** Indian immigrants, help-seeking, mental health, youth, South Africa

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## PREFACE

The stipulated guidelines by the North-West University in the A-rules are adhered to within this mini-dissertation.

Section 2 (the presented article) will be submitted to the Journal of Psychology in Africa (JPA) for possible publishing.

This mini-dissertation complies with the guidelines established by the American Psychological Association (APA, 7th edition). Section 2 (the presented article) of this mini-dissertation was compiled according to the author guidelines specified by the JPA.

Chronological page numbering is followed, starting with Section 1 and ending with Appendix E.

A qualified language practitioner conducted the language editing of this mini-dissertation (see Appendix D).

Ethical Approval was obtained for this research study (see Appendix A).

The submission of this mini-dissertation for examination purposes (in fulfilment of the requirements for the master's degree in clinical psychology at the North-West University) was approved by the research supervisor, Prof. Choja Oduaran.

This mini-dissertation was submitted to Turn-it-in (similarity index 7%).

## DECLARATION

I, Timmy Joji, declare that this study, titled, “An exploratory study of facilitators and barriers to mental health help-seeking in Indian immigrant youth in Gauteng, South Africa”, is my own work. This research study serves as the completion of my master’s degree in clinical psychology at North-West University. This work has never been submitted for examination. All relevant parties provided consent to conduct this research study. Throughout this mini-dissertation, the necessary acknowledgement is provided for all referenced material.

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30/09/2022

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## **STRUCTURE OF MINI-DISSERTATION**

The mini dissertation is divided into three sections. Section 1 contains an overview of the literature, which will assist in providing background and context to the content of the study. The next section, Section 2, provides the methodology of the study, the findings of the thematic analysis, a discussion of the findings and the conclusion. The final section, Section 3, is a critical reflection by the researcher on the research process.

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## **SECTION 1: INTRODUCTION AND OVERVIEW**

Section 1 of the mini dissertation provides the background literature that is relevant to the study. A literature review was conducted to provide an overview of the notable concepts that are relevant to the study. Particular attention was given to concepts, including mental health, mental health help-seeking in Indian immigrants, facilitators to mental health help-seeking, and barriers to mental health help-seeking.

## LITERATURE OVERVIEW

### **Mental Health**

Mental health is a state of well-being, in which an individual realises his or her own abilities, can cope with the everyday stresses of life, can work productively and can make a contribution to his or her community (World Health Organisation [WHO], 2018). Mental health difficulties, while not formally defined, would be viewed in the context of this study as any state where the individual is not able to realise their abilities, is not able to cope with everyday life stresses, is unable to work effectively, and is not able to contribute to their community. Mental health difficulties therefore encompass an array of experiences and can lead to the development of more severe and diagnosable mental illnesses. Mental illness has become an increasingly significant problem over the last few decades. For instance, the total number of people worldwide living with depression increased by 18% between 2005 and 2015 (WHO, 2017).

South Africa lacks comprehensive data on the exact prevalence of mental illness in the population, but two comparable, nationally representative studies suggest that depression has increased almost three-fold between 2004 and 2012 (Adjaye-Gbewonyo et al., 2016; Tomlinson et al., 2009). Mental illness is associated with several negative outcomes including suicide, and in 2012 alone, there were an estimated 804 000 suicides globally – with little knowledge of the effect of underreporting (WHO, 2014, 2017, 2018). The coronavirus (COVID-19) pandemic has further contributed to the burden of mental illness, with a study regarding South Africa's first lockdown period indicating that 33% of South Africans were depressed, while 45% of South Africans reported that they felt fearful during this period (Human Sciences Research Council [HSRC], 2020). While mental illness broadly affects all populations and demographic groups, certain populations are more vulnerable to the development of mental illness – namely immigrant populations as well as youth populations, which will be discussed below.

### ***Mental Health in Immigrant and Indian Immigrant Populations***

One group that has been identified as being at particularly high risk for the development of mental illness are immigrant groups. Immigrant groups are often under huge strain to find work, while also integrating into new communities as they often leave their familiar social structures and families behind (Karasz et al., 2016; Meghani & Harvey, 2016; Roberts et al., 2015). South Africa finds itself in the top 10 countries with the highest levels of immigration globally, behind the United States of America (USA) and several other European countries (United Nations, 2019). Similarly, in Africa, South Africa ranks as the country with the highest number of immigrants, closely followed by Côte d'Ivoire and Uganda (Kamer, 2022). While immigrants were once regarded as grateful members of a community due to their new acceptance and opportunities, research suggests that mental illness may be even more pervasive in these communities. While the literature suggests that most immigrant populations are at risk for the development of mental illness, some nuances must be noted. Certain immigrant populations, due to their cultural background and characteristics, are more prone to mental illness than others – with Indian immigrants in particular noted as a high-risk group (Chaudhry & Chen, 2019; Karasz et al., 2016; Roberts et al., 2016).

Indian immigrants leave their country for better opportunities. Immigration is however often fraught with difficulties relating to settling into a new country – including adapting to the language, job-seeking or academic goals, supporting a family, and coping with discrimination (Meghani & Harvey, 2016; Roberts et al., 2015). Immigrants also need to build new support systems in the form of new friends, colleagues and social groups to replace the families and social structures they have left behind (Sharma et al., 2022). Additionally, there are also high expectations of Indian immigrants to acculturate, and thrive in their new communities, both financially and academically. This need for acculturation means that many immigrants face the pressures of having to adapt their behaviours and beliefs to avoid discrimination (Karasz et al.,

2016; Kumar & Nevid, 2010). The challenges experienced by this population may, therefore, be contributing to the high rate of mental illness amongst Indian Immigrants (Karasz et al., 2016).

### ***Mental Health in Youth Populations***

Youth, defined by the United Nations (UN) (2021) as individuals between the age of 15 and 24, are especially prone to the development of mental health disorders, with increased pressures around academic performance, financial concerns, leaving home for the first time and social pressures coming to the fore during this time (Aguirre Velasco et al., 2020; Batra et al., 2021; Stengård & Appelqvist-Schmidlechner, 2010). There are also significant costs associated with mental illness in youth, with a higher risk for self-harm, drug abuse, unemployment, as well as reductions in lifetime earnings (Egan et al., 2016; Radez et al., 2021; Smith & Smith, 2010). Adding to the risk is that several disorders, including depression and schizophrenia, along with substance abuse have their onset in this developmental stage (Aguirre Velasco et al., 2020; Stengård & Appelqvist-Schmidlechner, 2010). Mental illness is also often associated with reduced conscientiousness, lower probabilities of being married, and lower stability in work attendance (Goodman et al., 2011). Poor mental health leads to negative outcomes on a personal and social level. Many sufferers suffer greatly as a result of their conditions, while their social and familial relationships deteriorate as well. One large scale multinational study on first-year college students found that around 17% of participants experienced suicidal ideation in the last year, and 33% of participants experienced suicidal ideation in their lifetime (Batra et al., 2021).

Managing the burden of mental health difficulties and illness is a complex process and is often too heavy a burden for an individual to manage alone. Help-seeking is, therefore, critically important in managing mental health, but rates of help-seeking for mental illness are generally poor (Radez et al., 2021). One of the fundamental issues regarding mental illness is the underutilisation of mental health services and help-seeking.

## **Mental Health Help-Seeking**

Help-seeking encompasses a wide range of actions, but there is no commonly applied definition of the term (Rickwood & Thomas, 2012). A study by the WHO (Barker, 2007) defined help-seeking as any action carried out by an individual that perceives themselves as needing personal or psychological assistance to meet their needs in a positive way. However, the American Psychological Association (APA) (2015) defines help-seeking as requesting assistance from others either informally or formally, such as by using mental health services. Despite these broad definitions, a systematic review investigating the conceptualisation of help-seeking found that the most common element in help-seeking research was focussing on formal help-seeking sources, rather than informal sources (Rickwood & Thomas, 2012).

Large-scale studies have found that, globally, less than 40% of individuals with mental health problems seek any type of professional help (Vogel et al., 2006). In South Africa, the rates of help-seeking are equally concerning, with a nationally representative survey of 4 351 adults finding that less than 26% of individuals with a mental disorder sought treatment in the last 12 months, and only 5.7% had used any formal mental health services (Seedat et al., 2009). While there have been no recent nationally representative studies on treatment seeking, a 2014 study comparing expected admissions to actual admissions in Kwa-Zulu Natal found that less than 20% of the expected number of admissions took place during one year (Burns, 2014). As a result, there is a huge burden of untreated mental illness that undoubtedly has significant effects on the population; including higher mortality rates, higher suicide rates, marginalisation from society, social isolation, lower productivity, and difficulties in obtaining employment (Egbe et al., 2014; Haas et al., 2020; Jacob & Coetzee, 2018). While Indian immigrant populations and youth populations are prone to the development of mental illness, both populations are known for their low rates of help-seeking.

### ***Mental Health Help-Seeking in Indian Immigrant Populations and Youth Populations***

There is a large amount of literature suggesting that Indian immigrants severely underutilise mental health services compared with other demographic groups (Balaraman et al., 2022; Chu & Sue, 2011; Kumar & Nevid, 2010; Lee et al., 2009; Roberts et al., 2016). A study conducted in the USA which focussed on Indian Americans found that while 40% of US-born Indians utilised mental health services, only 23% of foreign-born subjects reported seeking help (Karasz et al., 2016). This suggests that foreign-born immigrants may harbour greater reservations about mental health help-seeking compared with Indians who are born and raised in Western countries. This pattern seems to apply to a range of Indian immigrants, regardless of gender, age or generation and leads to increased levels of depression, anxiety and general psychological distress (Leung et al., 2011; Roberts et al., 2016).

This pattern of low rates of help-seeking is also present in youth populations globally, with a systematic review of youth help-seeking showing that only between 18% and 34% of young people seek help (Batra et al., 2021; Gulliver et al., 2010). In adolescent populations, 75% of those with mental health difficulties are not in contact with professional help services (Aguirre Velasco et al., 2020). Another large-scale multinational study focussing on first-year students found that only 24% of first-year students reported that they would seek treatment if they experienced a serious emotional problem (Ebert et al., 2019). There is no comparable national representative research on youth mental health help-seeking in South Africa, but the numbers are expected to be even lower, based on both small and large-scale studies on university and school populations (Bantjes et al., 2020; Mall et al., 2018; Pillay et al., 2016; Van Zyl et al., 2017).

Considering the global pattern of lower rates of help-seeking in youth populations compared with adults, it is unsurprising that a lack of help-seeking is prevalent in Indian immigrant youth as well. A study investigating Asian American youth, including Asian Indian immigrants, found that they tend not to seek professional help for their mental health issues, and preferred to

turn towards friends or family for support (Lee et al., 2009). Participants in the study suggested that many Asian cultures do not consider mental health to be essential and this suggests that culture may play a significant role in accounting for the low rate of mental health help-seeking in Asian American immigrants (Lee et al., 2009; Sharma et al., 2022). One explanation for the low rates of help-seeking in Indian immigrant youth may be the influence of various facilitators and barriers to help-seeking.

### **Facilitators to Mental Health Help-Seeking**

Facilitators to help-seeking are regarded as any factors that encourage or improve the probability of successful mental health help-seeking. Systematic reviews have shown that there are significantly fewer qualitative studies that address facilitators of mental health help-seeking compared with the barriers (Gulliver et al., 2010). Additionally, much of the literature on facilitators for help-seeking in Indian immigrants focus on the adult population. Studies that focus on facilitators to help-seeking in Indian immigrant adolescent and youth populations, on the other hand, have not been performed in South Africa or internationally.

### ***Facilitators to Mental Health Help-Seeking in Indian and South Asian Immigrants***

There was a notable lack of studies that focus on facilitators to help-seeking in Indian immigrants specifically, with many studies focussing on South Asian immigrants collectively (Chaudhry & Chen, 2019; Sharma et al., 2022). A study focussing on Asian Indians in the United States of America found that strong familial involvement can be a barrier as well as a facilitator to treatment seeking – depending on the beliefs of the family members about mental illness (Conrad & Pacquiao, 2005). This suggests that the level of familial involvement may have the impact of directly prescribing the behaviour of the individual, as opposed to simply influencing the individual's perspectives about help-seeking. Another study focussing on South Asian immigrants (from India, Pakistan, Sri-Lanka, Bangladesh and Nepal) in the USA found that knowledge and

education about mental illness were considered the first facilitator for help-seeking (Rastogi et al., 2014).

A systematic literature review on help-seeking in South Asian immigrants in the United Kingdom found that participants who were aware of the benefits of help-seeking and accessing services were likely to seek help but still weighed this up against the risk of being misunderstood by professionals (Prajapati & Liebling, 2022). Having a clear roadmap of the course of the illness, treatment options and the risks and rewards related to treatment improves rapport and improves the chances of seeking treatment and adherence to treatment (Rastogi et al., 2014). It was also found that the use of the medical model for treatment was beneficial to treatment seeking, as it emphasised the biological influences of mental illness and the need for medical treatment (Rastogi et al., 2014).

Regarding immigrant youth populations, a Canadian study on South Asian youth found that participants felt that having culturally safe models of healthcare that would show respect for their beliefs would enhance the willingness of youth to seek help (Islam et al., 2017). Another study on South Asian university students in the USA found that participants' decision to seek help was often due to the intervention of friends and university organisations and was positively related to the availability of free or affordable services (Basri et al., 2022). Both the studies were, however, primarily focussed on barriers preventing help-seeking, with a narrow focus on facilitating factors to help-seeking. Another study from the USA that focussed on Asian adolescents found that participants' perceived connectedness to their help-seeking source, be it teachers, friends, or therapists, improved their preference to seek help (Chiang et al., 2022). It should, however, be noted that less than 5% of the participants in the above study were Indian Immigrants. Lastly, South Asian immigrant youth that move away to go to university feel less constrained by familial attitudes towards mental health treatment and are consequently also more likely to seek help (Sharma et al., 2020).

## **Barriers to Mental Health Help-Seeking in Indian Immigrants**

Barriers to help-seeking are regarded as any factors that prevent or reduce the probability of successful mental health help-seeking. While there was a notable lack of studies focussing on facilitators to help-seeking in Indian immigrants, several studies were found that focus on barriers to help-seeking in the population.

### ***Lack of Knowledge about Mental Health***

The first barrier that should be noted is related to a lack of knowledge about mental illness, which is a common issue that leads to individuals not knowing that they need professional help (Seamark & Gabriel, 2018). A lack of awareness of the nature of mental disorders, their characteristic symptoms or the consequences of untreated mental illness may be lacking in many Indian immigrant populations and could also be influenced by culture (Kumar & Nevid, 2010). One study evaluating the mental health knowledge of Asian Indian immigrant women found that they were not always able to recognise their symptoms as that of a mental health disorder – leading to a lack of help-seeking (Roberts et al., 2015). Similarly, as many young people depend on their parents for medical advice and assistance, parents' knowledge of mental illness may also be an important aspect of help-seeking in youth. Parents are viewed as gatekeepers to formal treatment, and their inability to recognise mental health problems in their children could lead to delays or even avoidance of treatment (Sharma et al., 2022; Villatoro et al., 2018).

### ***Somatisation***

Somatisation as a barrier is closely linked to the concept of knowledge but is different in that it allows even those with some degree of knowledge of mental illness to find alternative explanations for their symptoms. Such individuals may notice symptoms that they may know are consistent with a mental disorder but may dismiss the symptom by suggesting that it is simply a physical ailment rather than a sign of a mental disorder. One study found that Indian Immigrants align more closely with conceptualisations of mental health conditions as being either biological

or psychosocial (Kumar & Nevid, 2010). In such cases, an individual may attribute their mental health symptoms to a simple reaction to adverse psychosocial circumstances, dismissing the possibility that there is an underlying mental health disorder causing their symptoms and thus avoiding the need for treatment seeking (Balaraman et al., 2022; Rastogi et al., 2014).

Many patients also presented with somatic complaints, which they dismissed as biologically rooted, and not in need of mental health treatment (Karasz et al., 2016; Kumar & Nevid, 2010). This results in individuals presenting for treatment only when they present with apparent psychotic features, even when they had long-term symptoms, which they dismissed as physical ailments (Balaraman et al., 2022).

It must be kept in mind that a biological explanation for symptoms may also be influenced by culture, as a biological explanation for an individual's behaviour may suggest something that is out of their control. This may allow the individual to avoid blame by suggesting that they have a physical problem, as opposed to a psychological issue, which could be regarded as their fault or due to their weakness (Chaudhry & Chen, 2019). As a result, in Indian populations, there is a recognition of biologically rooted conditions such as bipolar disorder or schizophrenia as legitimate mental illnesses, while more psychologically or behaviourally driven conditions such as depression and anxiety are not acknowledged with the same legitimacy (Kumar & Nevid, 2010).

### ***Norms around Family Support***

Another critical area that has been identified in Indian Immigrants is the expectation for individuals to turn towards familial support. Another study in the US showed that Indian Immigrants do not seek help from mental health professionals but instead turn towards their families for support (Leung et al., 2011; Roberts et al., 2016). While familial and social support is a crucial element of the management of mental illnesses, it can also be a double-edged sword in some cases. For example, the expectation that one should turn to the family may mean that an individual who needs professional assistance may instead turn to their family in such cases.

It must also be considered that turning towards family may have other downsides, as families may not be able to provide accurate information, advice, or adequate support in the way a mental health professional would, particularly in cases where the severity of the disorder mandates formal mental health assistance. Additionally, families are also at the core of cultural identification and adherence and may perpetuate Indian cultural perspectives associated with mental illness, such as the minimisation of the importance of mental health. Lastly, an emphasis on familial support means that many individuals delay professional treatment seeking, and only report to a professional once their mental illness has become severe, significantly affecting treatment outcomes (Chu & Sue, 2011).

### ***Family Attitudes Towards Privacy***

Another fundamental barrier to help-seeking is an emphasis on privacy in many Indian immigrant families. The disclosure of a mental illness is often regarded as something that brings shame to a family and is a sign of weakness in both the individual and the family system and is, therefore, avoided (Chaudhry & Chen, 2019; Karasz et al., 2016). This leads to individuals compromising their own mental health in the hope of protecting the privacy of their families. This is particularly relevant in cases where mental illness may be precipitated or perpetuated by familial problems and discord. Additionally, Indian culture also perpetuates ideas around the individual's responsibility towards the family, further complicating the decision to seek help when it goes against familial wishes for privacy (Leung et al., 2011).

This may be particularly problematic for youth, as parents may emphasise the need for the internal management of problems. As a result, many Indian Immigrant adolescents report unshakable confidence in the stability and positivity of familial bonds, even in situations where families are controlling, or discord exists that may be an influence in the development or maintenance of a mental illness (Leung et al., 2011).

## *Stigma*

Stigma has also been found to be a significant barrier to mental health help-seeking, both in the general population and especially in the Indian immigrant youth population. Stigma is defined as stereotypes attributed to a person when their characteristics and behaviour are viewed as different or inferior to societal norms (Ahmedani, 2011). Two specific types of stigmas were identified as barriers to mental health help-seeking, namely public and parental stigma. Public stigma refers to the negative attitudes held by members of the public about people with devalued characteristics (Corrigan & Rao, 2012). However, parental stigma, or stigma of close others, is defined as negative attitudes held by parents and close others towards mental illness (Villatoro et al., 2018; Vogel et al., 2009).

The public stigma associated with mental illness is a common phenomenon in most societies, in differing degrees. Cultural perspectives also have a significant role to play in the development of public stigma against mental illness, particularly amongst Indian Immigrants. Mental illness is viewed as a weakness, and a source of shame in Indian Communities, and as a result, many individuals choose to live with their conditions rather than subject themselves to discrimination (Karasz et al., 2016; Leung et al., 2011; Roberts et al., 2015; Sharma et al., 2022).

This means that many individuals are forced to hide their illnesses from their families and communities at large. Psychological symptoms are stigmatised in Indian Immigrant communities as a representation of personal deficiencies and are believed to bring dishonour to the family (Chaudhry & Chen, 2019; Leung et al., 2011; Roberts et al., 2015). Beyond this, public stigma also impacts the individual, emphasising the need for a stoic acceptance of their situation, which often leaves the individual feeling even more isolated and flawed (Leung et al., 2011; Roberts et al., 2015). The public stigma associated with mental illness even affects treatment, with many families attempting to deny the illness for as long as possible and seeking professional services as a last resort (Karasz et al., 2016).

Recent literature also suggests a strong link between parental influences and treatment seeking. A 2014 study focussing on clinicians that care for South Indian mental health patients reported that helicopter parenting (parents who are overly involved in their children's lives and hover over them) was regarded as a significant barrier to children seeking mental health treatment (Rastogi et al., 2014). The study found that patients reported feeling that their parents would take control of scheduling, participate in evaluations, expect quick fixes, and demand to know what was discussed during therapy; leading to a reluctance to report mental health issues or find treatment. Parents with negative perspectives about mental illness may intentionally, or unintentionally, not recognise the symptoms that their children present with, preventing treatment seeking (Villatoro et al., 2018). Furthermore, there is evidence that the parent's level of stigma may be the determining factor as to whether youth seek help, even with the impact of a social stigma (Vogel et al., 2009).

## **THEORETICAL FRAMEWORK**

The theoretical framework selected for the study is the ecological systems theory, which was first proposed by Urie Bronfenbrenner in 1979 (Bronfenbrenner, 1979). While the theory is primarily focussed on understanding human development, it has been extensively applied in many other fields including health research (Richard et al., 2011). Bronfenbrenner's Ecological Systems theory was selected as the theoretical framework for the study due to its holistic view of the factors influencing an individual's decisions regarding mental health help-seeking. The theory suggests that the individual's entire ecological system must be considered when trying to understand their development and has thus been applied in several studies to understanding the ecological influences that may prevent or facilitate mental health help-seeking (Miville & Constantine, 2006; Vogel et al., 2007). Bronfenbrenner's theory views the ecological environment as a set of

structures, each inside the next – namely, the microsystem, mesosystem, exosystem, and macrosystem.

At the innermost level is the immediate setting containing the developing person (Bronfenbrenner, 1979). This innermost level is the microsystem and refers to the interpersonal relationships and roles experienced by the individual in a face-to-face setting in the immediate environment (Bronfenbrenner, 1994). Elements of the microsystem include the home, the classroom, peer groups, the workplace, health services and the neighbourhood. The microsystem is, therefore, the system that has the most direct influence on the individual's experience of development.

The mesosystem is regarded as a system of microsystems, in that it goes beyond viewing individual elements, and rather focuses on the relationships or systems between the different elements (Bronfenbrenner, 1994). Bronfenbrenner suggested that the mesosystem or the interconnections between the different elements that directly influence the individual can be as decisive for the development of the individual as the events directly influencing the individual (Bronfenbrenner, 1979). Interactions in the mesosystem may include the relations between home and the school or university and relations between friends and parents.

The third level of the ecological environment takes us yet farther afield and evokes a hypothesis that the person's development is profoundly affected by events occurring in settings in which the person is not even present (Bronfenbrenner, 1979). This level is referred to as the exosystem and is comprised of the linkages and processes that take place between two elements, one of which is a setting that does not contain the developing individual (Bronfenbrenner, 1994). This suggests that settings in which the developing person is not directly present can still have a significant impact on the development of the individual. Examples of such settings include the parent's workplace, friends of the family, and the mass media.

The macrosystem refers to the overarching pattern of micro, meso and exosystem characteristics that are common to a given culture or subculture (Bronfenbrenner, 1994). Bronfenbrenner suggests that the macrosystem serves as a type of blueprint of how different settings in a given cultural context are organised and function, and changes to this structure can cause marked changes in the behaviour and development of the individuals in the society (Bronfenbrenner, 1979). The macrosystem, therefore, includes the customs, belief systems, lifestyles and life course options of individuals of that specific culture or subculture (Bronfenbrenner, 2005).

Lastly, the chronosystem refers to changes or consistencies over time in the various environmental systems, as well as the individual (Bronfenbrenner, 1994). Changes in the developing person's family structure, economic status, employment, and place of residence are, therefore, all elements that influence the chromosphere (Bronfenbrenner, 1994).

One of the important considerations of the ecological systems theory is that what matters most to development, is the environment as it is perceived rather than how it exists objectively (McLaren & Hawe, 2005). As a result, the personal, subjective experience that an individual has is therefore invaluable in understanding how the individual has developed, as opposed to simply considering the elements factually. The ecological systems theory also considers the wholistic experience of the individual, including trends such as globalisation, urbanisation and environmental changes, which are all considered to be aspects that are relevant to understanding public health (McLaren & Hawe, 2005).

Bronfenbrenner's ecological systems theory has two core propositions that guide the theoretical framework of this study. The theory first suggests that human development occurs through regular interaction between the developing person and the persons and objects in its environment over some time (Bronfenbrenner, 1994). The second proposition is that the impact of the interactions between the developing person and the environment varies based on both the

characteristics of the individual and the environment and can lead to changes in the individual and environment themselves (Bronfenbrenner, 1979). This means that the individual's characteristics have the potential to influence the environment, either by varying the impact of the environment or by changing the environment itself. Similarly, the environment has the potential to influence and change the developing individual.

## **PROBLEM STATEMENT**

The literature suggests that there is an emphasis on understanding barriers to help-seeking, compared with determining facilitators or factors that contribute positively to help-seeking. Additionally, most of the studies focussing on Indian immigrants focus only on barriers, with little focus on facilitating factors. As a result, the studies that evaluate facilitators for help-seeking are focussed on youth in general and are not specific to Indian immigrant youth. Additionally, several studies also focus on Asian Americans in general (Le Meyer et al., 2009; Lee et al., 2009; Nishi, 2020; Spencer et al., 2010), which includes Chinese, Filipino, Vietnamese, Japanese, Korean and Asian Indians. As a result, the findings of such studies are relevant for the entire Asian American population, and there may be significant differences between the results for different nationalities that fall under the Asian American umbrella compared with Asian Indians. As a result, the findings of such studies are relevant for the entire Asian American population, and not specifically only to Indian immigrant populations. Furthermore, there may be significant differences between the results for different nationalities that fall under the Asian American umbrella when compared with Asian Indians.

Most of the literature on help-seeking in Indian immigrants is based in the USA or the UK. While there are studies that focus on the mental health of Indians in South Africa, these are focussed on the local population of Indians who are native to South Africa, rather than Indian Immigrants who are non-native to the country and moved here recently. As a result, little work has

been done to understand the experiences of Indian immigrants in the country, even though South Africa has a large contingent of international immigrants. Considering the lack of local statistics on mental illness and help-seeking in the country, it is perhaps unsurprising that no studies focus on Indian immigrants or Indian immigrant youth. As a result, there is a lack of understanding of the experiences of Indian immigrant Youth in South Africa, their knowledge of mental illness, and their ability to seek help (Sharma et al., 2022). If the local pattern is consistent with international trends, many Indian youths in the country may face significant barriers to seeking help for their mental illness.

### **Research Question**

The study focussed on answering the following research question: What are the potential barriers and facilitators for mental health help-seeking of Indian immigrant youth?

### **Aim of the Study**

This study aimed to explore and describe the potential barriers and facilitators to mental health help-seeking experienced by Indian immigrant youth.

### **Positionality of the Researcher**

I am a 30-year-old Indian male born to Indian immigrant parents, who is based in Johannesburg, South Africa. The study was, therefore, influenced by both my background and current location. I am based in Gauteng and therefore determined that young Indian immigrants in Gauteng would be the ideal population to focus on for my study. I was also born to Indian immigrant parents who immigrated to South Africa, and I am, therefore, part of the Indian immigrant population. I am, however, not directly related to or familiar with any potential participants in the community, and recruitment and sampling were done with the assistance of an independent person linked to a community youth organisation.

Over time, I was made aware of the increasing incidence of mental health-related problems in my friends and the Indian immigrant community in general. I noted that many young immigrants experience mental health problems, but not all of them seek help or are open about their difficulties. I hope that the study will improve the understanding of the experiences of Indian immigrant youth and the factors that contribute to a decision to seek help or avoid it.

The research is being done owing to the increasing need for an understanding of the mental health experiences of Indian immigrant youth, as the literature suggests that this may be a vulnerable population due to the low rates of help-seeking in immigrant populations, as well as the low rates of help-seeking in youth populations. This understanding may contribute to addressing the barriers that prevent help-seeking while promoting facilitating factors to improve the chances of young Indian immigrants seeking help for their mental health difficulties.

### **SCOPE OF THE STUDY/DELIMITATION OF THE STUDY**

As the study focuses on the experiences of Indian immigrant youth, other age groups, such as Indian immigrant adults or Indian immigrant children that may also share similar experiences, are not included within the scope of the study. Additionally, the study focuses on mental health difficulties, encompassing any situation in which the individual is not in an ideal state of mental health and is unable to realise their abilities, cope with normal life stressors, work productively or unable to contribute positively to their community (WHO, 2018). Mental health difficulties can, therefore, be viewed on a spectrum from mild to severe and may be diagnosed or undiagnosed. The study does not, however, focus on clinical diagnoses or diagnostic labels for disorders, or differentiating participants with mild mental health difficulties from those with diagnosed disorders. Anyone who has experienced mental health difficulties was, therefore, encouraged to partake in the study and share their views on help-seeking, as opposed to only including individuals with diagnosed mental health conditions.

## **SIGNIFICANCE OF THE STUDY**

The present study is valuable as there is a significant lack of research on the mental health of Indian immigrant youth in South Africa. Where studies do exist, they are also primarily quantitative and do not focus on the experiences of Indian immigrant youth, which are essential to understanding the factors that prevent or promote help-seeking.

It is hoped that the study will directly benefit Indian immigrant youth through a better understanding of the collective experiences of different individuals in the community. Additionally, it may also shed light on some of the prominent barriers and facilitators to help-seeking in Indian immigrants in general and Immigrant populations in South Africa.

The benefits of the study would be a greater understanding of the experiences and factors that act as barriers and facilitators to help-seeking in the Indian immigrant youth population. Such an understanding can directly inform other Indian immigrant youth of the complexities of seeking help and how they can potentially manage the barriers in their lives while enhancing the impact of facilitating factors to seek help. Additionally, such an understanding may also better inform parents, families and the community about the experiences of young people with the goal of better supporting the mental health treatment journeys of young Indian immigrant youth.

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## SECTION 2: ARTICLE

This article is intended to be submitted to the Journal of Psychology in Africa (JPA) for publication. The guidelines for authors for this journal are summarised below.

### **Instructions for Authors**

#### Manuscripts

Manuscripts should be written in English and conform to the publication guidelines of the latest edition of the American Psychological Association (APA) publication manual of instructions for authors. Manuscripts can be a maximum of 7 000 words.

#### Submission

Manuscripts should be prepared in MSWord, double-spaced with wide margins and submitted via the Journal's Editorial Manager system. Before submitting a manuscript, authors should peruse and consult a recent issue of the *Journal of Psychology in Africa* for general layout and style.

### **Manuscript Format**

All pages must be numbered consecutively, including those containing the references, tables and figures. The typescript of a manuscript should be arranged as follows:

- Title: This should be brief, sufficiently informative for retrieval by automatic searching techniques and should contain important keywords (preferably <13).
- Author(s) and Affiliation(s) of author(s): The corresponding author must be indicated. The author's respective affiliation where the work was done must be indicated. An e-mail address or the corresponding author must be provided.
- Abstract: Articles and abstracts must be in English. Submission of abstracts translated into French, Portuguese and/or Spanish is encouraged. For data-based contributions, the abstract

should be structured as follows: Objective – the primary purpose of the paper, Method – data source, participants, design, measures, data analysis, Results – important findings, implications, future directions and Conclusions – about the research questions and theory development. For all other contributions (except editorials, book reviews, and special announcements) the abstract must be a concise statement of the content of the paper.

Abstracts must not exceed 150 words. The statement of the abstract should summarise the information presented in the paper but should not include references.

- Text: (1) Per APA guidelines, only one space should follow any punctuation; (2) Do not insert spaces at the beginning or end of paragraphs; (3) Do not use colour in the text; and (4) Do not align references using spaces or tabs, use a hanging indent.

- Tables and figures: These should contain only information directly relevant to the content of the paper. Each table and figure must include a full, stand-alone caption, and each must be sequentially mentioned in the text. Collect tables and figures together at the end of the manuscript or supply them as separate files. Indicate the correct placement in the text in this form <insert Table 1 here>. Figures must conform to the journal's style. Pay particular attention to line thickness, font and figure proportions, taking into account the journal's printed page size – plan around one column (82 mm) or two-column width (170 mm). For digital photographs or scanned images, the resolution should be at least 300 dpi for colour or greyscale artwork and a minimum of 600 dpi for black line drawings. These files can be saved (in order of preference) in PSD, PDF or JPEG format. Graphs, charts, or maps can be saved in AI, PDF or EPS format. MS Office files (Word, PowerPoint, Excel) are also acceptable but DO NOT EMBED Excel graphs or PowerPoint slides in an MS Word document.

## Referencing

Referencing style should follow the latest edition of the APA manual of instructions for authors.

References in text: References in running text should be quoted as follows: (Louw & Mkize, 2012), (Louw, 2011), or Louw (2000, 2004a, 2004b). All surnames should be cited the first time the reference occurs, e.g., Louw, Mkize, and Naidoo (2009) or (Louw, Mkize, & Naidoo, 2010). Subsequent citations should use et al., e.g., Louw et al. (2004) or (Louw et al., 2004). ‘Unpublished observations’ and ‘personal communications’ may be cited in the text, but not in the reference list. Manuscripts submitted but not yet published can be included as references followed by ‘in press’.

Reference list: Full references should be given at the end of the article in alphabetical order, using double spacing. References to journals should include the author’s surname and initials, the full title of the paper, the full name of the journal, the year of publication, the volume number, and inclusive page numbers. Titles of journals must not be abbreviated. References to books should include the authors’ surnames and initials, the year of publication, the full title of the book, the place of publication, and the publisher’s name. References should be cited as per the examples below:

### Journal Article

Peltzer, K. (2001). Factors at follow-up associated with adherence with directly observed therapy (DOT) for tuberculosis patients in South Africa. *Journal of Psychology in Africa, 11*(2), 165–185.

#### Book

Gore, A. (2006). *An inconvenient truth: The planetary emergency of global warming and what we can do about it*. Emmaus, PA: Rodale.

#### Edited Book

Galley, K. E. (Ed.). (2004). *Global climate change and wildlife in North America*. Bethesda, MD: Wildlife Society.

#### Chapter in a Book

Cook, D. A., & Wiley, C. Y. (2000). Psychotherapy with members of the African American churches and spiritual traditions. In P. S. Richards & A. E. Bergin (Ed.), *Handbook of psychotherapy and religiosity diversity* (pp 369–396). Washington, DC: American Psychological Association.

#### Magazine Article

Begley, S., & Murr, A. (2007, July 2). Which of these is not causing global warming? A. Sport utility vehicles; B. Rice fields; C. Increased solar output. *Newsweek*, 150(2), 48–50.

#### Newspaper Article (Signed)

Landler, M. (2007, June 2). Bush's Greenhouse Gas Plan Throws Europe Off Guard. *New York Times*, p. A7.

#### Unpublished Thesis

Appoh, L. (1995). The effects of parental attitudes, beliefs and values on the nutritional status of their children in two communities in Ghana (Unpublished Master's thesis). University of Trondheim, Norway.

Conference Paper

Sternberg, R. J. (2001, June). *Cultural approaches to intellectual and social competencies*.

Paper presented at the Annual Convention of the American Psychological Society, Toronto, Canada.

## ARTICLE COVER PAGE

Running head: BARRIERS AND FACILITATORS TO HELP-SEEKING

Facilitators and barriers to mental health help-seeking in Indian immigrant youth

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## **ABSTRACT**

According to international literature, Indian immigrants tend to severely underutilise mental health services. There is, however, a lack of local research on the experiences of Indian immigrant youth, and their experiences around mental health help-seeking. The aim of this study was, therefore, to identify the facilitators and barriers preventing or prompting help-seeking in the Indian Immigrant youth population by evaluating the personal and lived experiences of Indian immigrant youth in South Africa. Participants were recruited through purposive sampling, and the data collection was performed through online interviews that explored the participants' lived experiences. Using thematic analysis, five categories of facilitators and four categories of barriers were identified. It is hoped that an improved understanding of the barriers and facilitators will also allow other Indian immigrant youth to manage their help-seeking process while increasing awareness about others in the community with similar experiences.

Keywords: Indian immigrants, help-seeking, mental health, youth, South Africa

## INTRODUCTION

Mental health is an important element of human health and is characterised by an individual being able to cope and be productive. Mental health difficulties on the other hand are a state in which the individual is unable to function well and fulfil the roles and responsibilities that the individual has. Mental health is becoming an increasingly significant problem, with global rates of depression increasing significantly over the last decades.

Mental health difficulties have a widespread impact on individuals from different countries, communities and backgrounds, but some groups are more prone to developing such difficulties. Youth populations, due to increased pressures around academics, independence and finances are one group that is more prone to the development of mental health difficulties (Stengård & Appelqvist-Schmidlechner, 2010; United Nations, 2021). Similarly, Immigrant groups, due to their cultural backgrounds, are also prone to developing mental health difficulties, with Indian immigrants found to be at particularly high risk (Karasz et al., 2016; Roberts et al., 2016).

A key issue that is relevant to both youth and Indian immigrant populations is the underutilisation of mental health services. A lack of help-seeking is prevalent in adult Indian immigrants, and Indian immigrant youth according to the literature (Chu & Sue, 2011; Kumar & Nevid, 2010; Lee et al., 2009), with both adults and youth often turning to friends or family for support (Lee et al., 2009).

According to the literature, there are significant barriers and facilitators to help-seeking for Indian immigrants, but most studies were noted to focus on barriers (Gulliver et al., 2010). Despite South Africa having a large contingent of international immigrants, no research has been done on the Indian immigrant population and this is particularly concerning when considering the lack of statistics around help-seeking nationally. The experiences of Indian immigrant youth are therefore

largely misunderstood, and this may lead many to avoid seeking help. The next section briefly describes the theoretical framework, which underpinned the findings of this study.

### **Theoretical Framework**

Bronfenbrenner's Ecological Systems theory was selected as the theoretical framework for the study due to its holistic view of the factors influencing an individual's decisions regarding mental health help-seeking. The theory suggests that the individual's entire ecological system must be considered when trying to understand their development and has thus been applied in several studies to understanding the ecological influences that may prevent or facilitate mental health help-seeking (Miville & Constantine, 2006; Vogel et al., 2007).

## **RESEARCH QUESTION AND AIM OF THE STUDY**

This study aimed to explore and describe the potential facilitators and barriers to mental health help-seeking as experienced by Indian immigrant youth. The study focussed on answering the following research question: *What are the potential barriers and facilitators for mental health help-seeking of Indian immigrant youth?*

## **METHOD**

### **Approach and Design**

The study was conducted with a qualitative approach, which is an approach for exploring and understanding the meaning individuals or groups ascribe to a social or human problem. A phenomenological design was used as the research aimed to understand the lived experiences of Indian immigrant youth regarding barriers and facilitators to mental health help-seeking. The phenomenological qualitative approach to research was the ideal approach to exploring this issue,

as phenomenological research is centred on the lived experiences of the participants (Lester, 1999; Neubauer et al., 2019).

### **Participants and Sampling**

The sampling method that was most appropriate for this type of study was determined to be purposive sampling followed by snowball sampling. Due to the number of participants (nine) who joined the study during the first purposive sampling phase, snowball sampling to obtain additional participants was not done. Saturation was already reached following the analysis of the interviews of the nine participants recruited through the purposive sampling phase.

The participants for the study were chosen according to the following inclusion criteria. All participants had to be between the ages of 18 and 24 and born of parents with Indian nationality that immigrated to South Africa. The participants must either have been born here in South Africa, or immigrated to South Africa before the age of 10 years old. The participants also must have experienced a mental health difficulty at some point in their life, but did not have to be formally diagnosed, or be in treatment for mental illness before participation. Each participant also had to be literate, and fluent in English, so they are able to study and understand the informed consent form. There were no specific exclusion criteria for the study.

The potential participants for the study were Indian immigrant youth between the ages of 18 and 24, and as such, it was determined that the best way to go about recruitment would be through community organisations. The South African Malayalee Writers Collective (SAMWRIC) is an organisation founded and led by Indian youth who originated from India and grew up in South Africa, and due to their strong presence in the Indian youth community, they were determined to be an appropriate gatekeeper to the community. Following contact between the research assistant (independent person) and the head of the South African Malayalee Writers Collective (SAMWRIC), the founder distributed the recruitment poster to 10 potential participants that were Indian immigrants that fit the age range. Participants had the freedom to decide if they

would like to partake, without the need to disclose this to the gatekeeper. Interested participants emailed the research assistant on the email provided in the recruitment poster, and the biographical form was sent to the participants to be completed and checked by the research assistant to confirm participant applicability according to the inclusion and exclusion criteria. The final sample consisted of nine voluntary participants, and their demographic details with corresponding pseudonyms are listed below (Table 1).

**Table 1: Participants’ demographic profile**

Participant	Gender	Age
1. Roshan	Male	22
2. Shreya	Female	23
3. Shiv	Male	23
4. Mirza	Female	23
5. Sita	Female	23
6. Divya	Female	20
7. Anushka	Female	22
8. Kavya	Female	22
9. Zaraa	Female	23

### **Data Collection**

Due to the risks associated with the coronavirus (COVID-19) pandemic, all participants were offered the choice between having an in-person interview, or an online interview over a video call, which would be recorded. All nine participants elected the online interview option.

A biographical form (Appendix B) was used to gather the details to confirm that the participant met the inclusion and exclusion criteria for the study. Semi-structured interviews were

conducted with the participants. While in-depth interviews are often the norm in phenomenological studies, semi-structured interviews that are flexible, but focussed on the topic of barriers and facilitators were regarded as most fitting for the study's aims. In order to explore and describe the lived experiences of Indian immigrant youth concerning help-seeking, the interview schedule (Appendix C) was developed to identify barriers and facilitators that affect help-seeking, as well as the effects of these barriers and facilitators on help-seeking behaviour. Field notes were also compiled by the researcher to maintain objectivity and to encourage the researcher to reflect on personal experiences that may influence their perspectives on the study and the topic at large.

### **Data Analysis**

Before the data could be analysed, all the recordings were transcribed verbatim, and pseudonyms were assigned to each participant and their interview. A thematic analysis was conducted to identify and evaluate major themes within the answers provided and allowed for the identification of common concerns amongst the participants (Hsieh & Shannon, 2005). The study focuses on the experiences of Indian immigrant youth in Gauteng and their experiences and does not differentiate between the experiences of participants based on their individual characteristics such as age or gender. Therefore, the thematic analysis approach was regarded as more fitting to the study as opposed to interpretive phenomenological analysis. The thematic analysis was conducted according to the steps recommended by Braun and Clarke (2006), which are familiarisation, generating initial codes, searching for themes, reviewing themes, defining, and naming themes, and producing the report.

### **Trustworthiness**

The study's credibility was enhanced by the interviews, which allowed for prolonged engagement to understand participant experiences, which were transcribed verbatim. The researcher conducted the coding and analysis himself, while also using an experienced and

objective co-coder (a Health Professions Council of South Africa [HPCSA] registered research psychologist). The transferability of the study was enhanced by the researcher's focus on the overarching goal of understanding the barriers and facilitators related to mental health help-seeking, allowing the findings to be potentially transferable to groups other than the one being studied. The study had a clear process, which was followed meticulously and stems from the aims and questions that needed to be answered to achieve the goals of the research, thus improving dependability. Lastly, the confirmability of the study was enhanced through a clear discussion of the conclusions and inferences that were reached through the interpretation of the findings.

### **Ethical Considerations**

The ethical approval for this study was obtained through the Health Research Ethics Committee (HREC) of the North-West University (ethics approval number: NWU-00022-22-A1). Goodwill permission to conduct the study was obtained by contacting the leader of the SAMWRIC. Interested participants emailed the research assistant anonymously and arranged video calls to discuss the study and informed consent, agreeing that they would be allowed to keep their video off to protect their identities and would only need to turn on their video to display their signing of the informed consent form. Verbal consent was also once again obtained at the start of the interviews, which were conducted via the Zoom platform.

The study itself had a certain level of risk as the population that was being interviewed is viewed as a vulnerable population, and safeguards were put in place to protect them further. To manage this risk, a trained lay counsellor from the South African Depression and Anxiety Group (SADAG) was available to provide support, and an HPCSA registered clinical psychologist was also arranged and was available after each interview for a video call to provide more in-depth assistance in the form of debriefing. Each participant was also provided with the details for the SADAG's 24-hour suicide helpline, as well as SADAG's crisis intervention line for the participant to be able to access telephonic counselling and crisis intervention, if needed.

## FINDINGS AND DISCUSSION

On the basis of the data, a thematic analysis was conducted, leading to three themes being discovered regarding the experiences of Indian immigrant youth concerning help-seeking (see Table 2 below). Verbatim quotations are provided to support the themes and subthemes that were discovered.

Three main themes were identified from the data, namely (i) factors contributing to the mental health difficulties experienced, (ii) factors serving as facilitators that encourage help-seeking, and (iii) factors that serve as barriers that discourage help-seeking. There were also some significant consistencies in the experiences of the participants, with most participants reporting that they knew that they were going through mental health difficulties but were not able to self-diagnose or evaluate the severity of their difficulties accurately – something that often led to several participants deciding that their difficulties are not serious enough to warrant help. Many participants reported that they first spoke to a parent about their desire to seek help, and often did not receive support for their decision. The responses from the participants also made it clear that for Indian immigrants, and particularly their parents, Indian culture plays a significant role in guiding decisions about career paths and mental health help-seeking. As a result, many first engaged in help-seeking after leaving home, reporting that the university environment allowed them more personal agency to seek help, even when doing so privately. Participants largely felt that help-seeking would be beneficial for someone going through mental health difficulties, but the responses also indicated that the barriers preventing help-seeking seemingly outweigh the facilitators that encourage help-seeking. The themes and subthemes were identified based on the research question, have been listed in Table 2 below, and are discussed in detail thereafter.

**Table 2: Themes and subthemes**

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**Theme 1:** Factors contributing to the mental health difficulties experienced by Indian immigrant youth.

Subtheme 1.1: Academic stress

Subtheme 1.2: Relationship difficulties

Subtheme 1.3: Social stressors

Subtheme 1.4: Adjustment difficulties

**Theme 2:** Factors that serve as facilitators of help-seeking in Indian immigrant youth

Subtheme 2.1: Sources of help

Subtheme 2.2: Encouragement to seek help for mental health difficulties

Subtheme 2.3: Social media and the mass media

Subtheme 2.4: University and school environments

Subtheme 2.5: Availability and awareness of resources

Subtheme 2.6: Open conversations about mental health

**Theme 3:** Factors that serve as barriers that prevent or discourage help-seeking in Indian immigrant youth

Subtheme 3.1: The individual's perspectives on mental health

Subtheme 3.2: A lack of access to resources

Subtheme 3.3: Parental factors that discourage help-seeking

Subtheme 3.4: Community factors that discourage help-seeking

## **Theme 1: Factors Contributing to the Mental Health Difficulties Experienced by Indian Immigrant Youth**

The first theme involved the factors contributing to the mental health difficulties experienced by the participants.

### ***Subtheme 1: Academic Stress***

Many participants reported experiencing anxiety relating to their academics, and several participants reported that this academic stress was further related to prescriptions about which careers are good or bad. Work anxiety was often compounded by other stressors and COVID-19-related changes to the academic environment. This was indicated by Mirza, who said, *“So, for most of my first year, I was thinking that I might drop out. It was mostly the fact that I make the wrong choice. Should I drop out? Will I still be able to carry on with this degree?”*

### ***Subtheme 2: Relationship Difficulties***

Participants indicated that their mental health was impacted by their relationships and the pressure of balancing relationships with other responsibilities. Some participants experienced difficulties in their relationship with their family or parents - often feeling unhappy with the lack of support they receive, or the prescriptive nature of their parents when it comes to career decisions, friendships, and appearance. One participant, Shreya shared, *“Then in terms of other pressures, like relationships: Whether it's like friend relationships, romantic relationships, again even family relationships [can be a source of stress]”*.

### ***Subtheme 3: Social Stressors***

Indian immigrant youth reflected on how social stressors, such as trying to fit in, making new friends, and coping with bullying contributed to their mental health difficulties. Roshan shared the following:

*If it's not the studies, then it's going to definitely be about making friends and getting into the university environment. Let's say people bully you and things – you can't really tell your parents about this. Because as ones from the first generation, they will just be like, just get over it. You know?*

#### ***Subtheme 4: Adjustment Difficulties***

Participants reported that adjusting to moving away from home and into the university environment was a significant contributor to their mental health difficulties as they often found it difficult to be responsible for themselves for the first time while juggling their academic demands, social lives, and health. Participants also reflected on how a sheltered upbringing can also lead to individuals rebelling or exploring for the first time at university. Roshan reported as follows:

*It's because, as a young adult studying in the university, we get a lot of pressure from the university with work and trying to balance our social lives, our going out, our playing sports and exercising.*

### **Theme 2: Factors that Serve as Facilitators of Help-Seeking in Indian Immigrant Youth**

The second theme that was identified was the factors reported by the participants to encourage or facilitate help-seeking and included the prominent sources of help that were reported by them.

#### ***Subtheme 1: Sources of Help***

Participants reported that cousins, and in some cases, parents were a source of support for them, though participants reported that mothers were considered closer and more understanding. Almost half the participants reported that they turned to their friends for support, with some reporting that they decided to not see a psychologist when they found that their support from friends was sufficient to help them to manage their mental health difficulties. Mirza shared, “I

*eventually just spoke to friends and then that helped and that kind of took off the psychologist thing. They're also going through it as well so they can also relate to it".*

### ***Subtheme 2: Encouragement to Seek Help for Mental Health Difficulties***

Almost half the participants reported that having the support and encouragement of siblings and friends and parents to seek help for their mental health difficulties provided a push to seek help. Anushka reported, *"Whenever I was with her [my sister], it gave me so much more openness to any facilities that would help my mental health"*.

### ***Subtheme 3: Social and Mass Media***

Some participants reflected on the role that the media and social media play in displaying help-seeking as something that is necessary and helps to encourage peer support. Divya shared, *"Also, these days there are a lot more movies surrounding mental health, which I think is very cool"*. Similarly, Shreya said, *"So, I think if we make Facebook groups to be like - listen, I have a problem and I would really appreciate somebody to listen to my problem and maybe give their perspective about this issue"*.

### ***Subtheme 4: University and School Environments***

The university environment was widely regarded as a place where almost half the participants were first exposed to mental health knowledge and promoted autonomy and free-thinking, as indicated by Divya, who stated the following:

*At the same time, I think a lot of times when you leave home to go to university and you're in your own space, you're exposed to a lot more. It does open up a lot of people and it does encourage them to get the help that they need.*

Participants also felt that the school environment could play a significant role in promoting mental health knowledge and normalising help-seeking from a young age. Shiv shared, *"So to try*

*and create awareness of it in a primary school level. I think, that would make it easier for them to talk about mental health difficulties”.*

#### ***Subtheme 5: Availability and Awareness of Resources***

Most of the participants that did see a psychologist reflected on how the affordability and convenience of seeing the campus psychologist encouraged them to seek help. The fact that parents would not be aware of their help-seeking compared with if they saw a private psychologist using their medical aid, also encouraged them to seek help. This perception was expressed by Sita:

*Yeah, it was convenient. And the fact that I didn't have a car at the time. So even if I went to private counselling, it will go through medical aid. And my parents would know because I did bring it up”.*

#### ***Subtheme 6: Open Conversations About Mental Health***

Participants reflected on community support around mental health help-seeking, and how this would encourage youth to seek help and create an environment for shared resources and knowledge. Shreya stated, *“I think having that community, it’s a nice step in helping somebody get sent to the help that they actually need. If there's a community that's actually there to help them and to guide them in the right direction”.*

Participants, however, did feel that the most significant community factor that would promote help-seeking would be to see other community members also seeking help and normalising the process. This perception was expressed by Mirza:

*I feel I'm very scared of judgment, and if more people are open to it then I don't think anyone's going to judge you for it. Because you're not the only one that's doing it. So, it won't make you seem like you're weak. So if everyone does it, then that's something that I won't be judged about.*

Participants felt that youth and community conversations regarding mental health would further normalise help-seeking. Zaraa shared, *“And I think relating your own experience, even if it's I don't know if it's the right way, but like, I think that definitely encourages someone else. Because then they're like I'm not the only one”*.

Participants believed that a youth community that promotes mental health and help-seeking for mental health difficulties would also be taken more seriously in the greater community and by parents, and potentially begin a greater communal discussion about mental health, as opposed to leaving it as a taboo topic. Anushka shared the following:

*I'm trying to think how you would like force all the aunties and uncles to just like, sit and talk about it. But, maybe even if we can, with the adults, have a consensus of being together and being united to fight that mental health help should be a priority. And to then take that back to our parents with that kind of unity as the youth.*

Through the thematic analysis, four categories of barriers and five categories of facilitating factors were identified. The findings of the study are largely in line with the existing literature, with barriers such as a lack of knowledge about mental health, norms associated with family support, the significance of family privacy, and stigma, all featuring prominently in the themes identified in the study. However, there was a lack of existing studies and background literature on factors that facilitate help-seeking in Indian immigrants.

The facilitators to help-seeking identified through the thematic analysis were, therefore, not anticipated and served to highlight the significance of a support system that encourages help-seeking; university environments and other environments that encourage free thinking and make help-seeking resources available. Moreover, the data analysis findings revealed the importance of open conversations normalising mental health difficulties and the positive role that the media and social media can play in this process.

### ***Theme 3: Factors that serve as Barriers that Prevent or Discourage Help-Seeking in Indian Immigrant Youth***

The third theme that was identified relates to the factors that participants felt were barriers that discouraged or deterred them from seeking help.

#### ***Subtheme 1: The Individual's Perspectives on Mental Health***

Participants often wanted to manage their mental health difficulties themselves – partly because they believed that this would help them grow, or because they would find it easier to take their own advice. Additionally, most of the participants were noted to minimise the severity of their difficulties and were also noted to do this often while comparing their own situations with those of others who they deemed to have bigger problems than their own. Mirza made the following comment:

*Yeah. Every now and then whenever it was getting worse I'd think, maybe I should. But then I just left it and asked myself is it really necessary? Their problems are so much bigger than mine, so mine is so much smaller and there's no point in getting that help.*

While many participants minimised the severity of their difficulties, they reflected on still wanting more support from their families. Roshan stated, “*You want to fight your own battles and stuff, but you actually really want more support from them*”.

Many participants also acknowledged and reflected on how parental and old perspectives are often passed down and internalised, particularly relating to mental health. Shreya stated, “*And for that reason, they sort of have passed that on to their children where they don't see the need to address mental health*”.

#### ***Subtheme 2: A Lack of Access to Resources***

A few participants noted that not everyone knows about the available resources and thus they do not use them. Other participants reported that while they knew about the available

resources, they were unable to use them as they could not pay for a psychologist themselves after their parents disapproved. Divya stated as follows:

*Because, our parents do pay our fees they get all the documents and all of that stuff. But then I think that also stops kids from getting the help they need from the university because they're so scared. Oh, my God, what if my parents find out that I am getting help?*

### ***Subtheme 3: Parental Factors that Discourage Help-Seeking***

Most participants reported that their parents have strong views about mental health and help-seeking and felt that community members will also judge individuals that seek help. Participants reported that depression is viewed as insignificant, and something that can be overcome personally. Kavya reported, *“Depression is just being really sad, in their eyes, and you can get over being sad. Because if they can do it, why can't we?”*. Mental health help-seeking, however, was often associated with the idea of severe mental health problems. Divya stated, *“Okay, if you're seeing a psychologist, they think that only someone that's crazy needs a psychologist”*.

Participants reported that their parents were concerned about the community becoming aware of their mental health difficulties for fear that their child would be judged as crazy, and that they may be viewed as inadequate parents and shamed. Sita reported, *“I think they have this fear that if society finds out that – oh my God, my child is fighting depression, or my child is fighting anxiety, it somehow reflects badly on them”*.

Fear of the community finding out about their child's mental health help-seeking led parents to minimise the severity of the participant's experience or by suggesting that help is received inside the family from themselves or siblings rather than externally, potentially due to them feeling inadequate or as though they have failed. Sita remarked as follows:

*And something I also noticed is that they always avoid the fact that you need to seek help elsewhere. Maybe on some level, it makes them feel like they haven't done a good job. Like, if my parents need to send me to therapy, then it means they failed as a parent.*

Parents' fear of community stigma was also related to fear that their child would be ostracised in the community or be viewed as a poor choice as a bride or groom. Sita remarked as follows:

*And there was a phase in my life where I needed therapy, and then I did mention it to my parents. And they were very much like, you know, don't push yourself to the point where you need therapy, so you don't need that kind of thing. Yeah, that it's gonna affect your future, it's gonna affect how people see you.*

The emphasis on image may be understandable considering how participants reflected on how their parents immigrated and built successful lives and were able to do so without seeking help for their mental distress. Roshan commented as follows:

*Yes, there is because for us, there's a set path that our parents said we should follow. They migrated from India, went to another country to get a better job. They got a wife or husband and then they settled down. They want their child to do much better compared with what they have done.*

This resulted in participants feeling as though they were required to also be successful without complaining and requiring mental health assistance, which their parents never had. Zaraa said, *“My mom said; in our days, like there was nothing – like you can't even tell your parents these things. She was like, but I'm here, you can talk to me”*.

Many participants, therefore, avoided disclosing problems to their parents for fear they would disagree about them seeking help. Sita shared, *“But I was so scared that they'd disagree*

*and I'd just suffer in silence-- that I just decided to do it on my own".* Participants rather chose to seek help through university structures. Kavya said, *"But I always knew once I got out, I would be able to. When things got very hard. I always feel like it will get better. Once I'm in varsity and I have more freedom".*

#### ***Subtheme 4: Community Factors that Discourage Help-Seeking***

Participants reported feeling as though the Indian immigrant community did not have a good understanding of mental health, and help-seeking was not normalised or understood. Sita made the following statement:

*And so they just suffer in silence, or they isolate and that causes a bigger problem. And then it probably pushes them to the point of even suicide. And then the parents wonder, like, what did I do wrong? And then it's too late. So I think one of the main barriers is the moment someone says mental something, they just shut down.*

Participants also reported that parents and the community placed a very high value on academic success throughout a young person's life. Roshan said, *"But in the Indian society we mostly want doctors or engineers. And then we want them to marry another doctor or engineer just to help society, and to get money".* This emphasis on achievement was reported to start with high standards of performance in school and continue into university, with a focus on an academic comparison between children in the same age group. Shreya shared the following:

*My parents will be comparing my sister with everyone in her age group, or me when I was in high school and everyone in my age group. And like, 'did you hear what this girl did, did you hear what that girl did, did you hear she got she graduated with cum laude?'"*

Participants also reported high standards for strength and resilience, or risking being viewed as weak by the community – something that held significant value for both participants

and their families. Kavya said, “*And I was scared of telling them because they might. Yeah, like, try get me to not go. Also feel judged like: Oh, are you that weak that you need to talk to someone?*”

Some participants were concerned that their mental health difficulties will be openly discussed with the extended family or the community, and they would be viewed as flawed. Shreya said, “*And then the community knows, and all of a sudden, I'm labelled as that problem child who's looking for counselling. That definitely is a barrier*”. Additionally, several participants reported that they believed that their image or reputation would be affected by the community knowing that they are experiencing mental health difficulties and seeking help. Anushka shared the following:

*So you don't want that to go around. You don't want this image of someone who's damaged and depressed or anxious or whatever, to be your image and to like, maintain that. It sounds silly but you don't want the aunties to be like: Oh, my gosh, Anushka was admitted in the hospital.*

Through both the background literature as well as the findings of the study, it is clear that culture plays a significant role in help-seeking decisions. This is in line with the current perspectives on the impact of culture nationally, as there are significant culturally rooted differences in how mental health and mental illness are conceptualised, judged, and treated. As a result, the evaluation of the findings required a systemic perspective that acknowledges the impact of culture on different spheres of life, such as Bronfenbrenner's Ecological Systems theory.

The identified subtheme above and the other subthemes and themes show that elements of the microsystem, namely parents, friends and peers, the university environment and health services have a prominent impact on help-seeking decisions, with parents perhaps playing the most prominent role. Participants discussed how parents often lacked knowledge about mental health and often viewed mental illness as something that should be hidden. Most participants agreed that there was pressure associated with trying to live up to their parents' achievements in coming to a

new country and being successful and resilient, leaving many participants feeling that they had to display the same resilience and be equally successful. Participants, therefore, felt that their local health systems or private psychologists were not an option as they feared that their parents would find out, leading many to seek help in secret to avoid their parents finding out. Friends, cousins, and peer groups played a significant role as a source of help in that participants often turned to friends for support and found this to be helpful due to their ability to relate to similar experiences. The university environment contributed to some participants' mental health difficulties due to academic stress but was also the first place where many participants became aware of mental health and found help-seeking to be something normal for people to do.

There were also notable interactions between the different elements mentioned above, which fall into the sphere of the mesosystem. These were centred around the parents, and their interaction with either their friends or the university. Participants felt that their friends seeking help may normalise the process for their parents and make it easier for them to seek help. The interactions between parents and the university were also significant, as participants felt that because their parents pay their university fees, they may be privy to information about their child's help-seeking when using university support services.

Elements of the exosystem, such as the role of extended family and the media, were also present in the barriers and facilitators identified, as participants were concerned that friends of the family might become aware of their help-seeking and disapprove. Participants reflected on how there are more positive depictions of help-seeking in the media nowadays, and how social media could connect and unify Indian immigrant youth who want to converse about mental health and help-seeking and provide support to each other without judgement.

The macrosystem, made up of the elements that are common to a specific culture, plays a significant role in the help-seeking decisions as participants' parents and the community at large are still very connected to traditional Indian culture. Indian parents and the community were

reported to put a huge emphasis on achievement at school, university, or their career, which connected to finding good marriage proposals. Participants also reflected on the pressure to always be strong and resilient, characteristics that were valued by the community of immigrants that had to move to a new country and become successful. Many participants were noted to minimise their mental health difficulties by suggesting that they should be strong enough to overcome it, or that the issue is not significant compared with the difficulties others face, leading to many deciding not to seek help.

The ecological systems theory therefore provided structure to the various barriers and facilitators that exist in the various participants' experiences. The microsystem and its elements were certainly the most prominent direct influence, but because the macrosystem encompasses the microsystem, the behaviour and decisions of various individuals in the microsystem were significantly influenced by the macrosystem. Standards of resilience, strength, stability, and success in the Indian immigrant community had led to many participants feeling overwhelmed by the responsibility to appear as though they are thriving, while also denying the need for help for fear that they won't appear independent or resilient if they are assisted.

Elements in the microsystem and exosystem also contributed as facilitating factors, with friends, cousins and peers providing support and normalising help-seeking. Lastly, social media was viewed as a possible tool moving forward with which to connect Indian immigrant youth and provide a space for advice and support, while also promoting mental health and help-seeking to the Indian immigrant community at large.

Through the thematic analysis, four categories of barriers and five categories of facilitating factors were identified. The findings of the study are largely in line with the existing literature, with barriers such as a lack of knowledge about mental health, norms associated with family support, the significance of family privacy, and stigma, all featuring prominently in the themes

identified in the study. However, there was a lack of existing studies and background literature on factors that facilitate help-seeking in Indian immigrants.

The facilitators to help-seeking identified through the thematic analysis were, therefore, not anticipated and served to highlight the significance of a support system that encourages help-seeking; university environments and other environments that encourage free thinking and make help-seeking resources available. Moreover, the data analysis findings revealed the importance of open conversations normalising mental health difficulties and the positive role that the media and social media can play in this process.

### *Implications for the South African Context*

The participants in the study discussed the facilitators that encourage help-seeking and barriers that prevent help-seeking in the Indian immigrant youth population. Immigrant populations, and specifically Indian immigrant populations, have displayed low rates of help-seeking for their mental health difficulties, according to the existing literature. This pattern was also observed in the participants that took part in the study, with many either minimising their difficulties or attempting to overcome their difficulties on their own and choosing not to seek help despite their largely positive perceptions about help-seeking and therapy. Through the study, it has also become clear that the influence of parental and community perspectives on mental health has had a significant impact on the participants' decisions to seek help. While there were also various facilitators identified, the impact of the four categories of barriers outweighs them; leading to many participants displaying a disinclination to seek help.

This suggests that there may be many Indian immigrants across the country who are experiencing similar difficulties in seeking help for their mental health difficulties and suggests that there is a strong need for change. As suggested by one participant, such change would have to take the form of open conversation about mental health and help-seeking; something, which many participants believe does not happen in the home or the community. Several participants also

reflected on the importance of young people taking responsibility for collaborating, communicating and providing support through social media platforms, in the hope of encouraging Indian immigrant youth to seek help, which in turn normalises the process for others as well.

Considering the prominent immigrant population in South Africa, along with the known impact of culture on mental health perspectives, it is also clear that interventions to improve help-seeking rates must consider cultural background. It was noted in both the literature as well as in the participant responses that a culturally sensitive approach to understanding mental illness improves the individual's ability to speak openly and feel understood. National policies around mental health awareness should therefore tailor intervention programmes, and awareness programmes to different cultural perspectives as opposed to taking a one size fits all approach for all backgrounds and cultural contexts.

It is hoped that an improved understanding of the barriers and facilitators will also allow other Indian immigrant youth to manage their own help-seeking process and be more prepared for possible obstacles, while also being aware of how many other youths also have similar experiences regarding their mental health and help-seeking. Lastly, it is also hoped that parents become more aware of the complexities and challenges of their children's experiences and encourage and normalise help-seeking. It is hoped that, in turn, this will lead to a community that is more accepting of mental health difficulties and encourages the youth to seek help.

## **LIMITATIONS**

The limitations of the study included the demographics selected and the location. Indian immigrant youth in smaller cities or rural areas may have a different experience, with specific barriers and facilitators having a more pronounced effect on their lives. Additionally, the barriers and facilitators identified in the study may not be applicable or consistent with the experience of

non-immigrant youth, or even immigrant youth from other countries that bring their own cultural perspectives, which may be vastly different to those of Indian immigrants.

## **CONCLUSION**

This study aimed to explore and describe the potential barriers and facilitators for mental health help-seeking experienced by Indian immigrant youth. The findings of the study suggest that several barriers and facilitators influence an Indian immigrant youth's decision to seek help. The findings also suggest that the barriers currently outweigh the facilitators, and much Indian immigrant youth may therefore avoid help-seeking due to issues such as a fear of judgement from parents and the community or a fear of appearing weak, crazy or as though they are not resilient. Many participants were also noted to minimise the severity of their problems by making comparisons to others who are in worse states of mental health or making comparisons to the difficulties their parents faced as immigrants and their resilience. Most participants felt that mental health conversations are not common in the Indian immigrant community, thus further stigmatising the process of help-seeking. Participants agreed that change was necessary, but also felt that this may need to start in the youth. Youth groups that could provide support, and advice, and open up the conversation on topics of mental health and help-seeking were regarded as a possible first step towards normalising mental health. Additionally, participants felt that a group of youth with the same message around normalising mental health and help-seeking might have a stronger impact on the perspectives of the Indian immigrant community at large, as opposed to isolated conversations at home with parents. A shift in perspective from the adult population in the Indian immigrant community to open up to conversations about mental health would better allow the community to understand the complexities and challenges of the experiences of the youth and encourage them to not only find but to access the necessary help.

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### **SECTION 3: CRITICAL REFLECTION**

Section 3 comprises a critical reflection on the researcher's (Timmy Joji) experiences in conducting the study.

#### **CRITICAL REFLECTION**

The critical reflection on the researcher's experience is discussed in terms of the topic of the study, the ethics approval process, the impact of COVID-19 on the study, gathering participants, generating data, data analysis, and the findings of the study.

##### **Topic of the Study**

Being an Indian immigrant youth myself, I was privy to the elements and experiences of meshing together my Indian and South African identities. I noticed from a young age that my experiences and the experiences of other Indian immigrant children had many commonalities. Whilst growing up, I realised that the same realisation applied to mental health. I found that mental health conversations were not common in our family system and greater social group. Many of my fellow youth were having similar experiences, and I noted that many were experiencing mental health difficulties but also feeling stuck. To me, this sense of being stuck was characteristic of the experience of an Indian immigrant youth who is struggling to cope with the standards of the community, while also being unable to take any action to get help or improve the way they feel. This has, in my opinion, led to many Indian immigrant youths choosing not to seek help, causing their mental health to deteriorate further, sometimes with serious consequences.

I felt that I wanted to try to understand the experiences of other Indian immigrants in a better way in order to change things. Being an inexperienced researcher, however, my naivety led me to think that most people would see the problem in the same way I did. Additionally, I did not

realise at that time the complexity and difficulty of choosing a topic that is meaningful to me, while remaining objective and not pushing my own agenda.

### **Obtaining Ethical Approval and the Impact of COVID-19**

Having started my master's degree in 2020, I hoped to be able to quickly decide whether my topic was appropriate, structure it well and obtain approval from the Community Psychosocial Research (COMPRES) scientific committee. As this was the first year of my master's studies, and my first year of being married, this was a challenge. Additionally, the COVID-19 pandemic led to normal classes and interactions being minimised from early in the year, and I struggled to keep up with my research goals. I felt overwhelmed during this time, as I wanted to work on my research, but I was often distracted by other concerns. It was also difficult not to be able to simply walk in and speak to my supervisor or lecturers about my questions and uncertainties. By the end of 2020, I had only obtained approval on my topic from my supervisor, and it was presented at the departmental level – which required me to present my topic again the following year owing to recommended changes. I presented once more after making changes to the structure and approach to the study and obtained approval from the Subject Group Psychology (Department of Psychology) early in the year and submitted my proposal to the COMPRES scientific committee mid-way through 2021. I went on to submit my proposal to the HREC in January 2022 and obtained ethical approval (Appendix A) in May 2022. At this point, I had been waiting for approval for a long time, and I was rearing to go.

### **Gathering Participants and Data Generation**

The process of gathering participants was significantly easier than I first expected, as I assumed that few young people would be willing to speak about their mental health and experiences. However, the first round of purposive recruitment yielded nine participants who all fitted the inclusion criteria and were willing to participate in the study. As a result of data

saturation, I did not need to engage in further recruitment, and this helped to speed up the process of data generation.

The data generation process itself also went smoothly. This was another change I had noticed following the pandemic – no one wanted to meet in person. All nine participants had elected for online video interviews, and, therefore, I had to revise my interview techniques and etiquette to match the setting. I was concerned that doing the interviews over video would lead to participants being distant or disengaged, but I was wrong once again. Participants seemed to appreciate not having to take the time and risk of contracting COVID-19 to come in for an interview and engaged openly and meaningfully. This made me wonder whether I, at their age, would have been so forthcoming about such a sensitive topic. It made me happy to see that young people were willing to talk about the topic and try and improve things. I was surprised at how none of the participants wanted to engage in debriefing or speak to a lay counsellor after the session. I noticed myself suggesting it and its benefits more than a few times to each participant, but none changed their mind. I was surprised by this and hoped that they were not avoiding debriefing because of me, or because they were afraid that I might judge them. I was unsure, but having provided the participant with the details of the psychologist, as well as for the SADAG, I felt they would reach out should they need assistance. Some of these experiences were taken to my supervisors during supervision which helped to guide me to be objective and do my part of being the researcher without allowing my anxiety to lead me to conclusions that were not certain.

### **Data Analysis and Findings**

The data analysis was an enjoyable process for me as it allowed me my first opportunity to get an idea of which elements come up consistently between different participants. I noticed myself being happy that many of the common elements and themes being raised were things I had perhaps expected, either through my review of the literature or through my own experiences. This led to another moment of shock/realisation that being objective in the study would mean that I have to

constantly be aware of my feelings and my positionality (as discussed in Section 1). Even feeling happy about consistent themes or patterns could lead me to ignore other data that does not fit my presuppositions. I took some time to reflect once again on why I was doing the study, which was to produce good, reliable, objective findings on an important issue. From this point on I tried to reflect daily on the data and how it was impacting me. The writing up of the findings allowed me to further clarify the patterns I was noticing into a coherent set of categories that made sense.

The co-coder was very helpful, as our discussions allowed me to become aware of my blind spots and particular ways that I was interpreting the data, compared with an experienced third party who was not directly involved in the research itself. The write-up process of the entire mini-dissertation was a challenge. By this time, I had conducted interviews, done the transcribing and completed the analysis and findings in the course of a few months, so I was quite exhausted. My primary motivation to keep working on the write-up consistently was to not lose more time, pushing me to complete the write-up in good time.

### **Write-up and Submission**

I was able to put the final article together, after putting much time into shortening it. My original article was almost 12 000 words and had to be cut down to 7 000 as per the intended journal's specifications. This was challenging, as I did not want to lose any meaning from what the participants were saying, and I certainly did not want to cut out their direct quotes, as I felt it gave them a voice. The final mini-dissertation was compiled, and the only word to describe my feelings was a sense of relief. It has been a very long journey. I am happy to have been able to do this study, as I believed and still believe that it is meaningful. I am, however, nervous about it being graded and how I will perform, but I have decided to let things go and see what happens.

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# APPENDICES

## Appendix A: Ethics approval letter



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South Africa 2520  
Tel: 086 016 9698  
Web: <http://www.nwu.ac.za/>

North-West University Health Research Ethics  
Committee (NWU-HREC)

Tel: 018 299-1206  
Email: [Ethics-HRECApply@nwu.ac.za](mailto:Ethics-HRECApply@nwu.ac.za) (for human  
studies)

26 April 2022

### ETHICS APPROVAL LETTER OF STUDY

Based on approval by the North-West University Health Research Ethics Committee (NWU-HREC) on 26/04/2022, the NWU-HREC hereby approves your study as indicated below. This implies that the NWU-HREC grants its permission that, provided the general conditions specified below are met and pending any other authorisation that may be necessary, the study may be initiated, using the ethics number below.

<b>Study title: An exploratory study of facilitators and barriers to mental health help-seeking in Indian immigrant youth in Gauteng, South Africa</b>	
<b>Principal Investigator/Study Supervisor/Researcher: Prof CA Oduaran</b>	
<b>Student: T Joji - 35523859</b>	
<b>Ethics number:</b>	<b>N W U - 0 0 0 2 2 - 2 2 - A 1</b>
	Institution Study Number Year Status
<b>Status:</b>	S = Submission; R = Re-Submission; P = Provisional Authorisation; A = Authorisation
<b>Application Type: Single study</b>	<b>Risk: Medium</b>
<b>Commencement date: 26/04/2022</b>	
<b>Expiry date: 30/04/2023</b>	
<b>Approval of the study is provided for a year, after which continuation of the study is dependent on receipt and review of a six-monthly monitoring report and the concomitant issuing of a letter of continuation. Monitoring reports are due at the end of October and April annually until completion of the study.</b>	

<b>General conditions:</b>
<i>While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, the following general terms and conditions will apply:</i>
<ul style="list-style-type: none"><li>• The principal investigator/study supervisor/researcher must report in the prescribed format to the NWU-HREC:<ul style="list-style-type: none"><li>- six-monthly on the monitoring of the study, whereby a letter of continuation will be provided annually, and upon completion of the study; and</li><li>- without any delay in case of any adverse event or incident (or any matter that interrupts sound ethical principles) during the course of the study.</li></ul></li><li>• The approval applies strictly to the proposal as stipulated in the application form. Should any amendments to the proposal be deemed necessary during the course of the study, the principal investigator/study supervisor/researcher must apply for approval of these amendments at the NWU-HREC, prior to implementation. Should there be any deviations from the study proposal without the necessary approval of such amendments, the ethics approval is immediately and automatically forfeited.</li><li>• Annually a number of studies may be randomly selected for active monitoring.</li><li>• The date of approval indicates the first date that the study may be started.</li><li>• In the interest of ethical responsibility, the NWU-HREC reserves the right to:<ul style="list-style-type: none"><li>- request access to any information or data at any time during the course or after completion of the study;</li><li>- to ask further questions, seek additional information, require further modification or monitor the conduct of your research or the informed consent process;</li></ul></li></ul>

9.1.5.4.2 Ethics Approval Letter of Study

1


<ul style="list-style-type: none"><li>- withdraw or postpone approval if:<ul style="list-style-type: none"><li>• any unethical principles or practices of the study are revealed or suspected;</li><li>• it becomes apparent that any relevant information was withheld from the NWU-HREC or that information has been false or misrepresented;</li><li>• submission of the six-monthly monitoring report, the required amendments, or reporting of adverse events or incidents was not done in a timely manner and accurately; and/or</li><li>• new institutional rules, national legislation or international conventions deem it necessary.</li></ul></li><li>• NWU-HREC can be contacted for further information via <a href="mailto:Ethics-HRECApply@nwu.ac.za">Ethics-HRECApply@nwu.ac.za</a> or 018 299 1206</li></ul>
---

#### Special conditions of the research approval due to the COVID-19 pandemic:

**Please note:** Due to the nature of the study i.e. (face-to-face collection of qualitative data via semi-structured interviews with Indian immigrant youth), this study will be able to proceed during the current alert level, following receipt of the approval letter. No additional COVID-19 restrictions have been placed on the study other than that indicated under the COVID-19 risk mitigation strategy as indicated in the application. The researcher must, however, ensure that before proceeding with the study that all research team members have reviewed the North-West University COVID-19 Occupational Health and Safety Standard Operating Procedure.

The NWU-HREC would like to remain at your service and wishes you well with your study. Please do not hesitate to contact the NWU-HREC for any further enquiries or requests for assistance.

Yours sincerely,

  
Digitally signed by  
Prof Petra Bester  
Date: 2022.04.26  
14:38:03 +02'00'

Chairperson NWU-HREC

Current details: (20220622) G:\My Drive\6. Research and Postgraduate Education\9.1.5.4 Templates\9.1.5.4.2\_NWU-HREC\_EAL.docm  
20 August 2019  
File Reference: 9.1.5.4.2

## Appendix B: Biographical form

It would be appreciated if you could take some time to complete this questionnaire. All information given will be treated as strictly confidential.

Please answer the questions below by placing an X in the appropriate box.

1. Gender: Male  Female

2. Age:

3. Home Language

English  Afrikaans  IsiZulu  IsiSotho  Other

Please Specify \_\_\_\_\_

4. Proficiency in English

Very Good  Good  Average  Bad  Very Bad

5. Country of Birth

India  South Africa  Other

6. Mother's country of birth

India  South Africa  Other

7. Father's country of birth

India  South Africa  Other

8. How many years have you been living in South Africa:

## **Appendix C: Interview schedule**

1. What has been your experience as a young Indian immigrant of seeking mental health help?

After this question is answered, probing questions such as “Can you tell me what you mean by...” may be asked to clarify concepts or have a more focussed discussion on the participant’s personal experiences.

2. What, in your experience as a young Indian immigrant, can be barriers to seeking mental health help?

After this question is answered, probing questions such as “Can you tell me what you mean by...” may be asked to clarify concepts or have a more focussed discussion on the participant’s personal experiences.

3. In your experience as a young Indian immigrant, how do these barriers influence your behaviour and decisions when it comes to seeking mental health help?

After this question is answered, probing questions such as “Can you tell me what you mean by...” may be asked to clarify concepts or have a more focussed discussion on the participant’s personal experiences.

4. What, in your experience as a young Indian immigrant, can facilitate seeking mental health help?

After this question is answered, probing questions such as “Can you tell me what you mean by...” may be asked to clarify concepts or have a more focussed discussion on the participant’s personal experiences.

5. In your experience as a young Indian immigrant, how do these facilitators influence your behaviour and decisions when it comes to seeking mental health help?

After this question is answered, probing questions such as “Can you tell me what you mean by...” may be asked to clarify concepts or have a more focussed discussion on the participant’s personal experiences.

6. What, in your experience as a young Indian immigrant, do you think can be done to assist young Indian immigrants to seek mental health help?

## Appendix D: Editor's declaration



DR-MAUREEN-LILIAN-KLOS¶  
PROFESSIONAL-EDITOR¶  
BA;-STD;-BEd-(cum-laude);-MED-(cum-laude);-DED¶  
Registered-with-the-SAPEG-(reg.-no.-KL0004)¶  
maureenklos@gmail.com¶

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### EDITOR'S-DECLARATION¶

I,¶

DR-MAUREEN-LILIAN-KLOS,¶

Being-the-holder-of-the-following-qualifications:¶

BA;-STD;-BEd-(cum-laude);-MED-(cum-laude);-DED¶

Hereby-certify-that-I-am-the-English-language-editor-of-the-following-document:¶

AN-EXPLORATORY-STUDY-OF-FACILITATORS-AND-BARRIERS-TO-  
MENTAL-HEALTH-HELP-SEEKING-IN-INDIAN-IMMIGRANT-YOUTH-IN-  
GAUTENG,-SOUTH-AFRICA¶

by¶

T. ~~AKLOS~~¶

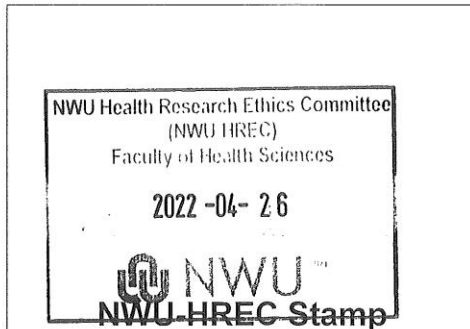
I-hereby-certify-that-I-have-edited-the-language,-formatting-and-referencing-in-the-  
above-mentioned-document-in-their-entirety.-However,-I-assume-no-responsibility-or-  
liability-for-any-post-editing-errors-or-omissions.¶

1-November-2022¶

## Appendix E: Informed consent form



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### INFORMED CONSENT DOCUMENTATION FOR INDIAN IMMIGRANT YOUTH WITH MENTAL HEALTH ISSUES BEING INTERVIEWED

**TITLE OF THE RESEARCH STUDY:** An exploratory study of facilitators and barriers to mental health help-seeking in Indian immigrant youth in Gauteng, South Africa.

**ETHICS REFERENCE NUMBERS:** NWU-00022-22-A1

**PRINCIPAL INVESTIGATOR:** Prof Choja Oduaran, Mr Curwyn Mapaling

**POST GRADUATE STUDENT:** Timmy Joji

**ADDRESS:** 1658 Maisantwa Road, Unit 6, Mmabatho 2735, South Africa

**CONTACT NUMBER:** 0710024691

You are being invited to take part in a **research study** that forms part of a Masters study. Please take some time to read the information presented here, which will explain the details of this study. Please ask the researcher or person explaining the research to you any questions about any part of this study that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research is about and how you might be involved. Also, your participation is **entirely voluntary** and you are free to say no to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part now.

This study has been approved by the **NWU-Health Research Ethics Committee of the Faculty of Health Sciences of the North-West University (NWU-00022-22-A1)** and will be conducted according to the ethical guidelines and principles of Ethics in Health Research: Principles, Processes and Structures (DoH, 2015) and other international ethical guidelines applicable to this study. It might be necessary for the research ethics committee members or other relevant people to inspect the research records.

**What is this research study all about?**

- *We plan to understand the experiences of Indian immigrant youth with mental health issues. We plan to develop a clearer understanding of whether participants believe that there may be barriers that prevent help seeking, or facilitators that encourage Indian immigrant youth to seek help for their mental health issues.*
- *This study will be conducted in Johannesburg during November and December 2021, and will be done by experienced health researchers trained in interviewing and qualitative research. Between 5 and 20 participants will be included in this study.*

**Why have you been invited to participate?**

- *You have been invited to be part of this research because you are between the ages of 18 and 24 and born to parents with Indian Nationality that immigrated to South Africa. You have also been selected because you were born in South Africa or have lived here since the age of 10 years old and therefore have experience of living in South Africa. You were also selected as you have previously or currently experienced a mental health issue, though you may not have been diagnosed or been in treatment. You were also selected as you are fluent in English, and are able to access Google meet for interviews.*

**What will be expected of you?**

- *You will be expected to attend a 1 hour interview with 6 questions, followed by a voluntary debriefing session. You will also be expected to arrange transport to and from the interview venue, and transportation costs will be reimbursed. Should the interview not be conducted in person, you will be expected to attend an online interview over Google meet, and the data costs will be reimbursed.*

**Will you gain anything from taking part in this research?**

- *The gains for you if you take part in this study will be in the form of the incentive of R100 for participation.*
- *The other gains of the study is for the Indian immigrant community at large, as well as for the research team. Through the study, we hope to gain a better understanding of perceived barriers and facilitators to help seeking. It is hoped that the findings will better inform parents, families, communities and Indian immigrant youth of the difficulties associated with seeking help for mental illness, as well as what factors may encourage help seeking.*

**Are there risks involved in you taking part in this research and what will be done to prevent them?**

- *The risks to you in this study are primarily related to psychological harm. The interview process explores personal experiences around mental illness, and may potentially trigger memories of negative experiences that could influence the*

participant's psychological state. As the study aims to explore the lived experiences of the population, it is impossible to avoid discussion of the participants mental health. To limit the risk, any participants who engaged in interviews will be debriefed to determine any risk related to a discussion around their mental health. Debriefing will be done by a trained lay-counsellor from the South African Depression and Anxiety Group who will be in attendance on the day of the interviews. Should it be necessary for the interview to be conducted via Google meet, the lay-counsellor will also be available to join the call and provide debriefing, after the interview session been concluded by the researcher. Participants who disclose, or who are observed to potentially be in need of intervention for their mental illness will be provided with the contact information for their local hospitals where they can access mental health care, along with the details for the South African Depression and Anxiety Group's (SADAG) 24-hour suicide helpline, as well as SADAG's crisis intervention line for the participant to be able to access telephonic counselling and crisis intervention. SADAG is a NGO that provides free counselling services, mental health advocacy and resources for those in need of mental health assistance.

- There are also additional risks to confidentiality in the study, as the data collection process leads to risks to confidentiality to the participants. Participants are however also allowed to answer and remain anonymous. The data collection process therefore requires for participants to provide their identifying information at least once. To limit this risk, all information gathered through recruitment of participants, as well as the interview process itself will be kept confidential through the use of physical, technical, administrative and research design safeguards (Canadian Institute of Health Research et al., 2014). The physical safeguards include the physical site for the interviews- which will be a private room where participants will not be subject to public observation. Hard drives on which consent forms and demographic forms are stored will also be kept in locked cabinets. Administrative safeguards include limiting access to any data related to recruitment, communication, and interviewing to only the researcher and the research assistant. The only other parties who will see the already anonymised audio recordings for the interviews will be the transcriber. The research assistant, as well as the transcriber will sign Non-Disclosure Agreements regarding any data they are exposed to during the course of the study. Access to the researcher's and research assistant's laptops will also be limited to the two parties only. Technical safeguards include the use of a password for the research assistant's laptop on which email communication with the gatekeepers and participants is done. Additionally, the researcher's own laptop will also be password protected as the data will be analysed on this device. Lastly, research design safeguards include the anonymization of the data after it has been received from the transcriber and compiled with the relevant participant's demographic form and consent letter. Additionally, the protocols around anonymization of the data to remove identifying information also function as research design safeguards to confidentiality.
- There are no risks to bodily harm or discomforts related to the study.
- There are more gains for you in joining this study than there are risks.

#### **How will we protect your confidentiality and who will see your findings?**

- Anonymity of your findings will be protected as specific consent will be attained before any participant is directly quoted, and direct quotes will only be included

with the use of pseudonyms. Your privacy will be respected firstly through the design of the study, as individual in person interviews are conducted so as to prevent the identification of participants by each other that would occur in a focus group setting. The interview site is also in a private area, and participant interviews are scheduled with half an hour between the completion of the first interview and the beginning of the next interview. As a result, participants will not come across each other when arriving or leaving the interviews. Your results will be kept confidential by the use of physical, technical, administrative and research design safeguards (Canadian Institute of Health Research et al., 2014). The physical safeguards include the physical site for the interviews- which will be a private room where participants will not be subject to public observation. Hard drives on which consent forms and demographic forms are stored will also be kept in locked cabinets. Administrative safeguards include limiting access to any data related to recruitment, communication, and interviewing to only the researcher and the research assistant. Technical safeguards include the use of a password for the research assistant's laptop on which email communication with the gatekeepers and participants is done. Additionally, the researcher's own laptop will also be password protected as the data will be analysed on this device. Lastly, research design safeguards include the anonymization of the data after it has been received from the transcriber and compiled with the relevant participant's demographic form and consent letter. Additionally, the protocols around anonymization of the data to remove identifying information also function as research design safeguards to confidentiality. .... Only the researchers and transcriber will see the already anonymised audio recordings for the interviews. The research team including the assistant, as well as the transcriber will sign Non-Disclosure Agreements regarding any data they are exposed to during the course of the study. Access to the researcher's and research assistant's laptops will also be limited to the two parties only. Only the research team will be able to look at your findings. Findings will be kept safe by locking hard copies in locked cupboards in the researcher's office and for electronic data it will be password protected. As soon as data has been transcribed it will be deleted from the recorders as well as the laptop of the researcher. Data will be stored for 2 years.

**What will happen with the findings or samples?**

- The findings of this study will only be used for this study.

**How will you know about the results of this research?**

- We will give you the results of this research when the study has been evaluated by the Department of Psychology at North West University and approved. The results will be shared through an infographic that summarises the key findings of the study, and should be emailed to you before April 2022.
- You will be informed of any new relevant findings by the researcher via email.

**Will you be paid to take part in this study and are there any costs for you?**

- This study is funded by the researcher and has no external funding. You will be paid an amount of R100 when you complete the interview. Travel expenses will be paid for those participants who have to travel to the site. Should the interviews be held online and not in person, the participants will be required to do the interview online, and data costs will be reimbursed.

**Is there anything else that you should know or do?**

- You can contact Timmy Joji at 0714379414 if you have any further questions or have any problems.
- You can also contact the NWU-Health Research Ethics Committee via Mrs Carolien van Zyl at 018 299 1206 or [carolien.vanzyl@nwu.ac.za](mailto:carolien.vanzyl@nwu.ac.za) if you have any concerns that were not answered about the research or if you have complaints about the research.
- You will receive a copy of this information and consent form for your own purposes.

**Declaration by participant**

By signing below, I ..... agree to take part in the research study titled: An exploratory study of facilitators and barriers to mental health help-seeking in Indian immigrant youth in Gauteng, South Africa.

I declare that:

- I have read this information/it was explained to me by a trusted person in a language with which I am fluent and comfortable.
- The research was clearly explained to me.
- I have had a chance to ask questions to both the person getting the consent from me, as well as the researcher and all my questions have been answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurised to take part.
- I may choose to leave the study at any time and will not be handled in a negative way if I do so.
- I may be asked to leave the study before it has finished, if the researcher feels it is in the best interest, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ..... on (*date*) ..... 20....

.....  
**Signature of participant**

.....  
**Signature of witness**

**Declaration by person obtaining consent**

I (*name*) ..... declare that:

- I clearly and in detail explained the information in this document to .....
- I did/did not use an interpreter.
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I gave him/her time to discuss it with others if he/she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

.....  
**Signature of person obtaining consent**

**Declaration by researcher**

I (*name*) ..... declare that:

- I had the information in this document explained to ..... by ..... who I trained for this purpose.
- I did not use an interpreter
- I encouraged him/her to ask questions and took adequate time to answer them or I was available should he/she want to ask any further questions.
- The informed consent was obtained by an independent person.
- I am satisfied that he/she adequately understands all aspects of the research, as described above.
- I am satisfied that he/she had time to discuss it with others if he/she wished to do so.

Signed at (*place*) ..... on (*date*) ..... 20....

.....  
**Signature of researcher**

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7 February 2019

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