Volume one

Mental Health and Shame: A Foucauldian Analysis of the Discourses of South Asian Girls and their Teachers

A thesis submitted to the University of Birmingham for the degree of Applied Educational and Child Psychology Doctorate

by

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Abstract

Dominant discourses construct South Asian girls and women as having a high risk of internalised problems such as depression and anxiety. The existing literature suggests that services for mental distress are under-utilised by South Asian women with the construct 'Shame' cited as a potential barrier to seeking help. Little research has examined how South Asian girls construct the notions of 'Shame' and 'Mental Health' and how these constructions relate to help-seeking. This study explores the discourses of 'Mental Health' and 'Shame' through the talk of South Asian girls and their teachers. A Foucauldian Discourse Analysis (Willig, 2008) is employed to analyse semi-structured interview data from seven girls and five teachers. This research specifically explores how South Asian girls are positioned within the discourses of 'Shame' and 'Mental Health' and how they "open up" or "close down" opportunities to seek help for mental distress. The analysis highlights that discourses of Mental Health are complex and contradictory and are tied to prevailing discourses of abnormality and the medicalisation of mental distress. Pupil and teacher discourses surfaced contemporary understandings of Mental Health as a universal and dynamic state, demonstrating a shift in discourse. Similarly, 'Shame' was constructed as oppressive, sexist and regulatory as well as helpful and protective. These constructions have implications for psychological practice and the work of educational psychologists.

Dedication

To my parents for all you have done and continue to do.

To Anmol, Sehaj and Mehar with love.

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CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

1.1 Introduction

This research forms one volume of a two-part thesis for the requirements of the Applied Educational and Child Psychology Doctorate at the University of Birmingham. This exploratory study analysed discourses of Mental Health and Shame through the talk of South Asian girls and their teachers in one secondary school. The research was conducted whilst completing a professional practice placement within a local authority as a trainee educational psychologist. This chapter presents the origins of the research, including personal and professional influences as well as my position as the researcher. Finally, a brief overview of the structure of this volume is detailed.

1.2 Origin of this study

1.2.1 Personal influences

I identify myself as a 26-year-old British Punjabi woman, daughter to immigrant parents, sister to two brothers and one sister, and aunt to three nieces. By profession, I am a trainee educational psychologist working in a diverse city in the West Midlands, where a high percentage of the pupils and families that the educational institutions serve are from ethnic minority groups. It was through these complex and sometimes conflicting identities that I began to reflect on experiences where I and family members were subject to the contradictory and disconcerting discourses of Mental Health and Shame.

The powerful discourses of Shame and the related construct of Honour have shaped my experience in particular ways. Growing up with two brothers it became apparent that the discourses of Shame can be gendered and linked to societal expectations and the upholding of particular cultural norms. Hence, Shame shapes an individual's subjectivity and informs; who they should be, what they should be and how they can achieve this.

Discourses provide a way of interpreting the world, hence identities are formed through the prevailing discourses available within a culture, which may be taken up or resisted (Burr, 2015). The construct Shame exists as a discourse and I became interested in whether this had become a 'regime of truth' (Foucault, 1975) for South Asian girls and the resulting implications of this.

1.2.2 Professional influences

These reflections coincided with the professional experience of a planning meeting at an all-female secondary school where a high percentage of pupils identified themselves as South Asian. At this meeting, a number of pupils were discussed with reference to concerns around their Mental Health. I noted that staff in this school were only alerted of Mental Health difficulties when they had escalated to self-harm, being sectioned into Mental Health institutes or the girls had attempted to end their life. I wondered why the difficulties had not been identified earlier and considered the influence of the socio-cultural background of the girls and the influence that Shame may have on help-seeking.

As part of the educational psychology training, we were introduced to the concept of 'anti-oppressive practice.' Reflecting upon the inequalities in education led to the decision that I wanted to ensure my practice as a psychologist and researcher enabled the voices of marginalised groups to be heard. As my training progressed I became increasingly aware of the ethnocentric bases of psychological theory and the discourses surrounding particular minority groups and cultures. The construct of diverse cultures cannot be ignored in education as it is through the lens of culture that people define their identities and negotiate their lives (Fernando, 2010). The profession of educational psychology plays a pivotal role in the construction of children and young people through language. Hence, the awareness of prevailing discourses and the challenging and reconstructing of them is integral to the role of educational psychologists (Bozic, 1999).

1.3 Theoretical orientation and methodology

Epistemological assumptions are key drivers which underpin this study. The theoretical orientation of this research is social constructionism (Burr, 2003). A fundamental premise of this orientation is that language is central to the construction of knowledge. Tied with social practice, language is considered to be performative (Gergen, 2007) and therefore plays a pivotal role in shaping the social world (Holstein and Gubrium, 1995). With this in mind, the exploration of discourse is central in this study. Discourse is acknowledged as having constructive power, thus it forms social structures, institutions and practices which inevitably impact upon how the world is experienced.

1.4 Study rationale

The aim of this research was to explore the discourses of Mental Health and Shame by analysing the talk of South Asian girls and teachers. Currently, the field is dominated by research examining the experiences of South Asian women's Mental Health and the barriers to service use and is lacking the voice of South Asian girls. Additionally, current discourses construct Mental Health using ethnocentric understandings. South Asian females are positioned as being particularly vulnerable to internalised mental distress and oppressed by cultural factors such as Shame. This research aimed to capture the discourses of South Asian girls and explore how they construct Mental Health and Shame. These discourses are specifically examined in relation to help-seeking.

A flexible research design is employed in this study, where the talk of seven South Asian girls and five secondary school teachers was gathered through semi-structured interviews. Foucauldian Discourse Analysis was utilised to analyse the transcripts and was deemed suitable for the aims of this research as it focuses upon the role of language in the formation of social and psychological life (Willig, 2008). Furthermore, power relations and positioning are key focuses of this analysis which allows the exploration of how discourses of Mental Health and Shame are constructed and how they function to position girls. This research has implications for educational professionals, including educational psychologists working within diverse populations where awareness of cultural concepts is crucial. The study deconstructs taken for granted assumptions around Mental Health and Shame and provides educational psychologists with the space to reflect on the influence of

prevalent discourses on their practice. In addition, this study utilises a range of person-centred activities to capture the voice of young people which can be employed within educational psychology practice with young people from diverse populations.

1.5 Reflexivity

As a South Asian woman who has lived experience of the notions of Shame, as well as experience supporting Mental Health problems, I occupy an 'insider position' (Berger, 2015); this places me within a unique position to write this thesis. My positionality is integral to the development of this research and effects how I read, perceive and interpret situations, hence this research has been both professionally and personally challenging. Through the practice of reflexivity, engagement in academic supervision and by adopting a critical approach I have attempted to delineate the bias my positionality may bring to the research, while accepting that research of this kind involves some level of subjectivity.

1.6 Structure of volume one

This volume comprises of seven chapters. Following this introductory chapter, chapter two provides a review of the literature and highlights the dominant discourses surrounding Mental Health and Shame setting the scene for the development of this research.

Chapter three provides detail on the methodological considerations, including discussion around social constructionism, the rationale and challenges of

undertaking Foucauldian discourse analysis and reflexivity in relation to my researcher position. Chapter four presents the research methods utilised and includes procedural detail regarding interviewing, ethical considerations and reflexivity.

Chapters 5 and 6 present the pupil and teacher data analysis and discussion in relation to the research questions. To close, chapter 7 provides a summary of the analysis, implications for educational psychology practice, strengths and limitations of this study and possibilities for future research. This chapter ends with my reflections upon the research journey in relation to my personal and professional training.

CHAPTER 2: LITERATURE REVIEW

2.1 Introduction

The aim of this research is to investigate how Mental Health and Shame are constructed by South Asian girls and teachers. This chapter reviews the literature to describe the current discourses around Mental Health and Shame. The implications of these discourses when considering help-seeking for mental distress are considered and particular attention is paid to how South Asian girls are constructed within these discourses.

2.1.1 Search strategy

An initial search was conducted using the terms 'Mental Health' and 'girl' within the University of Birmingham and Google scholar search platforms to obtain information on how girls are constructed in relation to their Mental Health and how Mental Health was constructed. In a similar fashion, searches were conducted on the notions of 'Shame' and 'Honour.' More refined searches included the terms: 'South Asian', 'women', 'girls', and 'help seeking.' Due to the limited literature in this area, sources relating to the Mental Health of South Asian women were used to explore the constructs relevant to this thesis.

2.1.2 Terminology

South Asian

The term 'South Asian' encapsulates a heterogeneous group from the Asian subcontinent (including: India, Pakistan and Bangladesh). Although I am using this terminology, the individuals I am referring to are those with South Asian heritage

born in Britain. It is recognised that this group differentiate according to linguistic group, religion, caste and sect, nevertheless they share the cultural ideology of interest to this research due to their common political, social and cultural histories (Cowburn, Gill and Harrison, 2015; Kushal and Manickam, 2014).

Honour

The term 'Izzat' is interpreted as 'family Honour' or 'self-respect' (Takhar, 2005), it is a complex construct and includes notions of reputation, dignity, respect, social standing and justice (Dorjee and Ting-Toomey, 2015; Kushal and Manickam, 2014). Shame and Honour are interrelated, Izzat is defined as a construct which should be protected from Shame and behaviours which can bring dishonour to the social standing of a family within the community (Gilbert, Gilbert and Sanghera, 2004). Individuals may go to great lengths to protect their family from Shame and to keep their Honour intact, this includes Honour-based violence (Gill, Strange and Roberts, 2014).

Shame

Shame is associated with the transgressions against community expectations which potentially influence family Honour (Gill, Strange and Roberts, 2014). Shame is translated loosely as 'Sharam' in Urdu and Punjabi. This research utilises the term 'Shame' when describing discourses as this is the term employed in the literature. Although, it was recognised during the interviews that the term 'Sharam' allowed full appreciation of the construct under investigation.

2.2 Discourses of Mental Health

The World Health Organisation (2014) defines Mental Health as:

> '… a state of well-being in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community.' (WHO, 2014).

The UK Mental Health Foundation (2018) and Children's' Commissioner report (2017) conceptualises Mental Health as existing on a continuum, recognising that an individual's Mental Health is dynamic, constantly evolving and influenced by a range of factors. This represents a shift in discourses in comparison to earlier essentialist notions of Mental Health, where positive Mental Health was thought to be a state that an individual does or does not have.

2.2.1 Policy context

In recent years, there has been a change in the discourse of Mental Health within government agendas and policies. With the introduction of the new Code of Practice for Special Educational Needs and Disability (SEND) in 2015, 'behaviour' was replaced by 'Mental Health' as one of the categories for SEND needs. With this change in terminology, the medicalisation of children's difficulties and the responsibility for providing Mental Health provision was placed within the educational domain.

In 2017, the 'Children and Young People's Mental Health Green Paper,' detailed the government's plans for transforming Mental Health provision in schools. The policy states that one in ten young people have some form of 'diagnosable Mental

Health condition.' This growing policy focus on children's Mental Health has led to the development of discourses that schools lack resources and skills to support the Mental Health of their pupils (Hannafin, 2018). Furthermore, demand for specialist services such as child and adolescent Mental Health services (CAMHS) is growing. It is reported that on average, CAMHS are turning away nearly a quarter of children referred to them for intervention (Patalay and Fitzsimons, 2017).

Government statistics suggest that Mental Health service use by ethnic minority groups is low (HM Government, 2017). This is despite the suggestion in the 'No health without Mental Health' strategy (DoH, 2011) that black, and minority ethnic groups have 'higher rates' of mental illness. More recently, the 'Achieving access to Mental Health services by 2020' report (DoH, 2014) acknowledges the lack of focus on ethnicity and diversity in Mental Health services. By constructing particular groups in this way, strategies called for targeted approaches to the prevention and the promotion of services that are accessible for black and minority ethnic groups. It is important to note that there are differences within these broad conceptualisations of ethnic groups. Within the 'South Asian' group, research suggests that children constructed as Indian are described as having better Mental Health than children constructed as being within the Pakistani and Bangladeshi ethnic groups (Goodman, Patel and Leon, 2008). Together this suggests that although there appears to be a shift in discourses around Mental Health and accessing support, there continues to be an underutilisation of services by some ethnic minority groups.

The level of cultural competence of Mental Health services may be one of many explanations for the lack of service uptake. Policy and government initiatives promote the 'identification' and 'diagnosis' of problems resulting in the medicalisation of mental distress. Hence, we see the dismissal of alternative discourses around Mental Health which position particular groups at a disadvantage. The consequences of constructing Mental Health problems in particular ways will be discussed in the following section.

2.2.2 Medical discourses

Psychology is historically rooted in positivist explanations of Mental Health. The assumptions and ideologies of the medical model have become embedded within everyday discourses (Lester and O'Reilly, 2017) resulting in the medicalisation of psychological distress (Shute, 2018). The dominant discourse around the cause of problems follows the premise that a person experiences a biochemical event which has implications for how they feel, think and behave. The main aim of this model is to diagnose a mental illness, usually consisting of within-person characteristics in order to identify the most suitable treatment plan. Thus the term 'mental illness' implies a disease which requires treatment to restore normal functioning (Davidson et al, 2016). Most medical practitioners, psychiatrists, and some psychologists ascribe to this 'disease' or 'medical' model by diagnosing and prescribing treatments which include medication. It has been stated that 92% of psychiatry service users are taking medication (Healthcare Commission, 2007 in Harper, 2016).

The medicalisation of mental distress is intrinsically linked with discourses of abnormality and normality. Psychology and psychiatry have attempted to make

universal claims about behaviour leading to the development of diagnostic systems such as Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM 5) (APA, 2013) and the International Statistical Classification of Diseases and Related Mental Health Problems (ICD-10) (WHO, 1992). The branch of psychology named, 'abnormal psychology' is an example of this as it attempts to categorise behaviour into 'normal' and 'abnormal' or 'acceptable' and 'unacceptable' (Foucault, 1977). Individuals who are considered to be non-compliant with societal norms are at risk of being labelled and diagnosed. Through the act of labelling as one 'outside the norm,' an individual is at risk of having practices enacted upon them to 'restore normality.' The utilisation of the concept of 'norms' can therefore be considered as institutionary and regulatory:

> 'The norm is something that can be applied to both a body one wishes to discipline and a population one wishes to regularise' (Foucault, 2003 p. 253)

Foucault argues that power operates through the discipline of behaviour of particular groups (Bracken and Thomas, 2010) hence, psychiatry is critiqued as it utilises power to enact coercive practices related to the institutionalisation of individuals experiencing severe distress (O'Reilly and Lester, 2017).

Additionally, critics argue that the evidence for particular symptoms occurring together to form 'illnesses' or 'disorders' is weak (Bentall, 2004). The categorisation of individuals into 'normal' and 'abnormal' is criticised as being ethnocentric, particularly as the definition of 'normal' is based upon western notions of well-being. Hence, the constructions of disorder have failed to account for the influence of diverse cultures as well as the constructions of gender (Harper, 2016).

The categorisation of individuals is undertaken by ‘experts’ and those considered to have epistemic authority to comment on whether a number of symptoms constitute a mental illness or disorder (O’Reilly and Lester, 2017). Hence, the issue of power is integral to the deconstruction of the language of medicalisation, as it legitimises the authority of ‘experts’ (Nettleton, 2013). In light of this, it is contended that the act of ‘labelling’ individuals in particular ways serves to suppress distress and detract attention away from wider socio-economic inequalities (Davidson, et al, 2016). This also serves the financial and political objectives of institutions such as pharmaceutical companies or government systems. Consequently, the medical position on mental distress assigns responsibility and blame to the individual, who is constructed as ‘deficient’ particularly if they cannot be ‘fixed’ or ‘treated’ through medical treatment (Gilson and DePoy, 2015).

2.2.3 Biopsychosocial discourses

Underpinned by medical principles, the biopsychosocial discourses arose out of the need for the medical profession to recognise social and psychological aspects of the individual (Lester and O’Reilly, 2017). Coined by Engel, (1977) the biopsychosocial discourse acknowledges that there may be multiple causal factors of Mental Health problems. The interaction of an individual’s biological makeup, personality, psychological style and socio-cultural environment is thought to contribute to Mental Health problems. Thus, intervention includes a combination of approaches e.g. medication, psychological therapy and changes to the environment.

2.2.4 Mental Health as a continuum

A further discourse of Mental Health is the continuum model which views Mental Health as occurring along a spectrum from mental wellbeing to mental disorder or mental illness (Dogra, et al., 2017). This discourse is also underpinned by medicalised assumptions and distinguishes between 'normal' human functioning and 'disordered' human experience. Yet it acknowledges that mental distress can occur along the continuum and therefore does not always constitute a diagnosis of mental disorder or illness.

2.2.5 Social discourses

Based on sociological ideas, social discourses of Mental Health argue that mental illness and health are constructed and reproduced in historical and social contexts. Social theories that attempt to make sense of mental illness, include social causation and societal response (Rogers and Pilgrim, 2014).

Social causation discourses argue that there are viable causal relationships between social problems and mental distress. Manifestations of distress may, therefore, be a result of experiences of oppressive social situations, disadvantage, poverty, lack of social opportunity and poor social support (Carr, 2013).

The societal response discourse suggests that stigma and secondary deviance contribute to wider systems of discrimination. Individuals perform normative roles and the identities which are commonly ascribed to patients diagnosed with 'mental disorders' are negative and therefore reinforce institutionalised stigma (Rogers and Pilgrim, 2014).

2.2.5.1 Social construction of Mental Health

A further social theory is found within social constructionism, which assumes that knowledge is created and sustained through language via interactions between people (Burr, 1995). This acknowledges that discourses of Mental Health have evolved over historical, cultural and social contexts. Mental Health is therefore not a single construct and does not have universal meanings. Social constructionism opposes the widely reported assumption that mental illness exists as an objective entity which is 'discovered' via assessment and diagnostic practices (Walker, 2006).

This orientation considers an individual's sense making of their reality as important and focuses upon how the external world is constructed by them, moving away from the internal deficit model (McCann, 2016). Realities of Mental Health problems are therefore constructed through language which is considered constitutive and central in defining what is considered normal and socially deviant in society (O'Rielly and Lester, 2017). Furthermore, language is situated and tied to social practice (Gergen, 2007), hence the use of medicalised and diagnostic language transforms individuals into the 'mentally ill' (Foucault, 1975).

> 'Madness cannot be found in a wild state. Madness exists only within a society, it does not exist outside the forms of sensibility which isolate it and the forms of repulsion which exclude it or capture it.' (Foucault, 1961 p.48)

Constructions of 'sanity' vs 'madness' are produced through discourse (Foucault, 1967; Foucault, 1977). The process of diagnosing and labelling by 'experts' can be considered a form of cultural disciplining (Foucault, 1975) maintained by the

institutions' of medicine, psychiatry and psychology to produce disciplinary regimes through the use of languages of classification.

2.2.6 Summary

This research takes a social constructionist perspective; thus language is considered to be a tool through which reality is created. Dominant discourses constructing Mental Health are centred on the medical disease and deficit model. Rendering the human subject into the 'assessed' 'diagnosed' and 'treated' based upon models distinguishing between 'normal' and 'abnormal.' The existence of a branch of medicine called psychiatry preserves this reality. By labelling the pathological the implication is that the individual is in need of treatment from an expert. It is argued that diagnostic labelling validates suffering and enables access to resources, yet the consequences of labelling include being positioned as the 'disordered,' locating the problem within the individual. Historically, the consequence of being diagnosed mentally ill has been incarceration, over time a more seemingly 'humane' treatment has emerged. The new diagnostic and treatment orientation appears more humane, however, the language of disorder and abnormality remains. These pathologising discourses are dominant in society and promoted by those in power, devaluing non-dominant cultures and marginalised groups (Walker, 2006).

By taking a social constructionist position, considerations around the context, systems and institutions of power can be made. It is important to acknowledge that prevailing discourses surrounding Mental Health have not emerged in a 'neutral space' but have arisen within a particular culture and society and cannot be

separated from political concerns, norms and values (Roberts, 2005; Foucault, 2002b). Current discourses are shaped within the socio-political context of austerity measures where cuts are being made to services resulting in a lack of resources. Consequently, although dominant discourses of Mental Health and diagnosis may enable access to support, the availability of resources remains constrained.

2.3 Girls and Mental Health

Discourses of Mental Health cannot be separated from wider discourses in society. In this section, discourses surrounding gender and femininity will be discussed before moving onto discussions around the implications that these discourses have for the conceptualisation of the Mental Health of girls, more specifically South Asian girls.

2.3.1 Gender and social constructionism

Aligned with social constructionism, gender is not thought of as a fixed set of qualities, or a fixed identity. Instead, gender is considered to be a multidimensional construct, negotiated, and jointly constructed within societal contexts (Worrell and Goodheart, 2005). It is influenced by the prevailing gender norms available within particular social and cultural contexts (Burr, 2015). By constructing gender as performative (Butler, 1990) femininity and masculinity are considered to be something that one ‘does’ as opposed to something that one ‘is.’

2.3.2 Girls and Mental Health

Existing literature on girls and Mental Health is based upon essentialist notions of gender which attribute gender disparity of Mental Health problems to sex differences. Thus externalised problems are more often attributed to boys whilst internalised problems are associated with girls (Shute, 2018). The over identification of depression in girls may be a contemporary example of how mental distress in girls is conceptualised. Recent research proposes that there has been a rise in the prevalence of emotional problems for girls, reporting 1 in 10 (9%) boys and 1 in 4 (24%) girls indicate symptoms of depression (Patalay and Fitzsimons, 2017). This constructs girls as being at a particular risk of experiencing high levels of emotional distress and has the potential of ascribing the cause of mental distress internally (Worrell and Goodheart, 2005). In addition to depression, girls are constructed as being more susceptible to other internalised problems such as anxiety and eating disorders (Kaess, 2011; Hawton, Saunders and Connor, 2012). The construction of Mental Health problems in girls is associated with the inappropriate positioning of women and girls as being 'neurotic' or 'emotionally disturbed' (O'Reilly and Lester, 2017).

These constructions of girls may also be linked with wider discourses of femininity. Discourses of masculinity and femininity are maintained through social structures and assumed, similarly to gender, to be distinct categories. Typically, girls are socialised in ways which result in a greater likelihood of placing their self-esteem and worth on successful relationships with others, body image and avoidance of conflict (Chaote, 2013). Furthermore, girls are socialised to please others, to behave

in a dutiful and ‘proper’ manner, alongside being exposed to cultural messages of having a particular appearance (Worrell and Goodheart, 2005). By adolescence, girls may have internalised these cultural messages, that their self-worth is based upon being modest and docile (Chaote, 2013).

Furthermore, females are universally constructed as subordinates and devalued as inferiors (Ortner, 1995 p.69) hence internalised responses to distress may be more approved by society as girls are socialised to avoid overtly expressing emotions which could potentially express dominance and disrupt relationships.

2.3.3 Discourses of the Mental Health of South Asian girls and women

Discourses of Mental Health are influenced by discourses of “race”**,** which is itself a politically and culturally constructed category. Different races or ethnic groups are categorised as being more or less susceptible to particular forms of mental distress (Morris, 2002). The notion of cultural differences has been considered to be a predisposing factor in the cause of problems such as depression in South Asian women by professionals (Burr, 2002). Therefore, there is the risk that ethnic minority groups are presumed to be more susceptible to mental illness because of defective genes or a defective culture (Fernando, 1989).

Historically, South Asian women are constructed as having low rates of mental distress and as being resilient (Anand and Cochrane, 2005). This may be the result of assumptions around the strong family unit of South Asian communities as a support system or the incompatibility of western categories of mental disorders (Fenton and Sadiq-Sangster, 1996). However, more recently, high rates of Mental

Health problems have been associated with this group, constructing them as being especially vulnerable to mental distress. South Asian girls and women are constructed as being more susceptible to particular types of internalised Mental Health problems, such as self-harm (Bhui, McKenzie and Rasul, 2007), eating disorders (Goodman, Patel and Leon, 2008) and depression (Kumari, 2004). This is supported by studies which describe low rates of treatment and high rates of suicide in women from South Asian communities (Bhardwarj, 2001).

Individuals from other minority ethnic backgrounds are cited as having lower rates of access to Mental Health support services, (Bradby et al, 2009; Hussein and Cochrane, 2013; Ali et al, 2017). With one paper referring to British Asian families as a 'hard to reach group' in relation to accessing Child and Adolescent Mental Health Services, suggesting there is an unmet need within this population (Bradby et al, 2007).

Caution should be taken when examining the literature on the Mental Health of South Asian women as it constructs them in stereotypical ways. Burr (2002) argues that Mental Health professionals, position South Asian women as passive or immobile which results in their cultures being considered as inferior and repressive. By constructing South Asian girls and women in this way, the literature constructs the low service uptake as an issue of culture. Within the context of education, this may reflect discourses which position South Asian girls as being passive hence, their Mental Health needs being overlooked.

Moreover, studies have examined South Asian women's experiences in relation to subordination and entrapment, which constructs them as being isolated and

subjugated by patriarchal cultures (Gilbert, Gilbert, and Sanghera, 2004; Rafique, 2010; Mustafa, Zaidi, and Weaver, 2017). Yet, the subordination of women is universally observed (Ortner, 1995). Traditional gender role ideologies legitimise male domination and attribute greater status and power to men and subsequently apportion submissive and passive statuses to women. Females are constructed as being nurturing, caregiving and responsible for the domestic realm, which legitimises the control and obedience of women (Talbani and Hasanali, 2000). Associated with traditional feminine roles, Mental Health professionals assume South Asian women are more likely to suffer from depression (Burr, 2002). Despite the increasing numbers of South Asian women accessing higher education and employment, this research constructs South Asian women as experiencing the pressure to conform to gender norms and societal expectations (Mustafa, Zaidi and Weaver, 2017). The dual burden of managing workplace and domestic responsibilities may continue to be a universal feature of the female experience. Therefore, girls continue to receive conflicting messages about achieving in education and career but remaining within a subordinate status in society (Shute, 2018).

2.3.3.1 South Asian Girls

South Asian girls living in the UK experience a unique upbringing due to the intersection of their cultural values and the values of the dominant western society. Accordingly, dual-identity formation and cultural conflict have been noted as key factors for first and second generation adolescents in relation to the development of mental distress (Gupta, Johnstone and Gleeson, 2007; Mustafa, Zaidi and

Weaver, 2017; Mustafa, Khanlou and Kaur, 2018). However, this suggests that adoption of the dominant society's norms may lead to resolution of this conflict while portraying eastern cultures as repressive, and rigid (Burr, 2002).

2.3.3.2 Constructions of Mental Health

South Asian women and girls are constructed in the literature as having limited awareness of Mental Health problems (Rafique, 2010). Contesting this, research suggests South Asian women have differing conceptualisations of mental distress (Anand and Cochrane, 2005; Dein and Illaiee, 2013; Ali et al, 2017), which are linked with help seeking for British Asian and Pakistani adults (Sheikh and Furnham, 2000). These constructions may not directly translate into the western classifications of mental disorders. Hence the construction of mental distress as a biological disorder would warrant 'treatment' from medical professionals but conceptualised as a religious problem it would warrant alternative sources of support such as religious and spiritual healers (Dein and Illaiee, 2013; Ali et al, 2017). This is supported by literature arguing that individuals who viewed problems as being socially located were less likely to seek help from medical professionals (Rafique, 2010). More recent evidence suggests South Asian girls were aware of the support available from psychologists and distinguished this from medical treatment (Ali et al, 2017). They, therefore may have differing conceptualisations to adults and may explore a range of help seeking options.

2.3.3.3 Accessing Mental Health Services

Literature examining South Asian women's experiences of Mental Health services acknowledges the need for culturally competent counsellors. The importance of having professionals from similar ethno-cultural backgrounds with an awareness of cultural issues was highlighted (Ali et al, 2017). An important issue omitted is the cultural inadequacy of ethnocentric understandings of Mental Health which are dominant within therapeutic training.

Stigma regarding the usage of Mental Health services and a lack of trust has been cited as a barrier to seeking support (Ali et al, 2017; Mustafa, Zaidi and Weaver, 2017). Depression is constructed as having higher stigma in South Asian cultures than western cultures (Thapar-Olmos and Myers, 2018). The importance of trust was related to 'stigma' and Shame attached to being constructed as having Mental Health problems. A fear of stigma and gossip about a child's 'madness' is discussed as a barrier to CAMHS service use (Bradby et al, 2007) however, this research fails to deconstruct 'stigma' and does not examine the issues surrounding Shame associated with help-seeking.

Overall, the discourses surrounding the Mental Health of South Asian women are embedded within discourses of race, gender and femininity. Burr (2002) argues that constructions of South Asian women in particular ways forms racist discourses. Eastern cultures are therefore considered to be inferior, repressive and patriarchal in comparison to western cultures which are presumed to be homogenous, superior and normative. South Asian culture may, therefore, be pathologised and considered

to be a predisposing factor for mental distress with the cause of Mental Health problems located within the eastern culture.

2.4 Discourses of Shame

This section describes the varied constructions of Shame within the literature, before focusing upon how Shame is described in relation to South Asian culture. Following this, research linking the construction of Shame to implications for Mental Health help-seeking is discussed.

Within the literature, Shame is constructed in two ways, typically it is described as a 'feeling,' or an 'emotion' (Gilbert, 1998, 2002), (represented in lower case as 'shame'). 'Shame' (with an upper case S) encompasses a socio-cultural construct, which exists and is maintained within discourse. This research is concerned with 'Shame' and examines how it is constructed and how it functions.

2.4.1 Shame as an emotion

Shame is widely constructed as a social and psychological emotion, which is understood to be primitive and universal. It is depicted as 'hidden' or 'masked' by more socially acceptable emotions such as anger, guilt or embarrassment. And thought to be 'triggered' within social interactions resulting from inadequacy or misbehaviour (Scheff, 2013). Gilbert, (1998, 2002) breaks down this construction of shame into three forms.

Type of shame	Description
Internal shame	Related to negative self-perceptions and feelings
External shame	Related to perceptions of how an individual thinks others feel and think about them
Reflected shame	Related to one's behaviour, which has potential to bring shame to others, as well as the potential of others behaviour to bring shame to oneself.

Table 1: Forms of shame (Gilbert, 1998, 2002)

These constructions of shame are based upon essentialist notions within mainstream psychology which argue that emotion is fundamentally physiological. Social constructionism challenges these assumptions by considering emotions as biological, psychological and social (Wetherell 2012; Burkitt, 2014). In line with the theoretical orientation of this study, feelings or emotions are considered to be constructions which come into being through social interactions. The following section discusses Shame as a socio-cultural construct.

2.4.2 Shame as a social construct

Discourses of shame as an emotion prevail within Western societies, where the focus is upon the individual and the self. In contrast, collectivist societies construct Shame in a relational way.

2.4.2.1 Shame and Honour

The definition of Honour varies in accordance to differing cultural and linguistic groups. Honour beliefs are not bound to a particular religion or culture, hence

understanding the phenomena of Honour and Shame requires us to look beyond cultural stereotypes and examine the constructions of Honour and Shame within different communities. Of interest to this research, are the Shame and Honour constructs associated with the South Asian diaspora in the UK, this includes those belonging to Muslim, Sikh, and Hindu communities. These communities have shared cultural norms because of their collective past and shared territory before and during the partition of British India (Kushal and Manickam, 2014).

The Urdu/Punjabi word 'Izzat' refers to Honour and encapsulates a wider definition which includes the socio-cultural relationships and ties that bind family and community groups together (Gill and Brah, 2014). The importance of Izzat extends to all family members who are expected to preserve and enhance family Izzat hence the actions of an individual reflect on the entire family (Gilbert, Gilbert and Sanghera, 2004; Thapar-Olmos and Myer, 2018). Preservation of family Honour can therefore lead to powerful effects on behaviours (Bhugra, 2002; Reavey, Ahmed and Majumdar, 2006). The extreme consequences of disgracing family Izzat include social ostracism, or Honour based violence (Cihangir, 2012; Cooney, 2014).

2.4.2.2 Shame regulates behaviour

Shame and Honour are therefore interrelated, with Shame constructed as a mechanism to protect Honour (Pask and Rouf, 2018). Honour relates to the *'behaviour expected of members of a particular community, while Shame is associated with transgressions against these expectations'* (Gill, Strange and Roberts, 2014 p.2). Shame exerts influence by delineating normal and abnormal

and what is considered shameful from that considered honourable (Gill, Strange and Roberts, 2014).

The breaching of social values, could potentially cause the loss or damaging of Honour with the potential to bring Shame to oneself and their family (Gill, Strange and Roberts, 2014; Pask and Rouf, 2018). Accordingly, individuals in communities that value Honour are not only motivated by a desire to obtain and maintain Honour but are equally concerned with avoiding Shame (Wikan, 2008).

2.4.2.3 Shame and gender

What is judged to be acceptable, unacceptable, Honourable or Shameful is gendered. The obligations placed upon females and males are related to the constructions of masculinity and femininity and relate to inequalities of gender and power. South Asian cultures are collectivist and patriarchal in nature and exertion of Honour as a construct perpetuates the patriarchal order (Kushal and Manickam, 2014). Thus, an emphasis is placed upon familial obligations, where the welfare of the group takes precedence over the welfare of the individual. Traditional gender norms and hierarchical parent-child relations place domestic responsibility, including the care and socialisation of children within the responsibility of females.

Females are positioned as the repositories of Honour (Kushal and Manickam, 2014) therefore family Honour is achieved and maintained by the conduct of females, their conformity with social norms, traditions and regulation of their social and sexual behaviours (Gill, 2009; Gill, Strange and Roberts, 2014):

> '…ideas that the reputation and social standing of an individual, a family or a community is based on the behaviour and morality of its female members. Like other forms of Honour, this concept does not exist in a vacuum but rather as a central part of a complex social structure which governs relationships between different families, genders and social units within a given society.' (Brandon and Hafex, 2008 p.3).

Shame and Honour create complex hierarchies of power. Women and girls are constructed as being obedient, pure, and modest which leads to overprotection by family members (Furnham and Adam-Saib, 2001) and the positioning of females as subjects of control. Males are constructed as powerful, strong and protectors of Honour and preventers of Shame (Gill, Strange and Roberts, 2014; Pask and Rouf, 2018). Males and females are therefore viewed in terms of: 'men are respected and women are protected,' positioning women and girls with a subordinate status (Shute, 2018). Thus men's masculinity and reputation is tied to the behaviours of girls and women. Honour-based violence is an example of a public display of disciplinary power which affirms the masculinity of male members by exerting control over their female relatives (Gill, Strange, and Roberts, 2014). These constructions are related to dominant discourses of womanhood and embedded within cultural systems which ensures control and compliance of females (Ortner, 1995).

> '…female 'Honour' becomes a currency that is used to measure the worth and social standing of the entire family and any deviation from the Honour ideal is dealt with severely. Through the practice of dowry exchanges at weddings, women's bodies and sexuality acquire a monetary value which encourages men of the family to guard them as they would any other capital.' (Kushal and Manickam, 2014, p.6)

Gender inequality and power differentials result in Shame being constructed as a tool to prevent dishonour by placing the responsibility upon female members to avoid shameful behaviours (Kushal and Manickam, 2014; Gilbert, Gilbert and

Sanghera, 2004; Pask and Rouf, 2018). This includes the failure to align with expected gender roles, and the varying roles of a female within a family unit which are thought to bring about Shame (Gilbert, Gilbert and Sanghera, 2004). The consequences of misbehaviour relate to the marriage prospects of female members of the family. As the extent to which a woman conforms to the cultural and religious norms determines how she and her family are perceived by the community (Gill and Brah, 2014).

2.4.2.4 Shame as a mechanism of control

The construction of Shame exerts extreme 'psychological, mental and physical control' over women and girls. It becomes internalised, resulting in difficulty imagining life outside of this construct as it functions as a 'guiding principle for an individual's actions and identities.' (Kushal and Manicham, 2014). Prevention of Shame is therefore maintained through self-monitoring and regulation of behaviour (Pask and Rouf, 2018).

Social institutions such as the family, community and religious establishments also play a role in surveillance. The goal is to prevent cultural deviancy and maintain moral and social order by upholding Honour and preventing Shame (Wardak, 2000; Zaidi, Couture-Carron and Maticka-Tyndale, 2016). Hence, Shame is constructed as a mechanism which has become a 'regime of truth' (Foucault, 1975) supporting the maintenance of patriarchal order linked to maintaining ethnic identity and establishing cultural order (Kushal and Manickam, 2014).

2.4.2.5 Shame as a barrier to help-seeking

Existing literature on help-seeking discusses Shame in relation to Honour-based violence. Disclosing violence and abuse poses the risk of bringing Shame upon the self and the family (Cowburn, Gill and Harrison, 2015). The notion of avoiding Shame and upholding Honour are constructed as powerful inhibitors of behaviour in relation to seeking help for sexual abuse and other forms of abuse (Haboush and Alyan, 2013; Cowburn, Gill and Harrison, 2015). Thus, Shame and Honour function to:

> 'legitimise gender violence and oppression and further silence women from being able to discuss, seek support or challenge such oppressions.'
>
> (Gilligan and Akhtar, 2006, p.1370)

2.4.2.6 Shame and Mental Health help-seeking

Mental Health difficulties constructed within the discourses of abnormality may bring Shame and pose threats to family Honour; Shame is therefore considered a barrier to seeking support (Gilbert, Gilbert and Sanghera, 2004; Gilbert et al, 2007). Research constructs the preservation of Honour and avoidance of Shame as being integral to decision making in regards to seeking help for Mental Health problems among South Asian women in Canada (Mustafa, Zaidi and Weaver, 2017) in the UK, (Bhardwaj, 2001; Baldwin and Griffiths, 2009) and in the Netherlands (van Bergen et al, 2012).

In relation to children, South Asian parents construct Shame as a barrier to accessing CAMHS for their children (Bradby et al, 2007). This was related to the

medicalised construction of mental distress and being labelled as ‘mad’ which was deemed Shameful. The parents in this study avoided Shame by resisting diagnostic labelling and utilising terminology describing the behaviour rather than the disorder. Those that adopted the biological discourse considered their child to have some sort of deficit which was ‘curable’ or ‘fixable’ through medical intervention. Whilst some parents kept the problem within the family and remained out of the reach of service provision and therefore did not seek professional help.

This demonstrates that the fear of being labelled ‘crazy’ is thought to bring Shame, which may result in being ostracised from the family and community (Gilbert, Gilbert, and Sanghera, 2004). A pathologising label may be considered to be a violation of the social norm resulting in dishonour.

2.4.3 Summary

Taken together, the existing literature conceptualises Shame as a construct which has the potential to damage family Honour. Seeking help for difficulties considered to be ‘abnormal’ could potentially result in Shame for the individual and the family, damaging their marriage prospects and the family’s social standing in the community.

As Shame regulates and inhibits behaviour, it has the potential to legitimize gender violence, oppression and silence women (Bhardwaj, 2001; Haboush and Alyan, 2013; Cowburn, Gill and Harrison, 2015). These constructions of Shame position and construct South Asian women as trapped, deprived of agency, and passive. Unable to escape or resist prevailing discourses of Honour and Shame result in

their oppression and submission. Consequently, essentialising South Asian culture and constructing South Asian gender relations as oppressive (Tummala-Narra, et al, 2013).

2.5 Research Questions

Alongside the analysis of the current discourses surrounding Mental Health and Shame presented in this literature review, the aims of this study are influenced by the critique of two key research papers (Gilbert, Gilbert and Sanghera, 2004; Kushal and Manickam, 2014).

Gilbert, Gilbert and Sanghera (2004) utilised focus groups with South Asian women to examine Shame, Honour, subordination and entrapment in relation to Mental Health service use. Critical appraisal of this study reveals several methodological limitations, this includes the limited complexity of data that can be constructed from focus groups due to group dynamics and the potential effects on participants discussions. The participants in this study were volunteers who had experience of being supported by a human rights charity which assists individuals who have experienced honour based violence; this context will have influenced the discussions. Furthermore, the definitions of Mental Health in this study are based upon positivist notions of mental ill health and referred to as 'psychopathology.' Whilst it is acknowledged that Shame is a cultural construct it is not deconstructed and constructed by the participants themselves in depth and in relation to its function when considering Mental Health help-seeking.

Similarly, Kushal and Manickam, (2014) provide a critical examination of autobiographical accounts of honour-based violence. This paper presents an

extreme construction of the impact of Shame in the lives of South Asian women living in the United Kingdom. Appraisal of these studies provided the basis for the development of this research, specifically the use of alternative methods to capture the voice of South Asian girls and explore how they construct the notions of Mental Health and Shame were central focuses of this study. The use of methods which captured rich data reflecting the complexity of discourses was important as alongside the voice of South Asian girls this was missing from the literature. (The research design and methods are described in detail in Chapter 4).

The research questions addressed in this study are:

Participants	**Research questions**
Pupils	1. How do South Asian girls construct Mental Health? 2. How do South Asian girls construct Shame? 3. What subject positions do these constructions of Mental Health and Shame offer? 4. How do these constructions open up and close down opportunities for help-seeking? 5. What disciplinary powers are present and how do they constrain or control subjects?
Teachers	A. How do teachers construct Mental Health? B. How do teachers Shame? C. What subject positions do these constructions of Mental Health and Shame offer? D. How do these constructions open up or close down opportunities for help-seeking?

Table 2: Research questions addressed in this study

CHAPTER 3: METHODOLOGY

3.1 Introduction

This chapter begins with a consideration of the ontological and epistemological issues relevant to this research. This is followed by a discussion of the relevance of the work by Michel Foucault (1977), specifically, the use of Foucauldian discourse analysis (FDA) as a tool for data analysis (Willig, 2008).

3.2 Research Orientation

The orientation of this research is influenced by the way in which the nature of social reality is viewed and based upon these assumptions how it is best examined (Bryman, 2001). Ontological assumptions are beliefs held around the form and nature of the existence of the world. Epistemology is the way a researcher comes to know the nature of knowledge and its types (Thomas, 2017). These philosophical assumptions feed into how research questions are formulated and thus how the research is conducted (Bryman, 2001).

Table 3: Common research orientations and their ontological and epistemological positions (Based on Guba & Lincoln, 1994; Thomas, 2017).

	1. Positivism	**2. Post-positivism**	**3. Social Constructionism**
Ontology	Realist: A single, knowable reality exists.	Critical Realist: An external reality exists which can only be known imperfectly.	Relativist: Multiple versions of reality exist and are constructed during interactions in numerous ways.
Epistemology	Objective: Findings are	An objective, critical approach is taken, with a	Subjective: findings are constructed by the researcher which aim

	viewed as 'truths' or 'universal laws.'	recognition that knowledge is imperfect.	to understand constructions or interpretations of the world.
Methodology	Scientific investigation, experimental observation, and measurement.	Use of both quantitative and qualitative methods.	Qualitative methods, typically interviews and focus groups.

Historically, positivism has been the dominant research paradigm in social sciences (Thomas, 2017). The positivist-empiricist view contends that knowledge can be obtained through unbiased observations and what we perceive to exist is what exists. In this way, mainstream psychology has made realist, essentialist and universalist claims about the world (Burr, 2015). Conversely, social constructionism rejects the claims to truth made by the natural sciences, viewing them as restrictive, pathological and oppressive. The rise in interpretivism in opposition to the dominant view has led to the development of alternative versions of knowledge, truth and the self (Gergen, 2007).

The position taken in this research is social constructionist. The study aims to understand how girls and teachers construct the socio-cultural concepts: 'Mental Health' and 'Shame' and the implications of these constructions.

3.3 Social Constructionism

Social constructionism is a theoretical orientation which underpins a range of approaches, including Discursive and Critical psychology. It is influenced by a range of disciplines including linguistics, philosophy, and sociology (Burr, 2015). With no

single definition, social constructionism is instead characterised by a range of assumptions as described by Burr (2015):

- There is not one objective single reality but multiple versions of reality
- Knowledge is constructed between people in social interactions
- Our understandings of the world are historically and culturally located therefore should not become ultimate descriptions or laws about human nature
- Different constructions are able to bring about and exclude social action and are therefore bound with power relations and what is/is not permissible to do.

Research taking a social constructionist approach is concerned with language and views language as a fundamental means by which the social and psychological worlds of individuals are constructed. Language is therefore seen as having a 'performative' function and a 'constructive force' (Burr, 2015); it is behaviour in itself and a form of social action (Fishbein and Ajzen, 2010). Analysis of discourse is one means through which multiple constructions of meaning and knowledge can be understood (Robson, and McCartan, 2016). As multiple meanings are possible, social constructionism offers opportunities to move from deconstruction to reconstruction (Gergen, 2007).

3.4 Discourse

Discourse is a widely used term with varying definitions that are contradictory in nature. One definition of discourse suggests it is 'a set of meanings, metaphors, representations, images, stories, statements… that in some way together produce a particular version of events.' (Burr, 2003 p.64). Discourses provide a frame of reference, a way of interpreting the world by giving it meaning and allowing objects to take shape (Burr, 2015). By analysing discourse researchers are able to interpret

experiences and the behaviour of people within social structures or practices by deconstructing them: ‘taking them apart and showing how they work’ (Burr, 2003, p.18).

Parker (2005) described four key ideas in relation to discourse:

1. Multivoicedness: people may contradict themselves when they draw on different discourses
2. Semiotics: the way we put language together is not always under our control and therefore may have unintentional consequences
3. Resistance: language does not just describe the world but also achieves things
4. Discourses can present oppressive versions of the world.

Discourses are productive and described as ‘practices that systemically form the objects of which they speak’ (Foucault, 2002a, p.54). This research is concerned with the objects ‘Mental Health’ and ‘Shame’ and how they are constructed through language. The discourses of ‘Mental Health’ and ‘Shame’ are capable of producing and forming social structures and practices which influence views of the world (Smith, 2008). For this reason, discourses are powerful as they have implications for what we can do and what we should do.

Social constructionism rejects the notion that individuals are authors of their beliefs, and choices; instead it considers properties such as opinions and attitudes as effects of language (Burr, 2015). Individuals are viewed as products of discourses and particular versions of things that are socially and culturally available at a particular point in time. As there are a limited number of discourses available, there are limited elements of identity on offer. However, as Foucault (1978) asserts in his writings on power and knowledge: ‘where there is power, there is resistance.’ Thus,

prevailing discourses can be resisted and identities can be reconstructed or renegotiated. This process of threatening the status quo through resistance, however, fosters conflict and resistance from social institutions (Burr, 2015).

3.4.1 Approaches to analysing discourse

Discourse analysis investigates which discourses are shared across texts and which constructions of the world they seem to be advocating (Coyle, 2007). Burr (2003) describes two types of social constructionism (macro and micro social constructionism) both types are based upon the assumption that language is performative and constructive.

Micro-social constructionism is concerned with constructions of accounts within personal interactions, it lends itself to approaches such as conversational analysis and discursive psychology (Potter and Wetherall, 1987; Willig, 2008). Conversely, macro-social constructionism views language as a form of social structure within a social and historical context which influences how we experience the world. It is concerned with power and ideology and commonly associated with approaches such as critical discursive psychology and Foucauldian discourse analysis (Coyle, 2007; Willig, 2008).

Types of analysis	Critique	Type of Social Constructionism
1. Conversational analysis Focus on small-scale naturally occurring interactions. Stresses the active role of the person in the interaction. Interested in the strategies used in building accounts and managing interactions. The analysis uncovers the nuances of spoken	Does not allow interpretation of power relations that may be implicated in interactions and so does not go 'beyond the text.' Focuses on identifying more or less objectively present features of interaction. Not	Micro-social constructionism

language, e.g. pauses and emphasis.	concerned with reflexivity but with traditional concepts of objectivity, reliability and validity.	
2. Narrative analysis Life stories describing coherent identities are constructed by tying together past, present and future in autobiographical narratives. The person is viewed as an active creator of the story.	Based upon the assumption that there is a relationship between subjective experience and our personal narratives. Takes a realist position, considers a person's experiences and the sense they make in their narratives as being directly expressed through language.	
3. Discursive Psychology Analysis of talk in naturally occurring interactions and interviews. Aims to identify the forms or arguments; rhetorical devices used by participants. Concerned with how people build defensible identities, how they construct and present 'versions' of themselves and events as 'factual' and how they legitimate their actions.	Looks at the micro-processes of interactions and not links with wider social, ideological and power relations.	Micro-social constructionism
4. Interpretive repertoires Analytical tool used to identify culturally available 'linguistic resources' and 'toolkits' that speakers use to build their accounts rather than the specific rhetorical moves that they make in an interaction.	Links with discursive psychology, the analysis is micro- smaller scale examines resources used and not the structures that may impose a certain kind of experience of the world.	Micro-social constructionism
5. Critical discourse analysis The central concern is the relationship between language and power and exposing power inequalities and ideology. Examines how discourses are	The focus is on analysis and critique of discourses in public or institutional settings.	Macro-social constructionism

struggled against and resisted. Has the ability to expose powerful ideologies transmitted via text.		
6. Foucauldian discourse analysis (FDA) Discourses bring with them different possibilities for what a person is able to do, what they may do to others or what they are expected to do for them. Discourses bring power relations with them. The focus is on how language is implicated in power relations. The ways in which discourse produce subjectivity through positioning, and practice.	No prescribed process. The procedure is subjective and interpretive.	Macro-social constructionism

Table 4: Approaches of discourse analysis (Based on Willig, 2008; Smith, 2008).

FDA is the most appropriate tool for analysing discourse in this research. In line with the research questions, FDA enables the exploration of constructions, power relations, subject positioning and actions. FDA is deemed suitable 'to examine issues where people's own bodies are regulated in some way' (Wiggins, 2017, p.50). Hence, an emphasis is placed upon the implications of language in terms of power relations. This is deemed to be of value and more appropriate in this study than the analysis of the tools used to manage stake, create identities or narratives about one's life in interactions. Additionally, this research is interested in the macrostructure of language and the social world and its implications on subject positions and action. FDA is often used to analyse discourses surrounding social inequalities such as Mental Health, gender, race and ethnicity (Burr, 2015). FDA enables the examination and the influence of institutions of knowledge such as

psychology and medicine whilst considering how particular objects and subjects are formed (O'Reilly and Lester, 2017).

3.5 Foucauldian Discourse Analysis

Foucault's broad definition of discourse as 'a general domain of all statements' (1972, p. 80) encapsulates the idea that discourse can be used to refer to all utterances and statements which have meaning and some effect. When adopting a macro-social constructionist perspective, discourse can be described as 'practices that systemically form the objects of which they speak' (Foucault, 2002a, p 54). Researchers adopting a Foucauldian perspective view the world as having a structural reality in terms of power relations and underpin how we understand and talk about the world (Burr, 2003).

Foucault associates discourse with power and demonstrates how discourse is regulated by a set of rules which lead to the distribution and circulation of certain utterances and statements:

> '…in every society, the production of discourse is at once controlled, selected, organised and redistributed by a certain number of procedures whose role is to ward off its powers and dangers…' (Foucault, 1981, p.52)

The restricted circulation of discourse and exclusion of some statements is important as it is this practice which results in discourses operating as both a means of oppression and a means of resistance (Mills, 2004). In this way, Foucault asserts that discourse determines the reality that we perceive and constrains our perceptions (Foucault, 1972). Discourses are seen to facilitate and limit, enable and constrain what can be said, by whom, where and when (Parker, 1992).

The practice of 'truths' within discourse sets standards for individuals, through which individuals shape their lives (Foucault, 1980). Power acts to subjugate alternative pieces of knowledge by privileging dominant discourses and versions of social reality that legitimate existing social structures and power relations (Smith, 2008). Discourse is therefore intrinsically linked with power and related to what is permissible to say, do, and be.

> 'Discourse transmits and produces power; it reinforces it, but also undermines it and exposes it, renders it fragile and makes it possible to thwart it.' (Foucault, 1978, p. 100-1)

Discourses construct both objects and subject positions and it is the availability of certain ways of seeing and being through particular subject positions which have implications for subjectivity and experience (Parker, 1994). When analysing discourse, the aim is not to describe which discourses are true or accurate representations of the 'real,' instead, FDA aims to describe the mechanisms through which subjects are produced by dominant discourses.

3.5.1 Objects

Objects are formed in discourses, they refer to 'things' constructed through language (Coyle, 2007) and many do not exist outside the realm of discourse (Parker, 1992). An object can be constructed by multiple discourses, which can be contradictory and bring into focus different aspects of the object (Burr, 2003).

3.5.2 Subjects

Discourses also have the ability to construct individuals, this brings with it possibilities of a range of subject positions that an individual may adopt or place

others within. Positioning is concerned with the functions served by subject positions (Davies and Harre, 1999; Hollway, 1989) and bring with them 'the structure of rights and duties for those who use that repertoire' (Davies and Harre, 1999). Particular images, metaphors and obligations concerned with the kind of responses that can be made are brought into being (Coyle, 2007). Positioning is important in Foucauldian perspectives as it is through this process that identities are produced:

> 'Availability of discursive positions on offer to us during social interactions may, therefore, play a central role in the extent to which we are able to negotiate satisfactory identities for ourselves, and in our ability (physically and morally) to behave and to take action as we would like.'(Burr, 2015, p.138).

Subjects are the bodies on and through which discourses act (Kendall and Wickham, 1999 p.53). Individuals can choose to accept or resist positions afforded to them through discourse, as discourse is related to power relations (Parker, 1992).

> 'Individuals are constrained by available discourses because discursive positions pre-exist the individual whose sense of 'self' (subjectivity) and range of experience are circumscribed by available discourses.' (Willig, 1999b, p.114)

3.5.3 Power

Foucault contends that power is not held by one particular group of people but can be held and used by anyone (Smith, 2008). Power permeates all relations in society, hence it is enacted in every interaction. All relations between people are viewed as power relations, each interaction involves a negotiation of power and an individual's position within a hierarchy is established no matter how flexible and ill-defined the hierarchy is (Mills, 2004). Power is not viewed as a negative oppressive measure but as productive and able to bring about new forms of behaviour as well

as restricting it. Consequently, power relations construct subjectivity and behaviour rather than simply repressing them (Mills, 1997).

3.5.4 Disciplinary Power

As dominant discourses produce subjects, Foucault (1982) asserts that individuals become 'docile bodies' guided by internalised discourses which prescribe to a set of social standards. Hence, discourses operate as a form of cultural disciplining, a method of psychological control of bodies which aims to create a population that is efficient as a result of its increased obedience.

Table 5: Mechanisms which produce docile bodies (Foucault, 1977)

Mechanism	Description
1. Hierarchical observation	The control of behaviour through observation. *'an architecture that would operate to transform individuals: to act on those it shelters, to provide a hold on their conduct, … to make it possible to know them, to alter them' (Foucault, 1977, p.172)* An example: lecture hall where the speaker and the students are in full view of each other which allows optimal conditions to listen but also, the speaker has optimal conditions for surveillance of their students.
2. Normalising judgement	Individuals are judged on a scale in comparison to others and not through their intrinsic rightness or wrongness. This type of control is pervasive in society across every level of achievement. The scale demonstrates that there is always a higher level of achievement possible. Societal norms define acceptable and unacceptable modes of behaviour which are then classified as 'normal' and 'abnormal.' The threat of being judged abnormal constrains us.
3. Examination	Combination of both hierarchal observation and normalising judgement. *'…a normalising gaze [that] establishes over individuals a visibility through which one differentiates them and judges them.' (Foucault, 1975)*

	This form of modern power is invisible but controls its subjects by making them highly visible e.g. criminals in a prison.

3.5.5 Panoptical society

The internalisation of discourses result in self-monitoring and self-regulation of behaviour. Individuals, therefore, conduct themselves according to a set of cultural norms (Foucault, 1977). Subjects are therefore controlled not only as objects of disciplines that have expert knowledge of us but are also controlled as self-scrutinising and self-forming subjects of our own knowledge:

> 'But in thinking of the mechanisms of power, I am thinking rather of its capillary form of existence, the point where power reaches into the very grain of individuals, touches their bodies and inserts itself into their actions and attitudes, their discourses, learning processes and everyday lives.'
> (Foucault, 1980, p.39)

Foucault described an architectural device which exemplifies self-regulatory discipline called the 'Panopticon' (Foucault, 1977). The Panopticon was a way of arranging people which ensured prisoners did not have contact with one another but it was possible to see all inmates without the observer being seen. This building exemplifies a new form of disciplinary practice which restricts behaviours as the individual is forced to behave in a way which assumes they are constantly being observed (even when they are not). The individual takes on the dual role of the oppressed and the oppressor as the desired way of behaving becomes internalised. This disciplinary regime operates upon the assumption that the 'guard' is always watching. Individuals are therefore both subject to and the subject of workings of power relations which: *'induce in the inmate a state of consciousness and*

permanent visibility that assures the automatic functioning of power' (Foucault, 1977, p.201).

3.6 Rationale for adopting a Foucauldian approach

The aim of a Foucauldian approach is to analyse inequalities and oppression (Burr, 2015), this is achieved by going beyond the interpersonal aspect of language as in discursive psychology. FDA asks questions about the relationship between discourse and what they may do (practices) and the material conditions within which such experiences may take place (Smith, 2008). FDA is concerned with the role of discourse in wider social processes of legitimation and power. Since discourses make available ways of being, and they are strongly implicated in the exercise of power (Smith, 2008).

The aim of this research is to explore the relationship between the discourses of 'Mental Health' and 'Shame,' the way South Asian girls and teachers are positioned and whether these positionings have the potential to influence their actions regarding help-seeking for Mental Health. FDA is an appropriate approach as it uncovers the discursive constructions of the objects of study (Mental Health and Shame). Revealing these constructions enables the range of subject positions of the individuals of interest (South Asian girls and teachers) to be considered. These positionings are thought to bring about opportunities for different actions to be enacted in relation to help-seeking for mental distress. The analysis of power relations and constrained positioning of subjects is, therefore, an opportunity to surface constructions of the world which may be otherwise unknown. Additionally, consideration is made upon the societal, cultural and historical context within which

these objects are constructed and how these may influence behaviour. This is critical as Mental Health and Shame are social constructs formed through discourse within a particular socio-cultural and historical context. FDA offers opportunities to think about individuals' compliance with oppressive practices without assuming they are passive victims of systems as it acknowledges the productive nature of power and resistance (Mills, 1997). The aim is therefore to surface the multitude of discourses and constructions of Mental Health and Shame. Discourses are not considered to be the truth but as one truth held in place by language and power, therefore, the analysis aims to display the range of discourses as opposed to placing a judgement upon them.

3.7 Challenges of taking a Foucauldian approach

It is widely acknowledged that Foucault's writings are contradictory and his views changed over time. Accordingly, it is important to be cautious about applying his works. Despite this, Foucault recognised that: 'all my books are little tool boxes' (cited in Patton 1979, p.115). Therefore, although a rigorous method of Foucauldian analysis is not described, researchers have the flexibility to apply his tools as deemed appropriate. The Foucauldian approach has also been criticised on the basis that it is androcentric, which skews the insights that are offered (Mills, 2004).

Further critique applies in regards to questions of subjectivity, free will and personal agency. Foucault's work implies that free will and agency are illusions and our lives fulfil the requirements of dominant discourses which maintain the status quo, and may be unequal and oppressive (Burr, 2015). Foucault describes this as the 'death of the subject' suggesting that individuals are mere puppets operated by invisible

subjects. This hopeless view of the world can be disempowering and can evoke the view that dominant, prevailing discourses are entrenched and consequently challenging them is virtually impossible.

Despite these criticisms, individuals have the power to use discourses for their own purposes. Sawicki (1991) argues, that by critically analysing discourses, we are able to resist them. Through consciousness raising, there is the possibility of opening up marginalised discourses and making alternatives available. The purpose of this type of analysis is therefore to free us from our usual ways of understanding ourselves.

CHAPTER 4: METHODS

4.1 Introduction

This exploratory study investigates pupil and teacher discourses of 'Mental Health' and 'Shame.' A flexible qualitative design is employed and data is collated via semi-structured interviews with seven pupils and five teachers. The data is analysed using Foucauldian discourse analysis (FDA) described by Willig (2008) and Parker (2002).

4.2 Research Questions

The research questions addressed in this study are:

Participants	Research questions
Pupils	**1.** How do South Asian girls construct Mental Health? **2.** How do South Asian girls construct Shame? **3.** What subject positions do these constructions of Mental Health and Shame offer? **4.** How do these constructions open up and close down opportunities for help-seeking? **5.** What disciplinary powers are present and how do they constrain or control subjects?
Teachers	A. How do teachers construct Mental Health? B. How do teachers Shame? C. What subject positions do these constructions of Mental Health and Shame offer? D. How do these constructions open up or close down opportunities for help-seeking?

Table 2: Research questions addressed in this study

4.3 Research Design

In line with the research orientation, the design of this study is flexible which is deemed appropriate for exploratory research (Robson and McCartan, 2016). The purpose of this research is to explore constructions of multiple realities hence, the aim of interpretivist study is not generalisability (Thomas, 2017). Thus, the researcher is viewed as an integral instrument for data collection and the researcher's subjectivity and personal qualities are acknowledged.

4.4 Research Methods

Qualitative methods are appropriate for exploratory research as they *'lend themselves to understanding participants' perspectives, to defining phenomena in terms of experienced meanings…'* (Elliott, Fischer and Rennie, 1999). As FDA can be carried out 'wherever there is meaning' (Willig, 2008), a number of means of data collection were considered. Collation of naturally occurring discourse was deemed impractical due to the time and resources required for this method. Focus groups were considered unsuitable due to the nature of the topics under investigation. Previous research proposes that confidentiality is a key concern for South Asian women when discussing Shame and Mental Health (Gilbert, Gilbert, Sanghera, 2004; Reavey, Ahmed and Majumdar, 2006; Gilbert et al, 2007), hence, it was considered that a focus group situation may silence individuals. Discourses are a product of their contexts, thus it was recognised that public discourses may be different to private discourses (Smithson, 2000). Furthermore, all participants attended the same school therefore it was deemed unethical to expose them to a group situation where discussion of sensitive topics would be encouraged.

In light of these considerations, semi-structured interviews were thought to be the most appropriate method as they allowed relative flexibility whilst ensuring discussions focused on the research aims. Interviews are social, interactional events between the interviewer and interviewee and in line with social constructionism, the process allows the creation of knowledge as a product of the interaction (Holstein and Gubrium, 1995). Accordingly, the interviews were viewed as 'meaning-making' processes, and interviewees were not viewed as 'holders of knowledge' but as collaborators who co-constructed discourses around the topics of interest (Holstein and Gubrium, 1995). Moreover, this method is suited to an analysis of discourse as it allows participants to informally talk about life and experience whilst being prompted with ease by the interviewer (Willig, 2008).

As the interviews were semi-structured, interview schedules were designed to illuminate and prompt discussions around how Mental Health and Shame were constructed (Appendix 1 and 2). The pupil interview schedule included practical activities, which functioned as stimuli to facilitate talk and the co-construction of discourse. The questions and activities arose from my experience as a practising trainee EP and through engagement with the literature on capturing voice and research methods. The schedules were not used as scripts but as guides to ensure the discussions focused on the research aims, hence new questions and prompts were included as the interaction unfolded.

4.5 Participant recruitment and sampling

4.5.1 Identifying a school

The school was identified utilising a purposive sampling strategy, this enabled the sample to be selected based upon the specific needs of the research (Robson and McCartan, 2016). The dual role of trainee EP and researcher enabled access to schools through the EP service within which the placement was based. The school which participated in this research was receiving the educational psychology service from myself as a trainee EP and a colleague from the EP service. The school was recruited purposively due to the initial concerns raised at a planning meeting about the mental health of pupils. The school was approached via the Special Educational Needs Coordinator (SENCo) and a meeting was arranged with the Headteacher who gave consent for the research to take place. A number of Pastoral Managers work within particular Key Stages at the school, their role includes managing behaviour of individual pupils and responding to safeguarding concerns. Demographics of the pupils are presented below.

	Ethnicity	**English as an additional language**	**Free School Meals**	**Pupil Premium**
Year 9	Pakistani 61% Black Somali 10% Kashmiri Pakistani 6% Bangladeshi 6% Mirpuri Pakistani 2% Arab 2% Other Black African 2% Other Asian 2% White Eastern European 2%	85%	21%	48%
Whole school	Pakistani 57% Black Somali 13% Kashmiri Pakistani 8% Bangladeshi 7% Mirpuri Pakistani 2%	86%	21%	29%

	Arab 2% Other Black African 1% Other Asian 1% White Eastern European 1%			

Table 6: School demographics

4.5.2 Identifying pupil participants

A purposive sampling strategy was utilised to recruit pupil participants. This was deemed suitable for the aims of flexible research which is not concerned with generalisability (Robson and McCartan, 2016). The inclusion criteria are described below:

Inclusion criteria	**Rationale**
Age 13-14 years	Research suggests that this is the age from when individuals become aware of talk around Shame and are able to discuss it. Practically more difficult to obtain consent for older pupils to be withdrawn from lessons due to school examinations.
No identified Mental Health difficulty	Ethically unsuitable to talk to pupils with an identified Mental Health difficulty as the discussions would be sensitive in nature.
Pupils identifying themselves as being South Asian	The construct of Shame under investigation is present within cultural ideology within South Asian cultures e.g. Pakistani, Indian and Bangladeshi.

Table 7: Pupil inclusion criteria

Discussions with the school's inclusion director, assistant SENCo and pastoral manager led to the identification of ten girls who met the inclusion criteria. An informal presentation was given to this group to provide an overview of the research. Verbal consent was obtained from the pupils to invite their carers into school for a coffee morning in order to: discuss the research in detail, answer questions and obtain written consent for participation.

An invitation was sent to the carers of pupils to attend a coffee morning in school. All ten pupils attended this event and three were joined by their carers. A presentation was delivered to the group where the aims of the research were highlighted in detail. Pupils and their carers were given verbal and written information on what participation would involve and relevant ethical considerations; opportunities were provided to ask questions.

Inviting and undertaking a meeting with the pupils and their carers was considered an appropriate method of obtaining informed consent due to the sensitive nature of the topic and recognition that carers may have questions which they may not otherwise ask. Interpreters were also present at this meeting for carers for whom English was not their first language. The terminology used to describe the research topics were translated into the range of languages relevant to the group. The aim of this was to further aid understanding of the concepts which the research was proposing to investigate.

Carers were invited to give written consent at this meeting (Appendix 3) and three carers gave verbal and written consent for three pupils to take part in the study. For the carers who were unable to attend, consent letters were given to the pupils and they were encouraged to speak to their carers about the research.

4.6. Pupil interviews

In total, seven carers agreed for their daughters to take part in the research. The first participant took part in a pilot interview from which adaptations were made to the activities and interview schedule. A further five interviews took place, interviews

were individually held although two pupil participants asked to be interviewed as a pair, which the flexible nature of this research was able to accommodate.

Arrangements for the interviews were made via the inclusion team at the school, who provided room bookings and made staff aware of pupil absences from lessons. The interviews took place at the school in a confidential space. Pupils were reminded of the purposes of the research and what participation would involve, they were then asked to sign a consent form before engaging in the activities (Appendix 4). All participants were provided with written information about their right to withdraw (Appendix 5), a debrief form (Appendix 6) and certificates to thank them for their participation.

It was recognised that the interviews required sensitive and ethical negotiation of rapport between the interviewer and interviewee and seamless transition into the questions and activities from the initial rapport building activities. Participants engaged in activities used to establish rapport at the beginning of the interview as it was important that pupils felt at ease and comfortable with discussing the sensitive topics under investigation. A 'getting to know you' activity took place prior to the planned interview, this allowed time and space for the participants to settle into the interview situation and involved the interviewee and interviewer answering questions presented on conversation cards e.g. name one thing you are grateful for today.

The pupils were from different cultural backgrounds. For this reason, an information gathering activity was undertaken in order to understand the ethnic and religious preferences of the pupils as well as their linguistic backgrounds (Appendix 7). With

the research orientation in mind, particular attention was paid to the linguistic variability of the group. When discussing the construct Shame, the word associated with this concept in the experience of the pupil was used, for all participants, this was ‘Sharam’ and for Honour the word ‘Izzat’ was used (Gill, Strange and Roberts, 2014). The word ‘Sharam’ does not directly translate to ‘Shame’ in the English language and therefore its definition could not be fully appreciated. Hence, it was considered to be more meaningful if the accepted term in the pupil’s linguistic experience was used for the duration of the interview.

4.6.1 Pupil participant characteristics

All seven pupils were born in the UK and were a part of families with South Asian heritage (Pakistan, Afghanistan or Bangladesh). With the exception of one participant whose mother was born in the UK, the pupil’s parents were born and raised in a country within South Asia.

Participant	Age	Ethnic Preference	Religious Preference	Family country of origin	Additional languages
1	14	British Bangladeshi	Islam	Bangladesh	Bengali
2	14	British Pakistani	Muslim	Pakistan	Urdu
3	14	Pashto Pakistani	Muslim	Pakistan/ Afghanistan	Broken Urdu Pashto
4	13	Pashto Pakistani	Islam	Pakistan/ Afghanistan	Pashto
5	14	British Pakistani	Muslim	Pakistan	Mirpuri
6	14	British Pakistani	Muslim	Mother: UK Father: Pakistan	Father: Punjabi / Mirpuri

7	14	British Pakistani	Muslim	Pakistan	Mirpuri

Table 8: Characteristics of pupil participants

4.6.2 Pupil interview design

The interview schedule consisted of a combination of activities and questions. The purpose of the activities was to stimulate discussions and engage interest in the subject. Furthermore, directly speaking to an interviewer about a topic which pupils may not have experience of talking about within a school setting may have been challenging for the pupils and so the questions and activities were viewed as triggers to stimulate discussions. As the interactions were semi-structured in nature, the approach to the interview was flexible in order to generate novel insights for the topic under investigation (Willig, 2008). Participants were asked open questions and were encouraged to speak freely and openly. Table 9 details the procedural steps undertaken within the pupil interviews, the interview schedule is provided in Appendix 1.

Table 9: Pupil interview procedure

Step	Activity	Described in
1	Welcome and Introductions	Appendix 1
2	Introductory 'getting to know you' activity	
3	Externalising activity: Mental Health	Table 11
4	Statement sort 1: Mental Health	Table 10
5	Introductory questions: Shame	Appendix 1
6	Externalising activity: Shame	Table 11
7	Presentation of scenario and follow up questions	Table 13

8	Statement sort 2: Scenario and help-seeking	Table 14
9	Concluding comments and debrief	Appendix 1

In total, pupil participants engaged in six activities excluding the rapport building introductory activity. Two activities involved sorting statements, the first considered the local community and the ways in which Mental Health was constructed. The statements were based on existing literature examining Mental Health and how it is described in South Asian cultures in relation to help-seeking (Gilbert, Gilbert and Sanghera, 2004; Mustafa, Zaidi and Weaver, 2017; Bhardwaj, 2001; Rafique, 2010). Participants were asked to rank statements based on their level of agreement, from strongly agree, agree, neither agree nor disagree, disagree or strongly disagree. Before presenting these activities, the pupils were asked to define culture and community and what this meant for them.

Statements	Follow up questions
• *My culture and community help me to deal with difficult feelings* • *I can talk to people in my community about how I feel* • *My culture encourages me to talk about my feelings* • *If I'm struggling with feelings, there is always someone that can help* • *My community and culture do not encourage me to talk about feelings* • *If someone is struggling with their Mental Health, they are crazy* • *Struggling with difficult feelings is normal* • *If you have Mental Health difficulties, you should see a professional e.g. GP*	• How does your community help with dealing with difficult feelings? • Do you feel the community supports people with Mental Health difficulties, if so, how? What factors in your culture and community help? • How do you find talking about feelings with your family? • Who is the best person to speak to if you're struggling with feelings?

• *If you have Mental Health difficulties, you should not tell anyone*	

Table 10: statements regarding Mental Health and the community

The externalising objects activity was adopted from reading around narrative therapy principles (White, 2007). Narrative approaches suggest that externalising is a creative and alternative way of eliciting talk around constructs that are difficult to express. The pupils were asked to imagine Mental Health and Shame were living beings or objects (separately). A series of questions were asked to bring the object 'alive', and participants were given the option to either draw, write or verbally respond, the questions were as follows:

Opener: Imagine Mental Health/ Shame as an object or living being
• *What would it look like?* • *What would it say?* • *What would it do? On a day to day basis?* • *What would be its job?* • *How would it impact/effect you?*

Table 11: Externalising objects activity (White, 2007)

The responses to this activity elicited discourses around the constructions of Mental Health and Shame respectively. Participants were also asked follow up questions to further illuminate their responses on Shame:

Follow up questions
• Is there a difference between feeling Sharam (Shame) and having Sharam (Shame)? • How do Izzat (honour) and Sharam (Shame) relate to each other? • Can you think of an example of where Sharam (Shame) has affected someone you know? • How did it impact their Mental Health? What did they do? • What would happen if Sharam or Izzat was lost?

Table 12: Follow up questions on Shame

The use of scenarios or vignettes in research examining experiences of mental distress is common (Gilbert, Gilbert, and Sanghera, 2004; Flink et al, 2013; Bradby et al, 2007; Loewenthal et al, 2012; Slone, Meir and Tarrasch, 2013). The scenario utilised in this research was constructed in order to maximise identification with the character. The situation was considered relevant to the participants due to the age of the character and the issues regarding her future. During my initial presentation with potential participants, a group of girls shared stories of their family members who were unable to go to university or choose a career that they wanted as it was deemed inappropriate by the wider family. These interactions fed into the content of the scenario ensuring it was relatable to the participants who were considering their own university and career opportunities.

Pupils were asked to read the scenario and the following questions were asked to elicit talk about positioning and opportunities for seeking help.

Scenario Activity
Hanna is 15 years old, she lives at home with her mum, dad and 3 older brothers. Hanna is in a relationship with an Afro-Caribbean boy, she has been seeing him in secret and has a secret mobile phone she uses to contact him. Hanna wants to study drama and performing arts at university but she is feeling hopeless about her future. She cries a lot as she is unhappy, worried and fearful. She has not spoken to anyone about how she is feeling.
Follow up questions
• What do you think Hanna is thinking and feeling about her situation? • What do you think her parents think? • What about her brothers? • Do you think Hanna is struggling with her Mental Health? • What do you think Hanna should do? • What do you think she will do? • If you were in this situation what would you do?

Table 13: Scenario and follow up questions

The second statement sorting activity looked specifically at help-seeking and how likely the character in the scenario would seek help. Statements were categorised

into what the participants thought was *most likely* to *least likely* to happen. The purpose of this activity was to discuss help-seeking and the circumstances which may help or hinder this.

Statements	Follow up questions
• Hanna will end the relationship with the boy • Hanna will speak to someone about how she is feeling • Hanna will go to see a GP • Hanna will seek counselling • Hanna will speak to her teachers • Hanna will share how she is feeling with her family and they will support her • Hanna will share how she is feeling with her family and they will not support her • Hanna will not speak to anyone and things will remain the same	• What do you think makes it difficult for Hanna to talk about her feelings? • Do you think Shame plays a role? • How do you think Shame affects her Mental Health? • What do you think Hanna thinks about her position in their family? • How do you think Shame impacts, girls and boys?

Table 14: Scenario statements and follow up questions

4.6.3 Piloting

The first interview was undertaken as a pilot. The participant was asked to comment on the activities and questions presented to them. Following this feedback and personal reflections, amendments were made to the interview schedule. Amendments included: ordering of activities/questions, wording of questions and omission of activities.

A good way of obtaining detailed and comprehensive accounts from interviews is to express ignorance (Willig, 2008), as a South Asian researcher, it became apparent after the pilot interview that assumptions were made that I possessed 'insider knowledge'. Hence, for the remaining interviews, it was important to position myself

and take the stance of a naïve interviewer, through prompting this encouraged the respondents to expand and further illuminate the topics under investigation.

Following the pilot interview, one activity was withdrawn from the schedule. This was due to time restrictions and it was deemed that the data it produced was not advantageous to answering the research questions. The activity was presented in relation to the characters in the scenario and involved completing an adapted version of a tool called the Perceiver Element Grid derived from personal construct psychology (Procter and Procter, 2008).

4.7 Teacher Interviews

4.7.1 Recruitment of teacher participants

To recruit teachers, a presentation was delivered at a routine staff briefing at the identified secondary school. An overview of the research was presented and an information sheet was provided to all school staff (Appendix 8). Five staff members expressed interest and thus participated in individual interviews. Similarly to the pupil interviews, arrangements for the interviews were made through the school's inclusion team who coordinated timings and room bookings.

4.7.2 Teacher participant characteristics

All five teachers worked at the same secondary school. The teaching experience ranged from 6 to 24 years. A range of ethnic preferences were expressed and all spoke English as a first language.

Participant	Role in school	Teaching experience	Ethnic Preference	Religious Preference	Gender
A	Teacher, Lead Practitioner for more able students	9 years Humanities, Religion, Philosophy & Business development	British Pakistani	Muslim	Female
B	PE Teacher, Teacher of the deaf, responsibility for health (mental and physical)	Total- 24 years At present school-17 years	White British	Christian	Female
C	Mathematics Teacher, Form Tutor	17 years	Indian	None	Male
D	PE Teacher, Duke of Edinburgh Award	6 years –mixed comprehensive 15 years at present school	White British	Christian	Female
E	Assistant Head Teacher Business, ICT	15 years	British Indian-Punjabi	Muslim	Male

Table 15: Teacher characteristics

4.7.3 Teacher interview design

Teacher interviews were conducted individually, recorded using a university Dictaphone and transcribed by the researcher (See Appendix 2 for interview schedule). The interviews were semi-structured in nature and initial discussions focused broadly on the teacher's understanding of Mental Health and Shame before moving towards more detailed talk of their experience of supporting pupils with Mental Health needs. Initial data was gathered around teaching experience, ethnic and religious preference prior to the interview. This fulfilled a dual purpose of established rapport and also obtaining information deemed relevant to making sense of their talk during the analysis. As the interview was considered a

collaborative meaning making social interaction, it was informal and flexible in nature (Holstein and Gubrium, 1995).

4.7.4 Piloting

The interview schedule was shared with an EP and university supervisor to ensure clarity of the questions. Following feedback, amendments were made accordingly.

4.8 Ethical considerations

A number of ethical considerations were made during the research. Guidelines from the British Psychological Society (BPS, 2010), the British Educational Research Association, (BERA, 2011) and the University of Birmingham's Code of Practice for research were adhered to. Ethical approval was obtained from the University of Birmingham's Ethical board.

Teachers, pupils and their respective carers were provided with written information regarding their participation in the research. An information sheet detailing the purposes of the research, what participation would involve and how data would be collected and stored was shared with participants and their carers (Appendix 5 and 8). Informed and voluntary consent was obtained from the teachers, pupils and their carers in written form (Appendix 4 and 9). Participants were also asked to consent verbally before the interviews commenced. Within the written information, the participant's right to withdraw from the research was provided. Participants were provided with the opportunity to withdraw themselves at any time before or during the interviews and their data could be withdrawn up to two weeks after the interviews. It was explained that if participants chose to withdraw, their data would

be deleted, including audio recordings and any scribed notes. Withdrawal from the study did not have any implications for the pupils in the school or the professional reputation of the teachers.

Interviews with all participants were anonymously audio-recorded on a university Dictaphone, they were subsequently transferred onto a password-protected and encrypted computer file which can only be accessed by the researcher. The audio recordings were then deleted from the Dictaphone. In line with university policy, data will be kept for 10 years after completing the project. After this time, all electronic data will be erased and printed transcripts securely shredded. Printed transcripts of the data are kept in a secure, locked cabinet which only the researcher has access to. Transcripts of the interviews do not include any individual names or organisational names. Pupil and teacher participants are allocated a code, their names or any other identifying details are not recorded.

The limits to confidentiality were shared with pupils, their carers and the teachers. It was explained that information would be shared with designated safeguarding professionals where there may be a risk to the participant or other individuals not involved in the research. Participants were also informed of the limits to confidentiality in the information sheet and verbally prior to participation.

Discussing sensitive issues such as Mental Health difficulties and Shame may have invoked feelings of distress in participants. In light of this, I remained vigilant during the interviews for signs of distress and all pupils were provided with a debrief sheet detailing the support they could access following the interviews (Appendix 6).

Additionally, teachers may have felt that their practice was under scrutiny or their discourses around Mental Health and Shame presented them in a negative light. Teachers were informed prior to interviewing that the purpose of the study was to explore differing constructions of Mental Health and Shame and the unintended implications of this.

As the researcher, I have undertaken the responsibility of sharing the findings from this research to all participants. A public domain presentation will be made available to the local authority and EP service where the research was conducted.

4.9 Data Analysis

Data was analysed using FDA. The process employed combined elements of Willig's (2008) stages of FDA and through the reading of Foucault's work and Parker's (2002) process. The steps taken in the analysis are described next:

Stage	Questions	Process
1. Discursive constructions	How are the discursive objects constructed in the text?	Implicit and explicit references to the objects were highlighted and notes were made to outline groups of statements identified. These statements were then grouped, reviewed and regrouped reflecting discourses.
2. Discourses	How are the objects constructed in relation to wider discourses?	Notes were reviewed and further notes were made around differences in the various constructions and whether they were located within wider discourses.

3. Action Orientation	What is gained from constructing objects in this way? What is its function and how does it relate to other constructions in the surrounding text? What are the various constructions capable of achieving in the text?	Discourses were analysed and potential gains and functions of the constructions were recorded.
4. Positioning	How are the discourses constructing its subjects? What positions are made available by these discursive constructions?	Notes were made on the subject positions made available by the discursive constructions.
5. Practice	How do the discursive constructions and the subject positions open up or close down opportunities for action?	How the discourses limit what can be said or done were noted alongside how the discourses may open up possibilities for action.
6. Disciplinary Power	What, if any, disciplinary powers are present within the discourses?	Constructions of the objects and the subject positions were reviewed, noting any instruments of disciplinary power.

Table 16: Stages of data analysis (Willig, 2008, 2013; Parker, 2002).

4.9.1 Reflexivity and researcher position

The position of the researcher inevitably influences the production of knowledge (Burr, 2015), the subjectivity, assumptions and values of the researcher are therefore an integral part of the research and cannot be detached from the research process (Robson and McCartan, 2016). It is acknowledged that my personal characteristics such as gender and ethnicity will have influenced the data collection process and the construction of meaning. Research adopting a social constructionist orientation recognises that meaning is created within an interaction between the researcher and the participants. Consequently, participants are viewed

as partners who collaboratively help to construct a ‘reality’ with the researcher during the interview. Reflexivity was practiced throughout the research by being aware of my positionality and how this influenced the interactions and interpretations. Through continual reflection, my role in the preceding interviews and interactions was adjusted.

Foucault acknowledges the importance of understanding the working of power relations within the production of knowledge (Mills, 2004). During the interviews, participants were encouraged to consider me as a curious researcher, interested in understanding the constructions of Shame and Mental Health. This was especially pertinent for the pupils as they are accustomed to being instructed by authority figures within school. I was conscious that I may also be positioned as an authority figure, who was looking for particular responses in my questioning.

Language within social interactions is considered an essential site for identity negotiation and power relations (Burr, 2015), interactions with the pupils across numerous occasions were therefore carefully executed. My personal characteristics were made explicit and shared, as an attempt to build rapport and establish a levelling of power dynamics. A key component of active interviewing is the recognition and use of identity in order to productively engage participants to open up talk around the subject of investigation (Holstein and Gubrium, 1995). My personal characteristics were considered invaluable resources which supported the exploration of and sense-making during conversations.

4.9.2 Reflexivity during data analysis

Reading around Foucauldian analysis supported the practice of reflexivity (Willig, 2008). Critical awareness was adopted in relation to knowledge production and interpretation as it was acknowledged that although this research opens up and presents discourses on Shame and Mental Health, it also has the potential to add to marginalising, stereotypical and oppressive discourses. A critical lens was implemented throughout interviewing, analysing and interpretation of findings. Use of peer review and academic supervision was a valuable mechanism for the verification of procedures, constructions and subject positionings.

CHAPTER 5: ANALYSIS AND DISCUSSION PART 1

5.1 Introduction

This chapter discusses the analysis of transcripts from the semi-structured interviews conducted with South Asian girls and sought to answer the following research questions:

Research questions
1. How do South Asian girls construct Mental Health? 2. How do South Asian girls construct Shame? 3. What subject positions do these constructions of Mental Health and Shame offer? 4. How do these constructions open up and close down opportunities for help-seeking? 5. What disciplinary powers are present and how do they constrain or control subjects?

Table 17: Research questions: Pupils

A Foucauldian Discourse Analysis was employed following the stages described in Table 16. The discursive constructions of Mental Health and Shame are presented in turn (Stage 1) and discussed in relation to wider discourses (Stage 2) together with discussions around what these constructions achieve within the text (Stage 3).

Following this, a separate analysis is presented around subject positionings (Stage 4) and opportunities for action (Stage 5). Lastly, a discussion of the disciplinary powers and how these may constrain or control subjects is presented (Stage 6).

5.2 How do South Asian girls construct Mental Health?

Analysis of the pupil transcripts surfaced a number of discursive constructions of Mental Health:

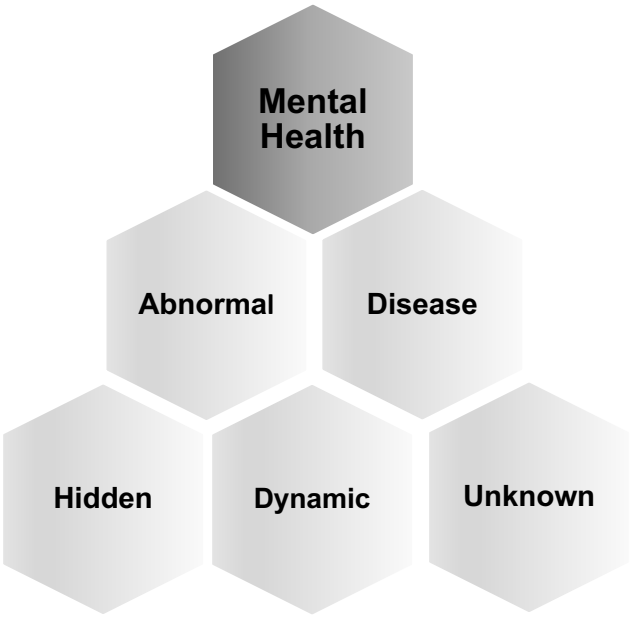

Figure 1: Pupil constructions of Mental Health

5.2.1 Mental Health as 'abnormal'

Mental Health was constructed in relation to 'abnormality.' An individual with Mental Health problems could be identified if their behaviour was not aligned with the norm:

"they would act differently, do things that normal people wouldn't do" (5)

The construction of 'abnormality' is reflective of wider medicalised discourses of Mental Health rooted within psychiatry and psychology. This construction is associated with wider practices of diagnosing difficulties by 'experts' who make judgements through the examination of behaviour. A consequence of this is the negative labelling of individuals e.g. 'crazy.'

Discourses of abnormality operate upon the premise that individuals' should think, feel and behave in particular ways, hence a deviation from this is thought to be

indicative of ‘symptoms’ of disorders. This discourse promotes compliance to societal norms, as this regularises society and serves the political and financial aims of institutions (Foucault, 2003). The act of labelling and treating individuals may serve to detract attention away from socio-economical inequalities (Davidson, et al, 2016) by placing responsibility and fault within individuals for their ‘atypical behaviour’ (Gilson and DePoy, 2015). By locating the problem within the individual, this attributes blame and responsibility for change within them whilst eliminating social responsibility.

5.2.2 Mental Health as a ‘disease’

Linked to discourses of ‘abnormality’ is the construction of Mental Health as a ‘disease’ or an ‘illness’.

“ok I’ve drawn a brain and then all of these things symbolise Mental Health because…if you have like a nice normal brain, it’s almost like a disease like there’s something infecting it, it hurts, hence the sharp bits and not like everyone will be able to realise that because it’s not like physical pain, it’s different for everyone…they’re like mental illness jabbing into you… it hurts” (7)

When discussing how the community would view an individual experiencing mental distress, one participant described Mental Health as a contagious illness which people would avert:

“like no one would wana get near it like … they would think of it as a disease and they might catch it”(3)

Constructions of Mental Health as an ‘illness, disease or medical problem’ reflect prevailing discourses which favour biological explanations of Mental Health problems (Shute, 2018). This discourse reflects wider practices within the medical field that rely on the diagnosis and subsequent treatment of ‘patients’ considered

‘ill.’ The attribution of responsibility for their recovery is placed within the medical field and the potential for unsuccessful treatment results in individuals being viewed as ‘deficient’ or ‘incurable’ (Gilson and DePoy, 2015).

5.2.3 Mental Health as an ‘unknown’

Mental Health was constructed as an ‘unknown’ object within the pupil’s talk. This was associated with the construction of Mental Health as an object that was difficult to understand and conceptualise:

“…because they won’t know what’s happening to you and you kind of don’t know what’s happening to you as well…You don’t know if it’s just like a phase you’re going through or if it’s an actual thing” (1)

This construction is associated with the construction of Mental Health as ‘inexpressible’ or ‘indescribable*’: “I don’t think it’s spoken about, it’s just like there” (1).* From a social constructionist perspective, this may reflect the notion that language is constitutive, hence, if the construct ‘Mental Health’ is not present within an individual’s linguistic experience then the narrative structure would not be present to describe this construct. This is supported by social discourses of Mental Health which argue that Mental Health is not a stable construct which can be discovered, but a construct which evolves over historical, cultural and social contexts (O’Rielly and Lester, 2017).

“‘I don’t know’ is a term that everyone uses because they don’t know how to, they don’t know how to express their feelings.” (6)

Alongside the use of the phrase ‘I don’t know’, a change in behaviour was constructed as a means of communicating mental distress:

“it shows through your actions” (1)

This discursive construction reflects wider discourses around Mental Health as being poorly understood which have led to national awareness campaigns (Time to Change, 2014). These initiatives attribute responsibility within the individual and their significant others to recognise changes in behaviour and to seek help from professionals about their problems.

5.2.4 Mental Health difficulties as 'hidden'

Mental Health difficulties were contrasted with physical health and constructed as an object which was intentionally hidden:

"it's meant to be this box with a key hole and there's a heart that's broken, for me I feel like when I think of mental health I think of something that's closed off, you're keeping to yourself and its locked away" (6)

Additionally, Mental distress was constructed as something which society and families would want to keep hidden. This is associated with wider discourses around the negative consequences of being labelled with having Mental Health problems (Ali et al, 2017; Mustafa, Zaidi and Weaver, 2017; Thapar-Olmos and Myers, 2018; Bradby et al, 2007).

"I think like some of the more kind of stricter, more religious people would see it as oh you need to keep your views or what's happened to yourself because they don't want the entire neighbourhood knowing or something, there's also that like, I duno if you have this but like there's this concept of secrecy like you shouldn't tell anyone anything" (7)

By constructing Mental distress as something to be kept hidden, the attribution of responsibility is placed within the community to keep watch for 'abnormal' behaviour and ensure it is kept hidden in an attempt to minimise deviation from the status quo. Furthermore, this construction may be reflective of the historical practice of segregation and institutionalisation of individuals who are deemed 'mentally ill'

(O'Reilly and Lester, 2017). These practices propagate the notion that individuals with Mental Health problems are not worthy of being included within society. Hence, by keeping Mental Health problems hidden this preserves and protects individuals from ostracism and exclusion. This may explain literature which constructs South Asian women as having high rates of suicide (Bhardwarj, 2001) and self-harm (Bhui, McKenzie and Rasul, 2007) as individuals may not seek help and view these acts as a way of managing distress.

The construction of Mental Health difficulties as 'hidden' reflects wider discourses of gender which ordinarily attribute externalised problems to males and internalised problems to girls (Shute, 2018; Patalay and Fitzsimons, 2017). This echoes research constructing South Asian females as vulnerable to experiencing higher levels of internalised problems e.g. depression (Kumari, 2004), and eating disorders (Goodman, Patel and Leon, 2008). Also mirroring arguments suggesting that girls are socialised to internalise distress and not overtly express emotions (Ortner, 1995).

5.2.5 Mental Health as 'dynamic'

Mental Health was constructed as a universal experience, which constantly evolved:

".. It's not only people with like depression and stuff … like any normal person could have like a really horrible day and they just feel down for the rest of the day" (7)

Normalised constructions of Mental Health may reflect shifts in wider discourses around mental distress from medicalised explanations towards interactionist perspectives e.g. biopsychosocial model (Engel, 1977). The pupils acknowledged

that multiple factors impact upon a person's mental health, which includes the language used by others, biological changes and negative cognitions.

By constructing Mental Health in this way, it is not considered something which can be 'treated' but as an object which can be improved:

"…it could be improved not fixed, I feel like with fixed is something that you have to decide what's your definition of being fixed..." (6)

The pupils demonstrated resistance towards the prevailing medicalised discourses of Mental Health and acknowledged that individuals in positions of authority had the power to label and therefore construct individuals as 'mentally ill.' This reflects the notion that through diagnostic language individuals are transformed into the mentally ill (Foucault, 1975):

"it's sad like if you think about it, calling people oh you're mental, if your doctors go oh you're mentally disturbed so we're taking you to mental home, but like they might not be mentally disturbed they might just be unique, just different like that think differently from you and that's why you're taking them to a mental home it's like why?.. They just make you feel like you really are mental with all the coats and the glasses sitting in a room." (2)

Talking therapies were viewed as positive alternatives to medical intervention. This shift in discourse empowers individuals as they demonstrated awareness of counter-discourses and is synonymous with findings which suggest that South Asian girls distinguish between the medical vs psychological support (Ali et al, 2017).

This discourse and the accompanying resistance towards medicalised interpretations of Mental Health were unanticipated. Partly due to the consideration that prevalent discourses for example those perpetuated by mass media were

based upon medical notions of ‘Mental ill health’ which were more likely to be taken up by individuals. These shifts in discourse may reflect changes and the opening up of alternative discourses within society which have influenced the private discourses of Mental Health examined here.

5.2.6 What subject positions do these constructions offer?

Discourses of abnormality and the medicalisation of problems are prevalent in society and can be considered as a ‘regime of truth’ (Foucault, 1975). As dominant discourses are difficult to escape from, the subject positions made available from them are limited. Discourses of abnormality position subjects as ‘defective’ or ‘disordered’ if their behaviour does not align with societal norms (O’Rielly and Lester, 2017). Norms in society and descriptions of what is considered ‘abnormal’ (e.g. classification systems, DSM 5 - APA, 2013 and ICD-10 - WHO, 1992) are constructed by those with epistemic authority (Harper, 2016). In relation to ethnic minority communities, the ethnocentric nature of classification systems has the potential to lead to racist discourses about communities and pressure for individuals to assimilate to the dominant norms of a society in order to ‘restore normality’ as the culture is considered repressive, inferior and defective (Burr, 2002).

Discourses of abnormality can therefore be considered institutionary and regulatory (Foucault, 1977) as they position individuals who display deviant behaviour as ‘abnormal.’ The creation of a homogenous society where individuals conform to norms, the tolerance and acceptance of difference in behaviours will be low and the social exclusion of those labelled ‘different’ will be high:

"I think it's because well they're probably seeing normal people throughout their whole life and if they see it they'll think they're crazy." (1)

Similarly, the medicalised discourse of Mental Health positions individuals as 'passive holders of disease.' This is exemplified in the pupils' use of clinical language: "*anxiety…depression, bipolar disorder"* (3)**.** This expert, disempowering patient-doctor discourse positions individuals as passive, and unable to cope without professional and medical intervention. A reliance on medication for 'treatment' may render subjects as powerless and broken (Davidson et al, 2016), and in need of fixing by experts. This construction serves to legitimise the authority of experts (Nettleton, 2013) rendering individuals as subjects who are at risk of being institutionalised (O' Reilly and Lester, 2017).

Drawing on liberal discourses of individuality and independence, the pupils positioned themselves in resistance to this hegemonic discourse:

"you can fix me but you don't have to … or like you can fix me but I don't want to be fixed, I like the way I am… hmm its job, be itself, feel free" (2)

This pupil positioned herself in opposition to the medicalised discourses which suggests that individuals should be treated to restore normality. Use of the words 'feel free' exemplifies the power that operates within the act of diagnosing and treating individuals and controlling them to ensure they behave in a particular way.

By positioning themselves as having a lack of understanding of Mental Health this potentially leads to a reliance on others to recognise a change in their behaviour as an indicator of distress, possibly resulting in them being blamed as they may be constructed as someone who is 'choosing' to behave in a particular way. This is

reflective of discourses which conceptualise emotional distress in girls as internally located (Worrell and Goodheart, 2005) and potentially constructs them as 'neurotic' or 'emotionally disturbed' (O'Reilly and Lester, 2017). Additionally, this could result in a lack of identification and distress not being recognised. This is synonymous with literature which constructs South Asian girls as 'passive' and has the potential to lead to behaviour not being recognised until a person becomes highly distressed (Burr, 2002).

The pupils' positioned themselves as being inexperienced when discussing feelings, this may suggest that the construct 'feelings' is not present within their narrative experience constraining opportunities to express distress verbally. One pupil linked this with wider discourses around South Asian communities:

> *"…you don't really talk about that… to Pathan's* [people of Afghanistan origin] *you're not meant to look feeble like weak you're meant to stand out and look strong" (3)*

If an individual attempts to express their distress verbally, this has the potential to place others in a difficult position if they are ill-equipped with how to engage in conversations about difficult 'feelings.' As one pupil shared her construction of women in the community:

> *"…a lot of pathan* [Afghan] *women…they don't really… free their emotions" (3)*

The discourse of being 'strong' could position individuals as 'weak' if they are distressed. This is reflective of literature which constructs South Asian women as resilient and therefore as having low rates of distress (Anand and Cochrane, 2005).

Mental health difficulties as hidden has the potential to position individuals in isolation. Pupils utilised the word ‘alone’ when discussing this construction which positions them as being solely responsible for mental distress. Coupled with the construction that society encourages hiding mental distress this has the potential to position individuals with the dilemma of wanting to seek help whilst being conflicted by discourses which suggest distress should not be disclosed. Additionally, this discourse endorses the idea that Mental Health problems are reprehensible and so the individual is positioned as being at fault. Literature which constructs South Asian women as entrapped, and subjugated, in relation to Mental Health service use is supported by this construction (Gilbert, Gilbert and Sanghera, 2004).

In contrast to the blaming and excluding nature of the discourses of abnormality, dynamic constructions of Mental Health position individuals as experiencing difficulties which are a part of ‘everyday’ life. This enables pupils to talk about mental distress as it is constructed as something which is universally observed. This individualised approach to supporting individuals presents a hopeful vision of the future as it suggests that Mental Health can be improved. Interestingly, participants who constructed Mental Health in this way spoke about their own experiences of distress, indicating that those who constructed themselves as experiencing distress differed from those who did not position themselves in this way.

5.2.7 What disciplinary powers are present in the discourses? How do they constrain and control subjects?

Instruments of disciplinary power were present within the pupil discourses. The categorisation of individuals as 'abnormal' made within medicalised discourses result in the examination of behaviour against 'norms.' Norms *'can be applied to both a body one wishes to discipline and a population one wishes to regularise.'* (Foucault, 2003 p.253) therefore normalisation and the practice of 'normalising judgement' is a form of societal control as it creates a homogenous society where conformity of behaviour is valued (Foucault, 1977). Conversely, deviance has the potential to lead to exclusion and ostracism. The pupils' discussed being cautious about discussing mental distress due to the fear of observation and surveillance by the community:

"…you have to be careful what you say and if you say something wrong they might like tell someone in your family, someone that you don't really want them to hear" (2)

The act of being labelled as 'abnormal' or 'disordered' threatens social inclusion and therefore can be considered disciplinary; constraining opportunities to seek help. A subtle method of cultural disciplining in modern society alongside the act of diagnosing is the prescription of anti-psychotic medication. The utilisation of this subtler and pervasive control of the body is a method of psychological control (Foucault, 1975). One participant opposed the use of medication:

"…psychologist might be able to completely and fully understand the situation whereas a doctor would be like, a GP would be like oh well here's some drugs" (7)

'Treating individuals' with medication and suppressing symptoms is a disciplinary regime as the aim is to produce 'docile bodies,' bodies that behave in ways considered the 'norm' and in ways that society prescribes. As a consequence, a

‘culture of compliance’ is produced where individuals are trained to behave in particular ways in order to produce an efficient and economical society. Hence through these acts of disciplinary power, defective bodies are controlled and an obedient population is produced (Foucault, 1975). If this fails, the seclusion and incarceration of individuals in secure psychiatric units is utilised as another form of cultural disciplining (Foucault, 1977).

The prevalence of medicalised discourses of Mental Health is promoted by the government, through national initiatives and campaigns to raise awareness (Time to Change, 2014). Policies and discourses which promote the view that ethnic minority groups are a ‘hard to reach’ population with high levels of mental distress produce pathologising discourses which marginalise groups (Walker, 2006). The increased identification of ‘mental disorders’ serves individuals in positions of power as it detracts attention from social discourses of mental distress which recognise the effect of socio-economic deprivation, poverty, lack of social opportunity on the wellbeing of individuals (Rogers and Pilgrim, 2014; Carr, 2013).

5.2.8 Summary

Pupil discourses of Mental Health reflect prevailing discourses in society which construct Mental Health as an ‘abnormality’ and ‘illness.’ Constructions which oppose medical discourses were also present in the pupil’s discourse which support a shift in discourses which acknowledge the social and interactionist nature of mental distress (Engel, 1977; Roger and Pilgrims, 2009). These counter discourses may also reflect the shift in discourses present in initiatives such as ‘Time to

Change' (2014) which promote openly discussing Mental Health. Despite this shift, the existence of constructions of mental health as 'hidden' and 'unknown' reflect the conflicting nature of discourses and the positionings made available from these prevailing discourses restrict and constrain actions.

5.3 How do South Asian girls construct Shame?

The discursive constructions of Shame included:

Figure 2: Pupil constructions of Shame

The complexity of Shame is exemplified by the overlapping and contradictory nature of the constructions within the pupil's talk. To illustrate this, one pupil discussed Shame in both positive and negative ways:

"Shame would be like the internet, or the computer or your phone… because we have the media, we have the internet, it's so wide, and we learn so much from it, it's bad or good and Shame comes through so many forms" (6)

5.3.1 Shame has implications for family Honour

Shame was constructed as an object which could be brought upon the individual and could potentially damage family Honour. This includes extended family

members and the Honour of ancestry. Honour is therefore considered to be fragile, and once it is lost it is difficult to regain:

"once you've lost your Izzat [Honour] *it's really hard to get it back because, like… Shame is a big thing" (3)*

This relates to wider discourses surrounding Shame which describe it as a mechanism to protect Honour by exerting influence on behaviour by defining what that is acceptable and unacceptable, or the Shameful from the Honourable (Pask and Rouf, 2018; Gill, Strange and Roberts, 2014). Thus, conformity of behaviour related to socio-cultural expectations and gender roles is valued and deviation from this is considered Shameful. This supports literature arguing that Shame is brought upon the self and the family if social values are breached (Gill, Strange, and Roberts, 2014; Pask and Rouf, 2018).

"the idea that you don't wana taint that (Honour), you wana keep it the same, you don't wana let differences come in, that difference may be good or bad so yeah Shame to not, to not change things, to not change how things are meant to be" (6)

Girls who are a part of the South Asian diaspora, are presented with the combination of western and eastern socio-cultural norms which may not always be compatible. The pupils acknowledged that the combination of competing norms was dependent upon the ways in which each family had adopted particular norms hence the impact would be unique to the personal circumstances of the individual. This challenges discourses which suggest that all South Asian females are subject to rigid social values and norms.

Nevertheless, conformity to South Asian norms is generally valued and deemed Honourable, this is reflective of wider discourses surrounding minority communities suggesting that conformity functions to preserve ethnic identity and values. This

may be particularly heightened for those living within a dominant western society (Kushal and Manickam, 2014).

All family members are expected to preserve family Honour, as individual actions reflect on the entire family (Gilbert, Gilbert and Sanghera, 2004; Thapar-Olmos and Myer, 2018) hence, responsibility is placed upon family members to maintain and uphold family Honour. In particular, the behaviour of children reflects the ability of parents to fulfil their duty:

> *"the whole idea that, that she's your daughter, you're meant to be the one that comforts her, you're meant to be the one that helps solve her problems or disciplines her and the fact that you can't do that brings Shame to you" (6)*

These constructions attribute responsibility to individuals to engage in particular behaviours, customs, and values in order to demonstrate they are Honourable. Individuals, therefore, hold responsibility for collective reputation:

> *"…once like you make people happy and yeah, have honour I guess? Izzat [Honour], once our family has Izzat [Honour] you're all happy you all get along. But if that one person just brings the family down everyone might turn on that one person" (2)*

Within this construction, to gain Honour is to make the family happy, achieved by doing the 'right thing.' The consequences are detrimental if an individual deviates from what is considered the 'right' or 'proper' thing to do. The pupils expressed resistance towards decision making for the benefit of family Honour at the detriment of the individual:

> "I feel that you should be doing what you think is right… don't feel Shame for doing that, you should actually feel happy with yourself that you're doing what's best for her" (6)

5.3.2 Shame is gendered

Shame was constructed as having different implications for girls and boys:

"…I think boys and girls have a different kind of Shame level, like boys can go off and do whatever they feel like, and their parents would have like oh just don't get her pregnant but if it was like a girl, … it would be like how dare you, that's not a woman's place, how dare you kind of thing… especially in Asian cultures, like some of my family members are quite like… misogynistic in their views I wana say, because they teach their little kids or my little cousins or whatever oh you need to, we're Asian we need to, oh you can do this, you're stronger than a girl, how dare you get beat by a girl, now I don't think they should be taught in that way, I think they should be taught like just work hard, see her as an equal not like oh a girl, so why you get beaten by a girl" (7)

The behaviour of females is considered as having particular importance to family Honour, corroborating discourses which suggest that the extent to which a female family member conforms to cultural and religious norms determines how the community perceives them (Gill and Brah, 2014). Females hold responsibility for maintaining family Honour (Kushal and Manickam, 2014) and a girl's Honour or 'name' being Shamed has implications for males as it threatens masculinity (Gill, Strange and Roberts, 2014):

"cuz brothers don't want their sister's name to be Shamed and they don't want their friends to know about it" (4)

This is reflective of discourses of masculinity and femininity which construct men as protectors and females as the protected (Gill, Strange and Roberts, 2014; Pask and Rouf, 2018).Thus, the attribution of responsibility is placed within females to behave in ways aligned with gender norms. Upholding traditional gender roles is valued and failure to align with and to fulfil these roles has the potential to 'bring Shame' (Gilbert, Gilbert and Sanghera, 2004). By maintaining a subordinate status to male members of the family, this perpetuates patriarchal order and the compliance of females.

The gendered nature of Shame was associated with the value placed upon a daughter's virginity in comparison to males:

"…for a girl it might be like a really really important thing but for boys it might be like whatever, they don't care…I see it, I've actually heard my uncle say to one of my older cousins, I think he was like 18 or something, and he's like dad I've got a girlfriend, and I was like this, (facial expression) … he was like ok just don't get her pregnant, as a banter kind of thing and I'm like god, if that was their sister doing that there would be like words" (7)

This results in the control, overprotection and policing of the sexual behaviours of females, and supports literature which discusses how girls are constructed as 'pure' and 'modest' and in need of protection (Furnham and Adam-Saib, 2001; Kushal and Manickam, 2014). Related to wider discourses of gender, the pupils demonstrated how they constructed males and females in their discourse:

"…it's boys their natural instinct is to be protective over family, especially, especially if it's a girl as well,... she's with this other boy that they don't know, … so they don't know anything about it, they can't watch her, they don't know anything she's doing…" (6)

5.3.3 Shame regulates behaviours

5.3.3.1 Shame inhibits behaviours

The pupils made distinctions between Shame which prevented behaviour from occurring and Shame which transpired after a behaviour had occurred:

"There's a difference, cuz feeling it, you've actually done something that makes you feel it and having it prevents you from doing it" (1)

Shame was constructed as an object which individuals should 'have' as it prevented engagement in behaviours considered to be inappropriate. Having Shame was constructed positively: *"if you don't have Shame you don't have anything then I guess" (2).* This form of Shame was observable through actions and behaviours, hence it was related to honourable ways of behaving:

"…if you don't have the Shame in you, you wouldn't have the Honour… if you have Shame you kinda know what Honour is." (1)

Pupil's discussed how the phrase 'have some Shame' was attributed to an individual's behaviour by others. This was referred to as 'Shaming' with the purpose being to change an individual's behaviour and to teach them what is permissible to do. This was sometimes internalised by the individual but also resisted if they felt they had not engaged in any wrong doing. This pupil discusses how Shame regulates how she can dress:

"…my mom says Sharam kar [Have Shame] *when I don't wear like Asian clothes, she's like Sharam kar and I'm like I would but I don't want to, that means like have some Shame, but I don't get what it means to have some Shame, you can't just have it, you have to feel it, it comes into you, you can't just suddenly go into a shop and go oh I want some Shame can you give it to me? That's why I don't like it when my mom says, have some Shame, it's like I would but I don't feel it so just let me wear what I wana wear" (2)*

Shame can be considered as a tool used for moral development, operating by preventing and enabling reflection upon behaviours. Having Shame places responsibility for one's actions within the individual. This is reflective of discourses which suggest that the regulation of social and sexual conduct results in individuals enacting Honourable behaviours (Gill, 2009; Gill, Strange and Roberts, 2014; Brandon and Hafex, 2008). Contrary to the current discourses of Shame which predominantly constructs it negatively (Kushal and Manickam, 2015; Gilbert et al, 2007; Gilbert, Gilbert and Sanghera, 2004; Gill, Strange and Roberts, 2014), the pupils constructed Shame as protective and helpful as it prevented dishonour. Though the pupils also demonstrated resistance towards this construction being imposed on them.

5.3.3.2 Shame as a tool used to teach and problem solve

Related to the construction of Shame as an inhibitor of behaviour is the construction of Shame as a tool used to teach and problem solve. This construction reflected the usefulness of Shame in decision-making:

"… it's a wooden cube I think it would show like different scenarios like each side it has erm there's like say there's culture, and erm religion, like it could have different like pictures kind of…they'd just be walking and showing them the different ways a person can be, yeah, it's showing them different ways a person can be…say if it was a relationship, it will show you the good side of it and then it will show you the bad side of it, and then it would show you the culture side of it and then the religion side of it, all the sides and then at the end you will, you will pick one. … say if you did it like this way what would happen and if you did it that way what would happen as well." (1)

Shame allows individuals to consider the religious and cultural implications of particular behaviours, hence it illustrates the potential consequences of behaviour and thus enables individuals to make choices. Additionally, Shame allows individuals to own up to their past behaviour and ask for forgiveness. Shame is constructed as something that 'should be felt' allowing individuals to be cleansed or liberated from their wrongdoing:

"…it supports your body to say to yourself you've done something Shameful think through it, ask for forgiveness, so it's giving support to and also to other people, so if you see someone as really Shameful like what my mom does… its giving them support too, …it would make you a better person I guess… but then not everyone is perfect so it would make you a good enough person to let people see that you're good that you're not actually full on Shameful" (2)

This form of Shame allows individuals to reflect: *"I'm not as good as I thought I was, it kind of humbles you a bit."* (7). Shame therefore functions to change individual's behaviour:

"Shame you into doing something else or kind of like push you almost. Sometimes it can discourage people as well, for example, if I got like a really really bad test result…there's two extremes, either they completely like give up and they don't care anymore or it's just, or they completely become like a different person, they almost fits the standards of what they're expected to do" (7)

Shame as a regulator of behaviour attributes responsibility to the individual to be better, do better and fit standards of society; but as one of the pupils acknowledge, 'no one is perfect' therefore individuals are likely to fall short of expectations. By attributing responsibility for one's actions within the individual, blame is also located within them. Therefore, external factors which may impact upon an individual's behaviour are overlooked**.**

The discourse of Shame as a regulator of behaviour was seen as a protective and helpful mechanism for the pupils as it provided them with boundaries of how to behave. This was an unexpected construction and differed from my interpretation of this discourse which constructed Shame as a mechanism for imposing unwanted regulation and control of behaviours. This construction also differs from the current literature which predominantly constructs Shame as a preventer of dishonour and therefore an oppressive mechanism of control of female behaviour (Kushal and Manickam, 2014; Gill, Strange and Roberts, 2014).

5.3.4 What subject positions do these constructions offer?

Shame exists and operates through language within social interactions and is upheld through gender socialisation. Shame is constructed as being 'fragile' and as having the power to impact the Honour of the family. Together with the gendered nature of Shame, this positions girls with heightened responsibilities to behave in an 'Honourable' way (Gill, Strange and Roberts, 2014). This is in line with literature which suggests that female members of the family are repositories of Honour (Kushal and Manickam, 2014) and places a responsibility upon them to behave in

particular ways which do not bring their parent's Honour into disrepute. Conforming to socio-cultural norms is valued and deemed Honourable, consequently, girls may experience pressure to conform and fulfil associated gender roles. The pupils discussed the fragility and subjective nature of what may be considered Shameful:

"…they would think the littlest thing is Shameful, look oh my god she left the little bit of dirt on her shoe, what's the Shame about that" (3)

Shame is a dominant discourse which has become a regime of truth for the pupils, hence it is difficult to resist and life outside this discourse is difficult to imagine (Kushal and Manickam, 2014):

"We've been taught it but we haven't literally been taught it, it's kind of grown inside of us" (1)

This positions girls with a restricted repertoire of ways of being as they are socialised to align with the cultural and social norms. On the other hand, an individual who resists conforming to societal expectations is positioned as an 'outsider' or 'immoral' which potentially leads to conflict and social exclusion. The pupils expressed that when this occurs they were 'Shamed' into behaving in particular ways which fit societal expectations. This restriction of ways of behaving can be considered oppressive. The positioning of girls within traditional, submissive gender roles and as vessels of Honour is upheld by the patriarchal nature of collectivist societies. The gendered constructions of girls positions them as being in need of 'protection' as the Honour which they encompass holds social value and is linked to notions of masculinity. This positions girls as subjects of control, under the surveillance of others and the self which constrains agency to behave in ways outside the socio-cultural norms of society.

Although the pupils sometimes constructed Shame positively, it was recognised that this was dependent upon the ways of behaving deemed acceptable by individual families. Consequently, some girls were positioned as being under unreasonable restrictions which led to resistance and rebelling:

"…some people, doesn't that make them want to do it more like you're preventing them from doing that so like they're gona wana do it more, so like I think there should be boundaries but there shouldn't be like, like complete restrictions so that you're like caged like an animal" (7)

5.3.5 What disciplinary powers are present? How do they constrain or control subjects?

Shame regulates behaviours and produces 'docile bodies' in order to fit norms of society. Therefore, the discourse of Shame is disciplinary and an instrument of control:

'A body is docile that may be subjected, used, transformed and improved'

(Foucault, 1977 p.136).

Shame operates to transform and regulate behaviours in order to modify individuals. The positioning of girls as repositories of Honour and in need of protection results in surveillance, restriction and monitoring of their behaviour. The girls discussed hierarchical observation by members of their family and the wider community which led to normalised judgements. The threat of being judged abnormal constrains their behaviour, and normalising judgement results in them being judged as not meeting the expected standards. Family, the community and the pupils themselves can be considered agents of surveillance:

"this Pathan [Afghan] *girl on *** street there's loads of Pathan* [Afghan] *like families there…she had all her hair open, everything, I thought to myself if I took a picture of you showed your family what would your family be saying then?" (4)*

Shame operates as an instrument of panoptic power as it controls subjects by enforcing judgement and comparison to others based upon social norms. Bringing Shame to the family and damaging Honour was seen as having dire consequences for the individual:

"Shame is just this thing that's gona come init and basically will ruin your life" (3)

And the family:

"Everyone in the community knows the family, they might look at them in a different way after that" (5)

Hence, hierarchical observation and judgement by the community are powerful mechanisms of control of individuals. This reflects a disciplinary practice which restricts behaviours as the individual is forced to behave in a way which assumes they are constantly being observed. The construction of Shame as an internal decision-making tool reflects the internalisation of this construct.

Within this disciplinary regime, the individual adopts the role of the oppressor and the oppressed by internalising Shame, self-monitoring and regulating their behaviour. Individuals are therefore positioned as being subject to and subjects of power relations (Foucault, 1975). As discussed, the pupils positioned themselves in resistance to these discourses. This suggests individuals have agency and are able to take up or resist discourses. However, this liberating view was contradictory in the discourse as the pupils also shared:

"I know my boundaries, and I know that erm I shouldn't do this thing cuz it would bring Shame to me or to my family" (3)

The girls therefore constructed themselves as having free will and agency whilst also acknowledging that there were certain boundaries they would not cross. This

supports Foucault's notion that what appears to be liberation, agency and free will to make decisions is in fact a reshaping of the self in accord to a new set of norms. The pupils discussed compromising on issues such as clothing which may reflect this. Hence, the girls are open to new ways of constructing themselves however this remains restricted by the discourses that are available to them within their socio-cultural context.

5.3.6 Summary

Shame is a complex construct, it is described as being helpful as it provides girls with boundaries to protect them, whilst simultaneously restricting their behaviours and operating in a sexist and oppressive manner. Discourses of Shame position girls as subordinates and subjects to be controlled and manipulated in order to serve the authority. This regime of truth is kept in place through the existence of Shame as a dominant discourse constructed through language within social interactions and transmitted via gender socialisation.

The pupils' demonstrated resistance towards the disciplinary discourses of Shame challenging the construction of South Asian girls in the literature as passive, obedient and subservient. Despite this, the discourses demonstrate that although the girls resisted they were not able to escape from the dominant discourses of Shame completely.

5.4 How do these constructions of Mental Health and Shame open up or close down opportunities for help-seeking?

Constructions of Mental Health	Constructions of Shame
• Mental health as abnormal • Mental health as an illness • Mental health as an unknown • Mental health as hidden • Mental health as dynamic	• Shame has implications for family Honour • Shame is gendered • Shame regulates behaviour • Shame is a helpful tool used to teach and problem solve

Table 18: Pupil constructions of Mental Health and Shame

The constructions of Mental Health as abnormal and as a disease has the potential to close down opportunities for help-seeking. As conformity is valued, being labelled with a disorder or as 'different' has the potential to damage family Honour. The pathologising nature of these constructions of Mental Health therefore have the potential to bring Shame to individuals and their family.

This is particularly heightened for females as their behaviour is deemed reflective of collective family Honour. These discourses of Mental Health can have a negative impact on their future marriage prospects:

> *"I asked my mom whys that and she was like because you know how Pathan's* [People of Afghan origin] *are, if they find out no one's gona marry you" (3)*

The positioning of girls as repositories of Honour potentially closes down opportunities to seek help as blame is attributed to them if they are viewed as having a 'disorder' (Gilbert, Gilbert, Sanghera, 2004; Mustafa, Zaidi and Weaver, 2017; Baldwin and Griffiths, 2009; van Bergen et al, 2012).

The construction of Mental Health as an unknown may lead to individuals not recognising indicators of distress and not seeking help. Pupils expressed difficulty

in talking about the experience of distress hence using their behaviour to communicate. This can be problematic as if an individual's behaviour is deemed 'abnormal' due to mental distress, school staff may not identify this as mental distress and may interpret it as 'bad behaviour.' Adding to the complexity of this, Shame preserves the view that individuals should behave in particular ways which fit societal norms and values. If individuals express distress through their behaviour they are potentially breaching norms and therefore may be considered Shameful and blamed. Furthermore, not all individuals demonstrate a change in behaviour when they are distressed which results in isolation and escalation of problems due to unmet needs. Linked to the construction of Mental distress as hidden, this serves to protect Honour by preventing Shame being brought upon the individual by disclosing difficulties. Prevention of judgement by the community was shared as an inhibitor of behaviour which may result in further isolation.

By constructing Shame as a tool to make decisions and problem solve, individuals may consider whether seeking help for Mental Health difficulties will bring Shame to them and their family. If Mental Health is constructed as 'abnormal' or a 'disease' then it is likely that seeking help results in judgement from the community and therefore damages Honour.

"like Shame and Mental Health if its spoken about, its spoken in a more negative view, it's not that positive so erm I think even if someone is dealing with that they'd think negatively and they wouldn't really want to say it" (1)

The girls demonstrated dissatisfaction towards medicalised discourses and constructed Mental Health in dynamic ways. This provides support for literature which describes the nuances of individual constructions of Mental Health and how

these impact upon help-seeking (Anand and Cochrane, 2005; Dein and Illaiee, 2013; Ali et al, 2017). Furthermore, this construction of Mental Health as dynamic may be reflective of the 'Time to Talk' agenda where individuals are encouraged to openly discuss Mental Health problems.

The way in which Mental Health is conceptualised impacts upon help-seeking opportunities and is recognised within the literature (Anand and Cochrane, 2005; Dein and Illaiee, 2013; Ali et al, 2017). Medicalised constructions result in individuals typically seeking help from GPs and Psychiatrists, where practices of identification, diagnosis and treatment are enacted. Social discourses of Mental Health reduce the likelihood of help-seeking from medical professionals (Rafique, 2010) hence open up alternative discourses. However, the system of allocation of resources is based upon diagnosis of difficulties which constrains opportunities for alternative discourses of Mental Health to be taken up.

5.5 Summary

This chapter explored how South Asian girls constructed Mental Health and Shame, how they linked to wider discourses and how pupils were positioned within these discourses. The disciplinary powers present were discussed and how pupils' constructions may open up or close down opportunities for help-seeking were examined.

The analysis demonstrates that the dominant constructions of Mental Health and Shame close down opportunities of help-seeking, supporting current literature on

this topic. The analysis also contrasts some of the current discourses within the literature on South Asian women and Mental Health. The pupils demonstrated resistance to dominant discourses and produced alternative discourses which challenged medical conceptualisations of Mental Health and the overall negative constructions of Shame. The multifaceted and contradictory nature of the discourses highlight the complexity of the social constructs investigated which is in line with the evolving nature of discourse.

CHAPTER 6: ANALYSIS AND DISCUSSION PART 2

6.1 Introduction

This chapter discusses the analysis of the semi-structured interviews with teacher participants which sought to answer the following research questions:

Research questions
A. How do teachers construct Mental Health? B. How do teachers construct Shame? C. What subject positions do these constructions of Mental Health and Shame offer? D. How do these constructions and positionings open up or close down opportunities for help-seeking?

Table 19: Research questions: Teachers

In line with the pupil analysis, Foucauldian Discourse Analysis was employed following the stages described in Table 16.

The discursive constructions of Mental Health and Shame are presented in turn (Stage 1) and reference is made to how they differ or concur with the pupils constructions. These are related to wider discourses (Stage 2) alongside discussion of what is achieved within the text (Stage 3).

How the teachers position South Asian girls within these constructions alongside how they position themselves is discussed with the constructions (Stage 4). Lastly, an analysis of the opportunities for action are presented (Stage 5).

6.2 How do teachers construct Mental Health?

Analysis of the teacher transcripts surfaced the following discursive constructions of Mental Health:

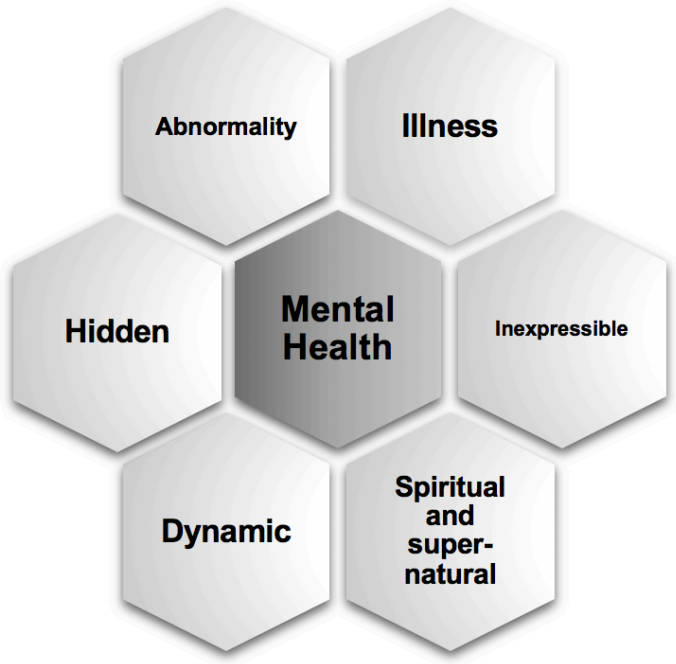

Figure 3: Teacher constructions of Mental Health

6.2.1 Mental Health as an 'abnormality'

Concurring with pupil discourses, the teachers constructed Mental Health in relation to behaviour, specifically, behaviour considered to be outside the norm:

"…they are identified as being different, different to the norm" (E)

This reflects the chief discourse of abnormality which constructs individuals as 'defective' if their behaviour does not align with norms within a particular socio-cultural context (O'Reilly and Lester, 2017). Pupils may be positioned as 'disordered' or 'badly behaved' which results in the attribution of blame being placed within them to be or do better by conforming to behavioural expectations. Pupils are

at risk of being labelled and as the problem is located within them, they are individually held responsible for change. External factors such as the teacher-pupil relationship, organisational and systemic factors may be overlooked (Miller-Lewis et al, 2014).

The teachers' talk demonstrated ambivalence positioning them with a dilemma of whether an individual's change in behaviour was symptomatic of an underlying 'disorder' or a response to a situation. This has the potential to disempower them as they may view themselves as unskilled to make this judgement.

"…it's very difficult for me to know that that child has a Mental Health issue, I can assume that their behaviour may not be normal but that might just be a reaction." (A)

This contrasts with the psychological discourse of abnormality which supposes that particular behaviours can be considered symptoms of 'disorders' as stated within classification systems, (DSM 5 - APA, 2013 and ICD-10 - WHO 1992).

6.2.2 Mental Health as an 'illness'

Mental Health was constructed within medicalised discourse: *"it's an illness that you can't see" (D)*. This construction was found within the pupil discourses and is reflective of the dominant biological understandings of Mental Health. Similar to the discourse of abnormality, responsibility for change is located within 'ill patients' who are positioned as passive and broken and in need of medical intervention from experts in order to be 'cured' or 'fixed' (Davidson et al, 2016). This supports literature which suggests that parents who constructed Mental Health as a medical problem assumed it was 'curable' (Bradby et al, 2007). However, the failure to cure an individual through medical treatment results in individuals being positioned as

defective (Gilson and DePoy, 2015).

Teachers constructed themselves as unqualified, and therefore helpless as this discourse disempowers them whilst simultaneously legitimising and empowering medical professionals (Nettleton, 2013):

"I don't think as teachers we are qualified to diagnose someone with a Mental Health issue, we can identify what's going on and it is only up to the experts to put the pieces together" (A)

Furthermore, the pastoral team within the school were deemed as having the knowledge and expertise to support pupils, which further disempowers teachers:

"It's not within my power to try to understand … as a classroom practitioner you just have to sometimes shut up and put up." (A)

By positioning the support of Mental Health problems within the realm of the pastoral team the responsibility for the Mental Health of pupils was attributed to them:

"I've passed it on to heads of year, if they need to pursue it further I think that's their, their job" (B)

Taken together, these constructions legitimise the position of 'experts' which result in teachers and front line staff being placed as subordinates and unqualified in supporting mental distress.

6.2.3 Mental Health difficulties as 'difficult to express'

In line with the pupils' construction of Mental Health as an 'unknown,' the teachers constructed Mental Health as difficult to understand and express. This may be reflective of the notion that communicating distress verbally is challenging: *"girls find it difficult to talk about things" (C*). As language is constitutive, this may reflect the notion that individuals require the narrative structure in order to make sense of experience and express it through talk.

This positions girls as having to rely on others to identify their distress and potentially explains the use of changes in behaviour as indicators of distress. Teachers are therefore assigned the responsibility of identifying pupils who are mentally distressed, this is problematic as they may interpret behaviour in differing ways. The unintended consequences include individuals being positioned as 'badly behaved' or 'attention seeking' which further pathologises them.

6.2.4 Mental Health difficulties as 'hidden'

Mental Health difficulties were constructed as a hidden problem. This is contradictory to the idea that a change in behaviour indicates mental distress. One teacher discusses a pupil who had been engaging in self-harming behaviours:

"I thought, she couldn't, she didn't look any different, she wasn't acting any different at all, just being her" (D)

Coupled with the construction of Mental Health as difficult to express this is problematic as it results in pupils coping with distress alone. The difficulty talking about Mental Health is compounded by wider discourses of Mental Health which construct it as an abnormality and medicalised problem. This unavoidably leads to harmful negative consequences resulting in the silencing of individuals:

"… they don't want their teachers or peers to know because they want to appear as normal and they don't want to be flagged up as this student has got issues because they may feel they're being labelled or I will be treated differently" (A)

This is reflective of literature which constructs Mental Health as being stigmatising particularly in relation to the negative consequences of being labelled as having a mental disorder (Ali et al, 2017, Mustafa, Zaidi and Weaver, 2017; Thapar-Olmos and Myers, 2018).

Whilst Mental Health problems were constructed as hidden they were also consciously hidden by individuals:

"If you're looking a bit rough and someone says to you, are you ok? It's easier to deflect them by saying yeah I've got a headache, or I went to sleep late or I'm not feeling well rather than opening up and saying I'm stressed, or I can't cope or I'm depressed. Because firstly, by mentioning it, is that individual going to be able to help you and by opening up, the word might get around, as soon as you say to someone you've got a headache, they're not going to tell your mates or the whole of your staffroom, such an has got a headache. But the idea of depression or this person is low in their mood or whatever may be talked about more and it's not on any human level to be talked about when it relates to something that's seen as negative" (A)

The use of a physical ailment to account for difficulties detracts attention away from social problems that may be contributing to the problem, diminishing social and societal responsibility. By constructing the problem as physical, individuals demonstrate that a treatment will 'cure' the problem therefore they will become 'normal'. These constructions further position pupils as isolated and teachers as unaware of the distress they may be experiencing, leaving little room for help-seeking to occur.

6.2.5 Mental Health as a 'state'

One teacher constructed Mental Health as being a state which fluctuates along a spectrum. This construction recognised the fluid and individualised nature of the object, which included a number of components:

"…depends on the individual … for me, positive Mental Health would be a positive wellbeing with a positive mental state along with a spiritual and physical wellbeing as well … same goes for negative Mental Health, that if you are not erm feeling balanced in your mental, physical, spiritual, psychological state then it's going to affect the balance and so I think it's how one feels on both ends of the spectrum" (A)

This construction mirrors the definition provided by the World Health Organisation (2014) which constructs Mental Health as a 'state of well-being.' This participant

differentiated between Mental Health as a biological difficulty from that which resulted as a reaction to social circumstances:

"there are two types of… Mental Health issues, one may be purely biological… the other type of Mental Health stems from a reaction to a situation and we as practitioners or anybody dealing with Mental Health needs to know when is it purely biological and when is it actually a reaction to something" (A)

This reflects a shift in wider discourses from medicalised constructions towards interactionist understandings such as the biopsychosocial model (Engel, 1977) and social understandings of Mental Health (Rogers and Pilgrim, 2014). These constructions reflect the fluid nature of discourse and the complex and contradictory discourses which surround Mental Health. Comparable to the pupil's construction of Mental Health as dynamic, this construction opens up alternative ways of considering Mental Health which are potentially more inclusive, and attribute social and collective responsibility to supporting mental distress. These constructions avoid pathologising and blaming individuals and allow social difficulties to be identified and addressed as potential contributory factors. They position individuals as vulnerable and in need of support rather than blamed for internal deficits. Furthermore, this construction allows teachers to consider their role and that of the school system in supporting individuals, this empowers them and positions them in ways which enable actions for help-giving. The understanding of social factors playing a role enables schools to consider how they as an institution can serve the community to ameliorate some of these issues.

6.2.6 Mental Health as 'spiritual and supernatural'

A South Asian teacher's talk surfaced a novel discourse, described in comparison to biological discourses as a spiritual imbalance:

"…there's a spiritual aspect to it, I feel. There is something about that individual which you can't see, which is not in balance, emotions you can feel, physical aspects you can see but there is something about the human, maybe their consciousness there is something about the individual that we cannot examine in an x-ray, in a CT scan or in an MRI scan"(A)

This may reflect discourses in the literature which propose that South Asian adults hold spiritual and religious constructions of Mental Health problems (Dein and Illaiee, 2013; Ali et al, 2017). By constructing mental distress as a problem within the religious or spiritual realm, individuals are less likely to seek help from schools or medical professionals as they are deemed to be ill-equipped to support religious solutions. Individuals may, therefore, seek support from their family, community or religious institutions. This construction was absent from the pupil discourses and may reflect a difference in the discourses which pupils are exposed to in comparison to adults. This also highlights the importance of hearing the voice of South Asian girls as their discourses differ from South Asian adults.

This teacher also shared talk around a particular community constructing Mental Health problems as being of supernatural origin:

"there are certain pockets within the community if somebody is suffering from a Mental Health disorder, they often think, they think they're being possessed by a jinn" (A)

Similar to the discourses of abnormality and illness, this discourse positions pupils with blame and with flaws as they are 'easily influenced' by supernatural elements. This participant suggests that this construction functions to detract responsibility away from the family and social factors which may be contributing to distress:

"it's easier to deal with… because you've found a cause, so it's easier for you to rationalise and say, oh they've been possessed, well no actually they might just be behaving like that because dad you don't spend enough time with your kids" (A)

A reliance is placed upon faith and spiritual healers to rid individuals of negative supernatural influences, this functions to construct individuals as deficient. Similar to medical intervention, if a treatment is deemed unsuccessful the individual is blamed. Furthermore, teachers are positioned as powerless as pupils and parents are less likely to disclose difficulties to them if they are viewed as problems within the religious and spiritual domain.

6.3 How do teachers construct Shame?

The teachers constructed Shame in similar ways to the pupil discourses, the discursive constructions included:

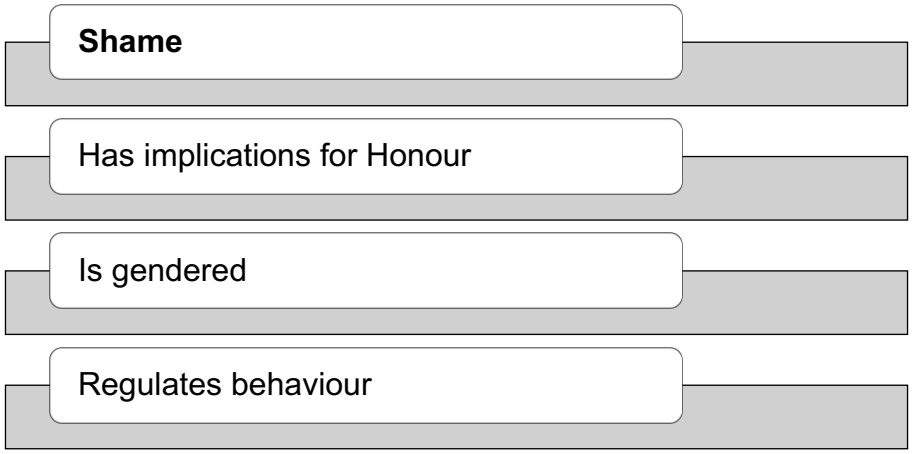

Figure 4: Teacher constructions of Shame

6.3.1 Shame has implications for Honour

Shame was constructed as an object which could be brought to oneself and one's family and as having the potential to damage family Honour:

"yeah I think some people are just stuck in their ways, it comes back to the Shame, bringing Shame to their family, that is their number one priority that you, you do not bring Shame to the family, anything that might is just swept aside, ok you do not bring Shame to the family full stop" (C)

Avoiding Shame was constructed as being of high importance to the families of the pupils. This is reflective of discourses which share the importance of not only obtaining Honour but also preventing Shame (Wikan, 2008). The teachers demonstrated an understanding of the extreme consequences of bringing Shame to oneself or the family which were not overtly discussed within the pupil's talk. This is reflective of discourses demonstrating that damaging Honour could result in being socially ostracised and/or being subject to Honour-based violence (Reavey, Ahmed and Majumdar, 2006; Cihangir, 2012; Cooney, 2014; Gill, Strange and Roberts, 2014):

"family Honour… erm well it goes back to that because they, they hold their head in society or in the community because their children follow what they, what that group has agreed to be the, the kind of standards by which they live their life. Because now they've fallen beneath that their standing in society, in the community has now fallen and that's the concept of this Honour thing now, that they cannot do that and they seek some sort of retribution and unfortunately as we know, that retribution is in the form of their girls being killed, murdered basically, or attacked" (E)

Behaviours thought to bring Shame included those which violated social norms, as conformity to societal expectations was valued and deviation from this was considered Shameful:

"Shame their families by being daring to be… by challenging the norms the old traditions and erm... and express themselves as they'd like to" (B)

These constructions of Shame are reflective of discourses within the literature which suggest that avoiding Shame protects Honour which is maintained through the maintenance of conformity of behaviour (Pask and Rouf, 2018; Gill, Strange and Roberts, 2014). These constructions attribute responsibility to girls to maintain the status quo and they are therefore held accountable if they do not meet the required standards. This positions girls with the responsibility of maintaining and upholding

Honour as their behaviour reflects upon the entire family (Gilbert, Gilbert and Sanghera, 2004; Thapar-Olmos and Myer, 2018).

6.3.2 Shame is gendered

The teachers discussed the construction of girls as the repositories of Honour:

*"that you represent the Honour of the family…your child in this case has made it impossible for you to now go out and be who you are and have this, this your name has been blemished because of the actions of your daughter, and it tends to be more the girls unfortunately in the community that we belong to and the girls have said this many many times that our brothers will go out and they'll have girlfriends and their fathers know that, they'll sell drugs on the streets of ****** and their father's know that, their mothers know that as well. They'll wear what they want to wear clothing wise, erm they will do everything that they are prohibited from doing" (E)*

This is associated with constructions of girls as pure, modest, virginal and in need of protection (Furnham and Adam-Saib, 2001; Kushal and Manickam, 2014). These factors are valued by the culture and associated with the marriage prospects of girls (Gill and Brah, 2014) hence they result in the regulation and policing of their behaviour which is thought to have the ability to bring Shame to one's family:

"it was all to do with marriage, the girl's marriage potential was being reduced if there was any, any defect, sorry to use that word but that's the way they, that's the word they would use so erm and any mental issues would be regarded as major issues in the future for her prospects of getting married basically" (E)

These constructions are associated with the maintenance of gender norms which endorse particular ways of behaving and acting in order to maintain patriarchal family systems (Gill, Strange and Roberts, 2014; Pask and Rouf, 2018). This positions girls within traditional, submissive roles which in turn transform them into subjects of control.

6.3.3 Shame regulates behaviour

The teachers discussed how the pupils regulated their behaviour in relation to what they deemed it was permissible to do:

"… we do dance in PE… sometimes the girls will say I'm not allowed to dance, erm, my parents won't let me dance or listen to music erm and if they do I think they wouldn't tell their parents at home because they would feel like they've let their parents down and have that sort of guilt that it's not acceptable for them to do that erm you know that guilt sort of…"(B)

This is reflective of pupil discourses which suggest that they '*know their boundaries*' and is indicative of literature which suggests that Shame operates by preventing behaviours deemed unacceptable (Pask and Rouf, 2018; Gill, Strange and Roberts, 2014). The internalisation of Shame is deemed powerful as it results in self-monitoring and self-regulation of behaviour as this South Asian teacher discusses:

"concept of Shame is far more powerful, it definitely goes within the psyche, it goes within the skin, it's deep rooted, that's more powerful that is, erm… one has a more psychological impact than the other, I would argue it's immensely powerful because it's a psyche thing as well, its deep rooted, it's part of the fibre that makes us" (E)

Shame is a powerful instrument of control, disciplinary in nature and capable of producing particular types of subjects. It operates by positioning pupils as individually responsible for their behaviour. Any deviation from the norm in policed by others within the community and individuals are blamed and held accountable for their actions. Associated with maintaining Honour, Shame results in the regulation of behaviour:

"if your gona take the Honour of the family, the Izzat of the family and I think that, that in a language sense, and also at a more psychological level has a far more greater impact and I think that kinda triggers some of the actions and also stops the actions of our girls and general people in society"(E)

This South Asian teacher constructs himself as being subject to the power of Shame demonstrating that Shame not only constructs and positions girls in particular ways but also the teachers:

"…we're talking about girls here and what not, would I do anything that would bring Shame upon my family? Probably not. Seriously and that's a guy saying that, because would I want erm, would I want to do something that would make my parents feel, erm Shameful of me or Shameful of my acts, I think I would think twice about it. And that's because of my love for my parents and my respect for my parents not because of society generally speaking, but but, that comes from the fact that I don't wana hurt my parents" (E)

As Shame may be a construct which permeates South Asian teachers' experiences this may support them in understanding and relating to pupils who may be reluctant to seek external support. Conversely it may position them with a dilemma as they are aware of the potential negative consequences of disclosing particular information to families about pupils.

The complexity of the construct Shame is further compounded by the emotional bond of the child with their parent. This strengthens the control and restriction of behaviour and the resulting compliance. Individuals are therefore entrapped within the potentially conflicting demands of fulfilling parent's needs, maintaining the Honour of the family by complying with societal expectations and following their personal desires (which may or may not align with the societal expectations).

The teachers constructed the girls as: lacking confidence, passive and restricted:

"the parents here are very strict with their, with their er girls… you know even though they'll misbehave, be silly or you know they know their limitations, once they get home, what it is, is they live a different life, they're someone different in school and when they get home, they still gotta conform to the house rules and then they come here, this might be the only freedom that they get" (C)

These constructions support the literature which constructs South Asian women and girls in stereotypical ways, as vulnerable to mental distress, submissive and passive (Gilbert, Gilbert, and Sanghera, 2004; Rafique, 2010; Mustafa, Zaidi, and Weaver, 2017). By doing this, a racist and pathologising discourse is employed which suggests that the culture is repressive and therefore the cause of problems:

"we're not a multicultural school we're er an Asian Muslim community that is very stuck in its Asian Muslim ways, you know it needs to be, instead of having these pockets of ethnicities that stick together… some haven't got televisions you know, their experience of the world is when they walk through the school gates and then when they get home at night erm you know how do they start to question things or become more aware or you know seek help, if they need to seek help from other people and have the confidence to approach these external sort of organisations, if they don't know that. Yeah so I think more cultural integration rather than pockets definitely, it's not healthy to have these pockets where you know and we try to culturally accommodate which is fine, … it doesn't really give a broader perspective on you know, other types of culture that exists" (B)

For one teacher things were improving as the girls were adopting the dominant western culture:

"I think the behaviour has considerably changed, that's the word I would use, changed because our girls are becoming more mainstream…" (E)

This corroborates with literature discussing how professionals construct the solution to mental distress for South Asian women being the adoption of western ideals (Burr, 2003). This functions to position girls as oppressed and the culture as repressive. Additionally, this contrasts with the pupils' discourses, where they demonstrated some resistance towards negative constructions of Shame and expressed agency in making choices.

6.4 How do these constructions and positionings open up or close down opportunities for help-seeking?

The construction of Mental Health as an abnormality and the medicalisation of mental distress has the potential to close down opportunities for help-seeking. They result in the negative labelling and pathologisation of individuals which has negative social consequences. The existence of 'normal' and 'abnormal' or 'ill' and 'well' lead to individuals being viewed as weak, defective and vulnerable if they are identified as distressed and has the potential to bring Shame to their family:

"I don't think they'll seek support, they'll just try and hide it" (B)

The constructions of Mental Health difficulties as hidden and difficult to express may be reflective of wider negative discourses surrounding Mental Health which in turn constrain opportunities to seek help.

The construction of Shame as gendered further constrains the girls opportunities to seek help. As the disclosure of mental distress has the potential of damaging their marriage prospects:

"I think they just yeah pretend it's not happening and erm yeah, you know I'm sure they don't want their daughters to be different, do they? They don't want there to be perceived as having a weakness or er a disability" (B)

As Shame is constructed as an object which inhibits and regulates behaviours deemed to bring Shame to one's family, it has the potential to close down opportunities for help-seeking, particularly if Mental Health is constructed as an abnormality or illness. The constructions of Mental Health as a spiritual or supernatural may have the same effect as they suppose a defect within the individual.

Conversely, the construction of Mental Health as a state provides a hopeful view as individuals are able to fluctuate along a continuum and are not thought to have a disorder. This construction also acknowledges the importance of external factors such as peer and family relationships as well as social circumstances. Accordingly, this opens up opportunities for help-seeking as it is non-threatening and non-blaming to the individual as mental distress is constructed as a universal experience.

6.5 Summary

This chapter explored how teachers constructed Mental Health and Shame, how pupils and teachers were positioned within these discourses and how these constructions may open up or close down opportunities for help-seeking.

The constructions highlight the complexity and contradictory nature of discourses of Mental Health. Consistent with the pupil discourses, the teachers constructed Mental Health as an 'abnormality', 'illness', 'hidden,' 'difficult to express,' and as an 'evolving state.' Apart from the dynamic construction of Mental Health, these constructions position pupils in restricted ways which constrain opportunities for help-seeking. The teachers talk also highlighted discourses which are reflected in the literature which construct Mental Health as a spiritual or supernatural object which was not present within the pupil discourses.

Consistent with pupil constructions, Shame was constructed as an object which regulated behaviour as it was considered that particular behaviours could bring Shame to oneself and the family, and in turn damage Honour. Furthermore, the

teachers described the gendered nature of this construction which positioned girls in ways which further constrained their opportunities for help-seeking. Absent from the teacher discourses was the construction of Shame as a helpful and positive tool, this was also missing from the existing literature which constructed Shame as predominantly negative.

CHAPTER 7: CONCLUSIONS AND IMPLICATIONS

7.1 Introduction

This chapter provides an overview of this research, the conclusions drawn from the analysis followed by implications for educational psychology (EP) practice. Recommendations for future research are presented with the strengths and limitations of this study. To close, issues of reflexivity are discussed with reference to the influence of the study on the researcher.

7.2 Overview and key findings

This research aimed to explore the discourses of Mental Health and Shame by analysing the talk of pupils and teachers. The literature review provided an overview of the dominant discourses surrounding the two objects of interest which were predominantly based around adult constructions. This study surfaced the ways in which South Asian girls and teachers constructed Mental Health and Shame and how these constructions impacted upon opportunities for help-seeking.

In conclusion, the analysis demonstrates the complexity and contradictory nature of discourses. Dominant medicalised discourses were present and reflected in the discourses of both pupils and teachers. The consequence of medicalised and psychological discourses include the positioning of subjects as disordered and defective, which close down opportunities to seek help. The pupil and teacher talk also surfaced counter discourses resistant to these hegemonic understandings. These constructions opened up hopeful and inclusive understandings of Mental Health demonstrating a shift in discourses.

Constructions of Shame by pupils and teachers were reflective of the literature which described it as an oppressive, sexist and disciplinary object. Some of the teachers' discourses were pathologising in nature and positioned girls in stereotypical ways, in contrast, the girls constructed themselves in ways which demonstrated resistance, power and agency. Absent from the literature was the construction of Shame as a helpful and protective tool used for decision making reflected within the talk of the pupils. Despite this positive construction, overall, the simultaneous existence of negative discourses of Mental Health and Shame close down opportunities for help-seeking.

7.3 Implications for practice

Psychological practice is rooted within practices of categorisation and assessment of individuals which perpetuate the discourse of abnormality. Supporting Mental Health problems has become integral to the role of EPs (Leadbetter, 2013) who are often asked to engage in assessment and therapeutic work with pupils constructed as 'having Mental Health needs' or displaying 'abnormal behaviour.' Awareness of prevailing discourses provides opportunities for reflexive practice and the interrogation of discourses that are embedded within society. EP practice involves the creation, manipulation and distribution of discourses about pupils (Bozic, Leadbetter, and Stringer, 1998). Hence, EPs are well placed to challenge and reconstruct negative and pathologising discourses which position pupils in particular ways. This research also highlights the importance of engaging in supervision as a reflective space to consider prevalent discourses within society and their influence on educational psychology practice.

This research highlights the importance of providing alternative counter discourses to the ways in which South Asian girls are constructed. The analysis surfaced the complex and contradictory nature of discourses which reflect the importance of seeking the voice of pupils as their discourses can be distinctive from adult discourses. How pupils are positioned by discourses may constrain actions and reflect issues of power, so by interrogating constructions and obtaining pupil's voice issues of power imbalances can be addressed. The use of person centred approaches within this research such as the statement sorting activity and the externalising objects tasks can be utilised as tools to capture the voice of children and young people within educational psychology practice.

The nuances of culture and individual experience are highlighted within the analysis, demonstrating the importance of avoiding considering South Asian girls as a homogenous group. This research emphasises the importance of cultural understandings of mental distress and provides awareness to those working with ethnic minority groups. The analysis allows opportunities to reflect upon the competence of services in relation to meeting the needs of communities where Shame and Honour are present in order to ensure they are accessible, safe and ethical. An example of this is the importance of cultural sensitivity when decision-making around confidentiality. The negative discourses surrounding the family and community highlight the need to challenge these discourses by adopting a community engagement approach to addressing Mental Health needs. It is important to note that cultural awareness requires a delicate balance in order to ensure that assumptions are not made as there is a danger of stereotyping.

Through consciousness raising, this research supports the need for EPs to ask questions which may uncover unmet needs. Peers were considered a key source of support for the pupils, suggesting that awareness-raising of approaching adults if a peer discloses difficulties would be beneficial. Furthermore, systemic work in schools, such as whole-school approaches can encourage shared language surrounding Mental Health which encourages young people to consider self-care; this may be more helpful than awareness raising of particular mental disorders.

7.4 Future research

This research could be extended by exploring the discourses of other subjects including, South Asian boys, parents, community members, and the pastoral managers of schools. These voices would further illuminate the way that Mental Health and Shame are constructed and the implications they have for action.

The intersectionality of constructs such as ethnic identity, dual heritage and culture were not examined in this study. Furthermore, the construct 'Honour' was not explored in depth due to the scope of this research. These concepts warrant further examination which may involve adopting a cultural psychology approach. Whilst the pupils readily communicated their constructions of poor Mental Health they did not discuss their constructions of positive Mental Health. Future research may specifically examine how this is constructed. Finally, Foucauldian analysis is critiqued for providing insights which are too broad hence the employment of alternative methodologies may illuminate the objects Mental Health and Shame in distinct ways. The use of ethnography would enable the capturing of naturally

occurring discourse which allows the analysis of discourses of Mental Health and Shame in action. Similarly, a discursive psychology approach may provide opportunities to explore how individuals use discursive resources to achieve particular objectives within social interaction, hence providing a micro-analysis of how South Asian girls and teachers manage interpersonal interactions in relation to Mental Health and Shame. This would further illuminate the ways in which teachers can approach Mental Health support in schools.

7.5 Strengths and limitations

The strengths and limitations of research are typically evaluated against the positivist criteria of reliability, objectivity and generalisability. These concepts are unsuitable for qualitative research (Thomas, 2017). Reliability cannot be examined in discursive research as the co-constructed nature of meaning acknowledges the influence of the context and positionality of the researcher in producing discourses (Yardley, 2008). Similarly, the interpretivist nature of the research acknowledges all interpretations as equally valid.

Generalisation is a key aim of positivist research, however, as discourses are formed in interactions between individuals within particular contexts the constructions produced are context specific. The aim of the analysis is therefore not to make broad generalisations to the wider population. Instead, this research provides local insights which may be useful in similar contexts (Yardley, 2008) and shapes the researcher's developing practice (Thomas, 2017). Consequently, differing discourses may surface within the context of conducting this research with

participants who have a diagnosed Mental Health difficulty or within a community setting.

7.6 Assessing quality in qualitative research

Validity is important in qualitative research and can be assessed in various ways**.** The quality of this research is evaluated using the eight criteria described by Tracy (2010).

Quality Criteria	Description	How this is achieved
Worthy topic	Topic of the research is relevant, timely, significant and interesting.	This study is an example of emancipatory research. The topic arose from the coinciding of personal and professional experiences. The research challenges and questions pre-existing assumptions and practices whilst enabling the absent voices of South Asian girls to be heard. Furthermore, the topic is under-researched within the domain of educational psychology and therefore adds to a limited knowledge base.
Rich rigor	The study uses sufficient, abundant, appropriate and complex: theoretical constructs, data, sample(s), contexts, data collection and analysis process.	The research is grounded in social constructionism which permeates the research from conception through methods, data collection and analysis. The sample was purposively selected within the context of the school where the issue of help-seeking was initially identified. South Asian pupils were recruited due to the cultural specificity of the topics under investigation. The data collection tools were aligned with the theoretical orientation of this research and piloted with participants. Semi-structured interviews are appropriate for exploratory research due to its flexibility, and the use of the active interviewing approach allowed the co-construction of data to occur. It could be argued that the inclusion of activities such as the externalising objects and statement sorting tasks provided excess data which was not necessary within a study of language. However, these activities acted as stimuli which enabled the pupils to talk about concepts which can be difficult to express. The data was transcribed by the researcher, proof read and checked for accuracy numerous times. The level of transcription was deemed appropriate as the analysis was less concerned with a micro-analysis of the structure and organisation of talk but focused on the content of the discussions. The framework of Foucauldian Discourse Analysis was utilised to aid the analysis of the data and consultation with original Foucauldian texts strengthened my theoretical understanding. (Appendix 10 provides an example of the initial stages of the analysis process).
Sincerity	The study is characterised by, self-reflexivity about subjective values, biases and	Due to my positionality, an introspective analysis of my own biases, motivations for this research, have been a key component of this study. Reflective conversations with colleagues, and during academic supervision has enabled the examination of how my presence as a South Asian woman impacted the participant recruitment and interviewing

	inclinations of the researcher. Including transparency about the methods and challenges.	process in both positive and negative ways. A self-reflexive commentary about my subjective sense-making and feelings was shared via a research journal. The interview schedule and activities were piloted with a pupil participant who highlighted the imbalance of time spent on discussing the construct Shame in comparison to Mental Health. Following this, adjustments were made in the ordering of activities and in my approach as the researcher. Furthermore, an activity was omitted following the pilot interview as it was deemed unsuitable in producing talk which would provide data relevant to the research questions. The level of reflexivity could have been improved by reviewing the interview audio recordings and the use of the active interviewing approach with supervisors, this would allow further adjustment in the approach employed in the subsequent interviews. Furthermore, by sharing the transcripts with the participants, they would have had an opportunity to clarify and elaborate on their responses which would provide richer data. The dual role of trainee educational psychologist and researcher brought with it particular advantages and challenges. These identities provided ease of access to the school and subsequently the participants. Equally, the role of trainee educational psychologist may have influenced the ways in which the participants interacted with me as a researcher as the teachers may have constructed the role of educational psychologists in particular ways, e.g. as 'experts' or 'specialists' in mental health. Consequently, this may have influenced the ways in which they positioned themselves, constructed their role in relation to Mental Health, and the ways in which they constructed the object 'Mental Health' within the interviews. A further discussion of reflexivity and the personal challenges of this research is provided in sections 7.7 and 7.8.
Credibility	The plausibility and trustworthiness of findings: the	The plausibility of claims is demonstrated through the use of illustrative quotes within the analysis which allow the reader to draw their own interpretation of the research. (An extract from a transcript is also provided in Appendix 10). The impact of hidden

	research provides thick description, concrete detail and 'shows rather than tells the reader.'	assumptions and tacit knowledge is discussed in section 7.7. Crystallization (gathering of multiple types of data through the employment of various methods) was utilised in the form of the externalising objects activity, statement sorting and questioning. This allowed the opening up of complex, in depth talk of the constructs under investigation which provided rich and thick descriptions. Furthermore, the surfacing of novel discourses within both pupil and teachers talk challenges pre-existing discourses found within the literature. All constructions and interpretations were identified through continuous examination of transcripts and shared with colleagues during academic supervision. Member reflections with participants could provide an opportunity for the pupils and teachers to react, agree, critique and reflexively elaborate on the analysis and strengthen the credibility of the analysis. Additionally, a range of activities were not employed within the teacher interviews, by utilising a range of methods this would crystallise the teachers constructions adding to the complexity of the analysis of their discourses.
Resonance	The research's ability to meaningfully reverberate and affect an audience. Achieved through aesthetic merit, transferability or naturalistic generalisations.	This research does not aim to provide findings which can be generalised to wider populations as the discourses and knowledge produced are historically and culturally situated. The analysis however will resonate with practitioners working with South Asian individuals and families and provide an opportunity to reflect on the cultural competency of services. Furthermore, the analysis of 'Mental Health' is of key relevance for the educational psychology profession and provides reflection points in relation to the language that is used, constructed and reconstructed in our practice.
Significant contribution	The research provides a significant contribution to knowledge and practice.	This research challenges the stereotypical constructions of South Asian women and girls in the literature, liberating them from taken-for granted assumptions through the analysis of their hidden voice. Additionally, it provides a deepened understanding of the concepts Shame and Mental Health which in some ways contrasts the discourses found in the literature. Hence, the analysis provides a new and unique conceptualisation of Mental Health and Shame demonstrating its theoretical significance.

		The research is limited in that it does not provide analysis of the ways in which 'Positive Mental Health' is constructed by South Asian girls which would add to the complexity of the discourses of Mental Health and provide further recommendations for action.
Ethical	The research demonstrates a consideration of procedural, situational, relational and exiting ethics.	As well as ethical approval from the University of Birmingham's Ethical board. Ethical guidelines from the British Psychological Society (BPS, 2010), the British Educational Research Association, (BERA, 2011) and the University of Birmingham's Code of Practice for research were adhered to. By introducing myself to the pupils over a number of sessions and meeting with parents/carers, full informed consent was obtained. I was introduced to the teachers at an all-staff briefing. Furthermore, careful selection of pupil participants ensured that those who had identified Mental Health needs were not included in the sample. Awareness of the sensitive nature of the topics resulted in mindfulness regarding the emotionality of the discussions and ethical decision making as to when to continue or end an interview. As the researcher I have accepted the responsibility of making the findings available to the participants, school and educational psychology service. The issues tackled in this research are challenging, hence I have attempted to strike a delicate balance of avoiding adding to the negative discourses surrounding particular cultures and communities' whilst acknowledging the inequalities and oppressive nature of particular constructs within the writing style.
Meaningful Coherence	Research which achieves what it purports to be about, uses methods and procedures that fit its stated goals and meaningfully interconnects	The aim of this research was to present the discourses of Mental Health and Shame through the analysis of the talk with South Asian girls and teachers. The analysis presents these discourses with reference to how they align or contrast with the discourses found within the existing literature and the implications of this. Careful considerations were made around the approach to the review of literature, formulation of research questions, methods, approach to the interview and analysis to ensure it was coherent with the social constructionist framework. The data from the interviews were not viewed as 'truths' but as 'one truth' within multiple realities. In line with this, 'member checks' were not enacted as

	literature, research questions and interpretations with each other.	the aim of this would be to determine the 'truth' of findings which contradicts the theoretical orientation. Furthermore, it was acknowledged that the analysis surfaced discourses which are context dependent, therefore the conduct of interviews and analysis by another researcher would result in differing interpretations.

Table 20: Evaluation of the quality of this research (Tracy, 2010)

7.7 Role of the researcher

Reflexivity is the application of a critical perspective to one's own knowledge claims (Kendall and Wickham, 1999). The goal of practicing reflexivity is to measure legitimacy, credibility and validity of research by considering the influence of positionality on the research process (Pillow, 2003). 'Prospective reflexivity' encourages researchers to understand the significance of their knowledge, feelings and values using an analytical lens (Attia and Edge, 2017).

As a South Asian woman undertaking professional training as a psychologist the topics of my research were familiar which brought with it certain benefits and struggles. My positionality placed me within an 'insider' role, this is a powerful position, enabling deeper engagement and insight into participants' experiences (Cooper and Rogers, 2014). It also enabled understanding of the nuanced reactions of participants, helped build rapport and aided participant recruitment.

Sharing my personal experiences during the interviews was at first viewed as potentially 'contaminating' the data. However, as the interviews unfolded it became apparent that the participants were keen to understand my experiences as much as I theirs. Sharing of 'insider information' reduced distance between myself and the participants and levelled power relationships. Thus, it enabled the building of solid foundations for rich and thick descriptions to be produced (Attia and Edge, 2017). Furthermore, the use of the 'active interview' approach encouraged the use of reflection in action resulting in intentional adjustments to my role in order to ensure that pupil talk was prioritised. For example, it was assumed by participants that I

understood the concepts being discussed, consequently, certain aspects of the constructions were not elaborated upon. My approach in subsequent interactions was to position myself as naïve to the concepts, probing, asking for clarification in order to elicit the participant's meanings.

7.8 Personal reflections

Research is a practice which enables a 'type of becoming' (Attia, and Edge, 2017), hence reflexivity is both how we shape the research and how we are shaped by it '…reflexive action changes the form of the self: a reflexive practice never returns the self to the point of origin' (Sandywell, 1996, p. 14). My own constructions of Shame and Mental Health were shared with supervisors and colleagues resulting in critical awareness of my influence in the conception, data collection, analysis and interpretation of the data which helped delineate bias (Drake, 2010). In addition to academic and peer supervision, supervision of the self was enacted through the use of a research journal, where my reasoning, emotional reactions and judgements were shared.

This research surfaced particular assumptions and prejudices and demonstrated the value of emancipatory research. My negative constructions of Shame were influenced by the discourses that were available to me. These included the extreme stories of Honour-based violence found in the media, in autobiographical accounts as well as the research literature. Coupled with the reading of Foucault's work on disciplinary power, the idea of the 'death of the subject' and the power of discourse in shaping social reality; this led to unhopeful, disempowering and helpless

constructions of the South Asian experience. These negative discourses were fundamentally challenged by the voice of the participants whom I interviewed. Through listening and reflecting I saw the transformation of my constructions towards hope, strength and resistance. This is not to diminish the view that dominant discourses present oppressive versions of the world but rather to acknowledge that alongside subjugation they also produce active agents who resist the mechanisms of power.

Throughout interviewing and analysis, I became caught up in the subjectivities of the girls, asking ‘am I listening to my teenage self?’ This was challenging and constructed feelings of helplessness, privilege, frustration and empathy. A deliberate effort was made to somewhat separate the two subjectivities, a necessary struggle in order to stay true to the data. Consequently, this research has enabled me to reflect on the emotional nature of research and psychological practice.

The aim of this research was not to obtain truths but to present discourses constructed within interactions. Although this research examined Mental Health and Shame in relation to South Asian girls, the analysis reflects discourses that are widely held in society. As a practitioner, this research has changed the ways in which I ask questions, listen to pupils, and interpret the ways in which pupils are constructed. Fundamentally, it has shaped the ways in which I use language and construct others in my talk.

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APPENDICES

Appendix 1: Pupil interview schedule

Appendix 2: Teacher interview schedule

Appendix 3: Parent/carer consent form and information sheet

Appendix 4: Pupil consent form

Appendix 5: Pupil information sheet

Appendix 6: Pupil debrief form

Appendix 7: Pupil participant information form

Appendix 8: Teacher information sheet

Appendix 9: Teacher consent form

Appendix 10: Excerpt from teacher transcript

Appendix 11: Analysis of data

Appendix 1: Pupil Interview Schedule

1. Welcome and introductions
2. Share information sheet
3. Provide overview of the activities
4. Ask pupil if they have any questions
5. Complete participant consent form
6. Complete participant Information Sheet (discuss their understanding of culture and community).

Introductory activity

Conversation starters: take turns to pick a conversation card and answer these.

Externalising activity: Mental Health (White, 2007)

Have you heard of the term Mental Health?

What do you understand about it?

(Young minds definition: we all go through times when we feel worried, confused or down but when these feelings take over, and it starts to become difficult to do everyday things it can be said that we are struggling with our Mental Health.)

I would like you to imagine that Mental Health is an object or living being…

- What would it look like?
- What would it say?
- What would it do? On a day to day basis?
- What would be its job?
- How would it impact/effect you?

Pupils given the option to draw, write, or verbally respond.

Statement sorting activity: 1

Sort the following statements into those you strongly agree to those you strongly disagree with:

- My culture and community help me to deal with difficult feelings
- I can talk to people in my community about how I feel
- My culture encourages me to talk about my feelings
- If I'm struggling with feelings there is always someone that can help
- My community and culture do not encourage me to talk about feelings
- If someone is struggling with their Mental Health, they are crazy
- Struggling with difficult feelings is normal
- If you have Mental Health difficulties, you should see a professional e.g. GP
- If you have Mental Health difficulties, you should not tell anyone

Follow up questions

- How does your cultural background help with dealing with difficult feelings?
- Do you feel the community supports people with Mental Health difficulties?
- If so, how? What factors in your culture help?
- How do you find talking about feelings with your family?
- Who is the best person to speak to if you're struggling with feelings?

Introductory activity: Shame

When I say the word Shame what do you understand it to mean?

Forms of Shame: (Gilbert, 2002)

- Related to a person's behaviour, which can bring shame to others and the behaviour of others can bring shame to oneself.
- Emotion linked with how particular behaviours reflects onto oneself and others.

- What is it called in your home language?

  Izzat, Ghairat = honour, Beh- izzat , Beh-Ghairat = shame

  Sharam= shame, Beh- sharam= without Shame

Externalising activity: Shame (White, 2007)

- Imagine Shame (sharam) as an object or a living being
    - What would it look like?
    - What would it say?
    - What would it do? On a day to day basis?
    - What would be its job?
    - How would it impact/effect you?

Invite RP's to draw, write or verbally respond

Follow up questions:

- ❖ Do you think there is a difference between feeling sharam and having sharam?
- ❖ How do you think (honour) izzat and (shame) sharam relate to each other?
- ❖ Can you think of an example of where shame has affected someone you know?
- ❖ How did it impact their Mental Health? What did they do?
- ❖ What would happen if sharam or izzat was lost?

Scenario - *Present in written form*

Hanna is 15 years old, she lives at home with her mum, dad and 3 older brothers. Hanna is in a relationship with an afro-Caribbean boy, she has been seeing him in secret and has a secret mobile phone she uses to contact him. Hanna wants to study drama and performing arts at university but she is feeling hopeless about her future. She cries a lot as she is unhappy, worried and fearful. She has not spoken to anyone about how she is feeling.

- What do you think Hanna is thinking and feeling about her situation?
- What do you think her parents think?
- What about her brothers?
- Do you think Hanna is struggling with her Mental Health?
- What do you think Hanna **should** do?
- What do you think she **will** do?
- If you were in this situation what would you do?

Statement sorting activity

Present pupils with cards showing alternative endings

These cards show alternative endings to the scenario. I would like you to rank them, with the ones you think are most likely to happen at the top and least likely at the bottom. If you think something else would happen I can write it on this blank card.

- Hanna will end the relationship with the boy
- Hanna will speak to someone about how she is feeling
- Hanna will go to see a GP
- Hanna will seek counselling
- Hanna will speak to her teachers
- Hanna will share how she is feeling with her family and they will support her
- Hanna will share how she is feeling with her family and they will not support her
- Hanna will not speak to anyone and things will remain the same

Follow up questions

- What do you think makes it difficult for Hanna to talk about her feelings?
- Do you think shame plays a role?
- How do you think shame affects her Mental Health?
- What do you think Hanna thinks about her position in the family?
- Do you think this impacts her Mental Health? How?
- How do you think Shame affects boys and girls?

Concluding comments

Thank you for your time and participation in my research.

You have the right to withdraw from the research which means I can remove your data within the next two weeks if you would like me to.

Present debrief sheet and certificate

Thank you for your participation in my research and good luck for the future! ☺

Appendix 2: Teacher Interview Schedule

- ❖ Welcome and introductions
- ❖ Share purpose of the research and information sheet
- ❖ Provide opportunity for participants to ask questions
- ❖ Consent form and background information sheet

Discussion topics/ questions/ probes

Topic	**Questions**	**Potential follow up questions**	**Probes**
Constructions of Mental Health needs	There are lots of definitions of MH and it means different things to different people. What does the term Mental Health mean to you? What are your views on the recent focus on supporting Mental Health in schools? How do you think Mental Health impacts pupils? How do you think teachers play a role in supporting Mental Health needs?	**Does it impact your role? If so, how?** **Do you have an example?** **How do you feel about that?**	*Can you tell me more about that?*
Experience of supporting pupils with Mental Health needs	In your experience, what kinds of Mental Health needs have you supported? What was helpful, what supported your role? What, if anything, hindered your role in supporting pupils with Mental Health needs?	**What did you do?** What happened next? **How do they respond?** **How does that make you feel?**	**Can you give an example?**
Shame as a barrier/ facilitator to help seeking	How did the pupils you supported access support?	**How did you respond?**	**How else?**

	How do you think the pupils felt about sharing their difficulties with a teacher? In what way was culture a factor in your experience? What role do you think Shame played in accessing support?	In what way has it been a factor? Are there benefits to this? Were there other factors at play?	*What does that mean to you?* **How so?**
Knowledge/ experience of South Asian culture and/or Shame	What is your understanding of the culture of the pupils in this school or of South Asian culture in general? In your role as a teacher in this school, how important do you think it is to be aware of the cultural background of pupils? What cultural factors do you think support good Mental Health? What cultural factors do you think contribute to poor Mental Health? What is your understanding of the concept of Shame in South Asian culture? How do you think girls feel about Shame?	In what way? Can you tell me more? What kinds of things do they do to show you this? **How do you know that?**	**And?** *Really?* *What else can you think of?*
	What do you think could improve Mental Health support and resilience building in schools?	Do you think this is possible?	

Closing comments

- Thank participants for their time and participation
- Remind participants of their rights to withdraw, provide contact details
- Provide opportunity for participants to ask questions.

Do you have any questions? Or is there anything you'd like to add?
Thank you! ☺

Appendix 3: Parent Consent Form and Information Sheet

Dear Parent/Carer,

Who am I, and what is my role in school?

My name is Maninder Sangar and I am a trainee educational psychologist completing my doctoral training at the University of Birmingham. I am working in (school name) as part of (local authority) Educational Psychology Service. Educational Psychologists work with schools and families to make learning a positive experience for children and young people.

Why am I writing to you?

As part of my training I am undertaking a research project, I am interested in learning about how girls and teachers talk about Mental Health. I will be interviewing girls in the school to talk about Mental Health. I have spoken to your daughter about this project and she is happy to take part but I will need your consent for this to happen.

What is the research about?

The aim of the research is to understand how teachers and south Asian girls talk about Mental Health. I am interested in finding out what factors support good Mental Health and the role that culture may have in getting help for emotional difficulties. As part of the research I will also be interviewing teachers to gain their perspective on supporting emotional needs in school. It is hoped that the findings from the project will help us to understand how we can support girls who may be struggling with their Mental Health in school.

How has my child been selected?

The Special Educational Needs Coordinator and the Form Tutors agreed who would enjoy talking to me about these topics. A group of pupils in your child's year group were given a short presentation about the research. The pupils were asked

whether they were interested in taking part, your child was then given this consent letter once they had expressed an interest to take part.

Does my child have to take part?

No, participation is voluntary. If you are happy for your child to take part I will ask your child to also agree and sign a consent form separately. Your child also can withdraw their information from the research up to 2 weeks after the interview.

What will taking part involve?

If you and your child agrees to taking part in the research, your child's participation will involve an individual interview lasting between 30- 40 minutes.
During the interview, we will be discussing issues around culture, good Mental Health and emotional difficulties. This will be done through several activities including a discussion around an impersonal scenario.
If your child changes their mind about taking part, they have the option of leaving the interview at any time.

What will happen to the information collected?

The interview will be recorded using a Dictaphone and some notes will also be taken. I will be the only person who hears the recording when I type up the discussions. When I have completed the project the recording will be deleted and the notes will be shredded.

The only time that information will need to be shared is if it is felt that a pupil may be in danger. If this is the case, information will be shared with the designated safeguarding officer in school, following child protection procedures.

I will not use your child's name, the school or the local authority's details when I write up the findings from the interviews. The findings will be written in a report which will be shared with the school and other educational psychologists that work

in the local authority. I will also share what I have found with your child in a summary report.

What happens next?

If you are happy for your child to take part in the research, please complete the attached consent form and return to (Special Educational Needs Coordinator) at school by (date).

If you would like to find out more information or ask any questions, please do not hesitate to contact me, my academic tutor or (Special Educational Needs Coordinator) at school via the details below.

My details:	**Supervisor:**	**School:**
❖ Maninder Sangar Trainee Educational Psychologist	 Academic and Professional Tutor University of Birmingham	❖ {Senco}
❖ Telephone:	❖ Telephone:	❖
❖ Email: ❖	❖ Email: ❖	❖

Yours sincerely,

Maninder Sangar

Trainee Educational Psychologist

Consent

Please tick your response:

I agree for my child to take part in the research ☐

I do not agree for my child to take part in the research ☐

Name of pupil: _____

Parent/Carer name: _____

Signed:_____ **Date:** _____

Appendix 4: Pupil consent form

Please read each statement below and circle your answer. If you have any questions, please ask.

I would like to take part in the research project	**Yes**	**No**
I understand that I do not have to take part in the research project	**Yes**	**No**
I agree to the interview being audio recorded	**Yes**	**No**
I understand that only Maninder will listen to the recording	**Yes**	**No**
I understand that what I say will be kept confidential unless I say something that suggests that I, or someone else is at risk of harm	**Yes**	**No**
I understand that I can leave the interview at any point if I would like to	**Yes**	**No**
I understand that I can withdraw my information for up to two weeks after the interview, and if I do this my information will be removed from the study	**Yes**	**No**
I know who to speak to if I decide that I want to withdraw my information	**Yes**	**No**
If I have any questions, I know who I can ask	**Yes**	**No**

Signed:

Initials:

Date:

Appendix 5: Pupil information sheet

Who am I?

- My name is Maninder Sangar
- I am training to become an Educational Psychologist
- Educational Psychologists work with parents, pupils and school staff to help to make learning a positive experience.

Why am I contacting you?

- I am studying at university and as part of my course I am doing a research project in your school
- I would like you to take part in my project.

What is the project about?

- The project is about how girls and teachers talk about Mental Health and shame
- I am looking at what supports healthy Mental Health in south Asian culture
- I am also interested in whether you think culture and shame plays a role in Mental Health
- The findings from the project will help us to understand how we can help girls who may be struggling with their Mental Health in school.

What will this involve?

- I would like to meet with girls in your school for about 1 hour to talk about Mental Health and shame in south Asian culture
- The meeting will involve doing some practical activities which I hope you will enjoy
- There are no right or wrong answers, I am interested in what you think
- You do not have to answer any questions that you do not want to
- You will have the opportunity to speak with me or (Special Educational Needs Coordinator) after the interview if you want to discuss anything we have talked about in more detail.

What will happen to this information?

- The meeting will be audio recorded using a Dictaphone
- I will be the only person who hears the recording when I type up the discussions
- When I have completed the project the recording will be deleted
- The only time I will share what you have said, would be if you told me something that could harm you or someone else
- The findings will be written in a report which will be shared with your school and other educational psychologists that work in the local authority
- I will not use your name when I write up the findings from the meetings so no one should know who has said what
- I will also share what I have found with you in a summary report.

What happens next?

- I hope you can help with my research project. If you would like to take part, then we will need to gain consent from your parent/guardian
- You can take a consent letter for your parents after this meeting, and I hope you can talk to them about taking part in my project
- If you and your parent/guardian agree to take part, then I will arrange a time to meet with you in school with (Special Educational Needs Coordinator)
- If you change your mind about taking part, you can let me know before the meeting, during or up to 2 weeks after the meeting. You can do this by contacting me on the details below or by telling (Special Educational Needs Coordinator) who will let me know.

My contact details:

- Maninder Sangar (Trainee Educational Psychologist)
- Telephone:
- Email:

My supervisor's contact details:

- Dr. Julia Howe, Telephone: Email:

Appendix 6: Pupil debrief form

Thank you for helping me with my project.

If you have been affected by anything we have discussed, you can talk to:

- Me (Maninder Sangar) on (telephone)
- Designated school staff:
- Your parent/carer(s)
- ChildLine Freephone: 0800 1111 (24 hours) or online chat on childline.org.uk
- Samaritans: 08457 90 90 90 (24 hours) or online Samaritans.org
- Young Minds: online at youngminds.org.uk

Thank you and good luck for the future!

Appendix 7: Pupil participant information form

Please respond to the following questions. Your information will be kept confidential. I will allocate you a participant code which will be used to identify your data. I will be the only person who has access to this information.

1. **Please indicate your age:**

2. **What is your ethnic preference?**

3. **What is your religious preference?**

4. **What is your family's country of origin?**

5. **Which region/state in the country of origin is your family from?**

6. **What additional languages do you speak?**

Participant code:

Appendix 8: Teacher information sheet

Who am I, and what is my role in school?

- My name is Maninder Sangar and I am a trainee educational psychologist. I am working in (school name) as part of (Local authority) Educational Psychology Service. I am completing my doctoral training at the University of Birmingham.

Why am I contacting you?

- As part of my training I am undertaking a research project, I am interested in investigating Mental Health difficulties in south Asian girls. I will be interviewing girls in the school to elicit their thoughts and would also like to invite you to take part in individual interviews.

What is the research about?

- The aim of the research is to explore how teachers and south Asian girls talk about Mental Health difficulties. I am interested in exploring what supports healthy Mental Health in south Asian culture and the role that shame may play in seeking help for Mental Health difficulties.
- A method of discourse analysis will be employed to analyse talk around these issues for both girls and teachers.
- It is hoped that the findings from the project will help us to understand how we can support girls who may be struggling with their Mental Health in school.

What will taking part involve?

- Participation is voluntary and you will be asked to sign a consent form if you agree to take part.
- Your participation will involve an individual interview lasting between 40 minutes to an hour. This will take place at a time and place which is convenient for you.
- The purpose of the discussion will be to discuss your thoughts and experiences around supporting Mental Health difficulties in south Asian girls.

- If you change your mind about taking part you can let me know before the interview, during or up to 2 weeks after the meeting.

What will happen to the data collected during the research?

- The interview will be recorded using a Dictaphone and some notes will also be scribed. I will be the only person who hears the recording when I type up the discussions. When I have completed the project the recording will be deleted and any notes will be shredded.

What will happen to the findings?

- The findings from the research will be written and published as a doctoral thesis.
- The findings will also be written in a report which will be shared with the school and other educational psychologists that work in the local authority. I will also share what I have found with you in a summary report.
- I will not use your name, school or the local authority's details when I write up the findings from the interviews.

If I agree to take part, can I change my mind?

Yes, you have the opportunity to withdraw:

- Before or during the interview
- Data can be withdrawn up to two weeks after the interview and,
- Specific information can also be withdrawn from the data.

How do I take part?

If you would like to take part in the research, please contact me via the details below by (date). Alternatively, you can express an interest by contacting (Special Educational Needs Coordinator).

Contact details:

Researcher: **Supervisor:**

Appendix 9: Teacher consent form

Shame and Mental Health: an exploration of the discourses of south Asian girls and teachers

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Please read each statement below and circle your answer. If you have any questions, please ask.

❖ *I would like to take part in the research project exploring the Mental Health of south Asian girls.*	**Yes**	**No**
❖ *I have read and understood the information sheet detailing what my participation will involve.*	**Yes**	**No**
❖ *I agree to the interview being audio recorded and understand that only the researcher will listen to this.*	**Yes**	**No**
❖ *I understand that only the researcher will listen to the recording.*	**Yes**	**No**
❖ *I understand that I can leave the interview at any point if I would like to.*	**Yes**	**No**
❖ *I have had the opportunity to ask questions and I am happy that my questions have been answered.* ❖	**Yes**	**No**
❖ *I understand that I can ask further questions at any time before or during the study.*	**Yes**	**No**
❖ *I understand that I can withdraw my information for up to two weeks after the interview, and if I do this my information will be removed from the study.*	**Yes**	**No**

Signed:

Initials:

Date:

Appendix 10: Excerpt from teacher transcript

The following extract provides an example of Stage 1 of the data analysis where implicit and explicit references of the objects 'Mental Health' and 'Shame' are highlighted.

R:	from your perspective because there are lots of definitions of mental health, erm there's no right or wrong, but how would you define it? What does it mean to you?	
E:	I think my, my understanding is, where a person isn't, for some reason they are identified as being different, different to the norm, what the majority would consider to be normal in that sense so behaviour wise, thoughts wise, so to come out with something irrational, you know, but not on a one off basis but on a regular basis, over time and if that condition progressively gets worse as well. So we've had a case of a girl talking to herself erm or coming out with really weird and wacky stuff and you just think to yourself, is there something wrong with that child, you know. And I think that is, in my own experience that would be deemed as being, is there mental condition there, is the mental state of that person right in that sense. But that maybe, in any I mean, and I hate to even say this but in the community that we serve, to be gay would be regarded a mental state, they would regard that as being kind of, going against the grain basically, going against the norm in society and that's another big issue that we're having to tackle at the moment. Not just that but the idea of erm, of how do you identify yourself as, what gender you know this concept of binary and all the rest and we are seeing all that now come through. And I spoke to, I spoke to, erm and it's a	**Mental Health:** Different to the norm in society **Mental Health:** Condition **Mental Health:** Within child **Mental Health:** Condition **Mental Health:** Societal norms

conversation I have regularly with staff in school, staff who argue that oh the behaviour in this school has gone downhill, right, since 2003 erm I think the behaviour has considerably changed, that's the word I would use, changed because our girls are becoming more mainstream

R: what do you mean by mainstream?

E: ok mainstream in the sense that, homosexuality would never, it was a taboo when I joined this school, it would never be discussed, people would never even think about wanting to openly come out or say that they were gay or had any sort of feelings, but that's becoming a norm because, because, they see it in society as becoming a norm aswell. And when I talk about behaviour, the idea that they don't need to erm be almost subservient to their parents as well. You know the idea that they don't need to conform to the culture that their parents belong to as well, all that is changing, you're finding that girls are rebelling against that as well. The concept of forced marriage as I said to you, they probably, didn't have a choice in the matter of who they were gona marry, that's changing as well. So what we're seeing is a complete change in the way that our girls behave in school

R: what do you attribute that change to?

E: I think society, it's a, it's a, I mean I'm no sociologist but I would argue that as society changes its an organic change, they are, they will see themselves as British full stop, they won't see themselves as Pakistani British, they will just say they're British because they won't have that affiliation, they won't have that, their language is going, that's the other thing that we're seeing as well, the

idea that they speak the language of their parents or their grandparents, their primary language will be English for that matter, the culture that they identify with, will be the mainstream culture of this country, erm, I mean even with religion as well, if you talk to the girls about religion compared to ten years ago, they have a very little, they have a very little understanding of the faith as well and I think, but if you talk about culture and things like that they've got a far more understanding of that and they have far more knowledge about what goes on as well. We went out the other day, we went out on Friday, the girls were singing bon Jove songs and a member of staff was just, really surprised that they were singing bon Jove songs as opposed to songs that they may have sang a couple of years ago, so things are changing and and they are developing an identity for themselves as opposed to an identity that was given to them by erm, from a cultural perspective and I think that's what we're seeing and it is a society change

R: what do you think the school is doing to promote that change, not promote but providing opportunities

E: yeah exactly, we support that, we, we give them, we've always felt compelled to give them opportunities that we felt they were denied by their, by their upbringing for example, in the sense that they may not go to museums, galleries, exhibitions, the cultural aspects of things but they are doing all those things now, they are beginning to do those things, and you speak to them about music or you speak to them about art, they have a great understanding of those things more than they used to do, many many years ago, erm so we still continue to give them those opportunities but we are now far more

supportive and understanding about if someone comes to us and talks about if they're having issues with their sexuality, or gender or they've got things at home about marriage, or abuse at home. I think the other fundamental change that we've seen , and it's not just here but across the board, speaking to other colleagues, is the fact that they can come forward, and they can talk about issues that they've gone through, domestic violence, forced marriage erm anything, they are far more open to discuss those things than in the old days when things just got swept under the carpet

R: hmm interesting, so you're saying that the children and girls are more open, when we're thinking about mental health difficulties, anxiety, feelings of low mood all of those kinds of feelings, do you think that they are more open with that as well?

E: yeah I think they're coming more, the fact that we are training mentors in school, adult staff to deal with those issues erm I think that comes from a cry of help from the part of the girls that when they come and they seek some guidance that we're fully prepared to give that support and guidance and that's where that's come from and if you speak to the pastoral managers and the heads of key stage, they will tell you that that that's what's happening now and we're more savvy at kind of, at identifying those students that need that kind of help as well and being kind of proactive

R: how do you do that? How do you identify pupils?

E: I think… pastoral… that's not my role

R: but as a teacher

E: as a subject teacher, as a head of department if you see a student being picked up for behavioural issues on a

regular basis you soon, you soon begin to delve and find out that there must be other issues, there must be underlying issues, and to be honest with the last couple of years a number of cases that we've had along the lines of CSE, child sexual exploitation erm and other conditions, other situations that have occurred at home, you're now, you now naturally begin to think there's more than meets the eye here

Mental Health: change in behaviour is a sign of a mental health problem

R: so what do you do in that situation? Think back to a time where that happened

E: I, I first of all I would seek support from pastoral because they have a far better understanding of, of those kind of personal things that are going on, as a subject teacher, I'm not, my remit doesn't go beyond that, in the sense, my remit is to support the child in the academic setting, with an understanding of what's going on, so for example we've dealt with students who, we've had conversations of particular students and in that sense, we look at interventions from an academic point of view but in terms of supporting the wellbeing of a child and all of that, we still leave that in the realms of pastoral managers, but we work alongside them and we'll say how is the child doing, what kind of state is she in, how can we, you know, what is, how flexible are they to kind of work in the model that we have or do we need look at a separate model to support that child, in the subject setting, that's what I would do erm. But so far as the kind of conversations to look at what the problems are and what the underlying issues and what can be done, that's still is within the remit of the pastoral managers

Mental Health: within child deficit

R: and do you feel that there is open communication between subject teachers and pastoral managers in terms of what is going on?

E: there is and there isn't and I and I respect that in the sense that, there are somethings which are deemed to be confidential and I'm just happy knowing that, a. that there is a situation, number one and number two that there are, there's work going on behind the scenes to kind of help that child and support the child and third that we're given advice on what we can do. And I think that's all, that's all we need to know, we don't need to be, yeah I've always argued that, I mean I've been a form tutor erm and as a form tutor I think I felt frustrated in those days that I didn't have a full and complete picture about what was going on with my students. And I'll give you an example, there was one girl who was constantly absent, constantly being the bane of my life because she would affect my attendance figures and what not, and only till the year later that I had learnt that that child had suffered from major period pains and that was why she was absent, so she had legitimate reasons to be off but that information was never relayed to me and I thought as a form tutor, as a front line teacher I should've been given that information. So I think there are certain things that should be shared, but there are certain things that are deemed to be confidential and I think we have to respect the privacy of the child there as well, we don't want the whole world to know about what the, you know the ins and outs are, I think but just to be told that there is issues, whether they're family issues whether they're mental issues, whatever they may be and and there are erm interventions going on to support that child, I think

that's enough from our point of view and the key thing is from my point of view is to say, or for someone to tell me that this is what you need to be thinking about, you may want to, you know look at the environment you're working in and how you address that child, if there are mental, if there is a situation where there is mental health issues etc. there may be ways that we tackle the you know, we don't shout at the child, there's a number of things we can do

Mental Health: mental issues within the child

R: be sensitive

E: exactly, that's crucial, from a subject teacher point of view

R: ok so as a subject teacher you think it's important to be aware of issues er but not know the ins and outs of what's going on but you feel that, to be aware would help you to change your approach maybe

E: Definitely definitely

R: What do you think hinders your role, if anything, when you're trying to support a young person with their mental health

E: I think, I think if I go back to the case we started off with, what hindered my approach there was having no understanding of a condition, I had no understanding at all, never heard of it before, never even knew about it, and that still haunts me today, if I'm gona be honest with you, as a teacher knowing that I was unable to serve the primary role as a teacher which was to, support that child you know, and that's what makes me want to have a better understanding about what's out there to support us in dealing with the nature of our students whatever that may be and I think that's what hinders I think not having that information, that knowledge to understand,

Mental Health: medicalised construct 'condition'

Mental Health: 'nature'– MH within the child

we don't need to be experts but I think having just a simple understanding that would hinder any member in the school from dealing with that child. For example when, three or four years ago, we never had CSE, I'm sure we had CSE before but never openly discussed or even labelled as being CSE and to be told what some of what those girls have gone through, really opened the eyes of staff who were moaning about that these girls were getting away with murder, they were getting away with murder because the head deemed this to be the best environment for them to be in to protect them basically, from these, these animals from outside school. And erm but staff were not sympathetic as to why they were behaving the way they were, they had no understanding, but the minute we were able to share with them the video or the situation we see now with the three girls in Rochdale I mean that's harrowing, that's what we were seeing, we were seeing the tail end of that, we were seeing the aftermath of that basically, what the girls were doing, they were showing the signs, it was a cry for help basically, there was something severely going wrong and, and that hindered our approach there you see. And I think information is key, I think knowledge is key I should say sorry not information, and having that understanding and from that understanding being able to empathise, not sympathise but empathise with the situation.

Mental Health: behaviour not aligned with the norm

Mental Health: change in behaviour is a sign of distress

R: do you think that, I mean you touched on it earlier, do you think that the girls are open about talking about mental health specifically?

E: I think, I think we're getting better at it, I don't think we're completely where we want to be, I mean I mentioned to

you about being proactive, I think we're still having to be a bit proactive on our part and bring children, is everything ok? I mean we've identified from the data, from your results, from your behaviour log that there's a recurring issue basically but having said that, I should say what we are also now experiencing is students who are coming forth themselves, who are feeling more confident

Mental Health: behaviour used as a mechanism for identifying need

R: can you think of an example just to illustrate your point, specifically with mental health?

E: specifically with mental health we've had in sixth form, erm… someone who shows that behaviour and it is mental health behaviour erm I duno what the ins and outs are there specifically with that child, but she's been, she's had that support from the sixth form team erm, ? because her behaviour has been completely erratic and what not, but the sixth form team have been really good in having an open door policy where she's concerned and I've seen the way that they've dealt with that situation and they really have erm tried to support it as much as possible, even the parents as well erm looking at other avenues, other agencies for support as well and I think that's really key and it's been really refreshing to see that because, like I said that's not something that we've seen in the past, but we are seeing that now, and I think also the other important thing is, the knock on effect on the other students as well because they feel that, at that point that their issues can be dealt with, that they can come forward and that there is support available for them erm as opposed to them just being victimised or being branded or being kind of, you know the idea of, this idea of shame because they've been

Mental Health: 'mental health behaviour' Erratic

Mental Health/ Shame: being labelled is Shameful

labelled as sometimes who's got mental health issues basically, I think that is where we are slowly moving away from now, hmm, I think also the idea that our girls will make in the future their own choices about what they want to do in terms of marriage, in terms of settling down, that also will play hand in hand with the idea of, this idea of being labelled and not being able to find a partner in the future I think that hopefully will change over time as well

R: sounds like from what you're saying that it is slowly changing

E: it is changing, it is, I think if you had this conversation ten years from now it would be very different, very different again and, and that's what is meant by becoming more mainstream, I think we will have those issues that we've never had to deal with that you would deal with in a mainstream school, I mean this is a mainstream school but it's very skewed in one way erm because we have a monoculture, yeah, it's a monoculture, and its very much set in a erm microcosm almost but if you, but if you went to a school in I duno, a school in I duno, great barr for example where you've got a mix of people, a mix of cultures and you've got a mix of issues therefore I think that's what we're gona start picking up on very soon. Which is, erm, which is great from my point of view because it, it it, presents more challenges for the future as well but erm that's that nature of the beast, that's the nature of what we do erm. It's fluid, it can change all the time basically. I was gona talk to you about discrimination actually which is a big area that we look at in business and erm the discussion we have about laws and equality and that's very erm interesting

because that always opens a can of worms especially along the lines of gender and about, I mean gender is always a good one because of, we deal with girls in this school er but then we go into the realms of religion and people of different faiths basically having the same rights as well and people in terms of the issues of the way they choose to dress as well and peers, we've got girls with headscarves for example and they talk about how they may be victimised or discriminated because of that and we talk about sexuality as well which is an interesting one and but I think, I think in terms of erm things to do with celebrating diversity I think we really have come leaps and bounds with that as well erm not just things to do with sexuality but a number of things as well. I thought it was really refreshing, I took a group of girls last week, was it last week or the week before? To a law firm in town and it was a, it's one of those aspirational days where the girls get to meet people in a setting and do like a project together and at the end there was an evaluation that the girls had to complete and there was a question to do with erm, about gender, how they identify themselves in terms of gender and erm the guy asked them the question, do you feel comfortable having that question and the girls said yeah, absolutely fine and I thought that shows how much we've moved on from an old day where you say no you're either male or you're female there's no in between basically and these girls were willing to say no there is, there is a grey area in between as well and we should be acknowledging that, and I think that said a lot about how far they've come so.

R: so going back to, you touched on shame, do you feel that that is one of the factors that makes it difficult for girls to talk about

E: yes

R: what other factors do you think contribute?

E: the pressure from home, it's the pressure from home and that ties in with this idea of shame because the idea that, that you represent the honour of the family I think, I know it's a very outdated kind of concept

R: do you think it's outdated for these girls?

E: no, no it's not, it's not because there's other communities as I said who have not moved with that time, who haven't really moved away from the concept that the girl is the honour of the family, they still believe in that. I mean we were talking about this the other day when I went out on a visit and I said that there are certain sections of, you see this community it isn't one homogenous community, it is a disparate group and there are certain sections of the community that we serve who have not moved with the times at all. They haven't and until they do, are we going to fully get to a stage where things have changed, and for them honour is a huge concept, a huge concept, and to bring about shame through any kind of means of I duno, having a boyfriend for example, let alone a girlfriend erm to have erm to have a sexual relationship outside of marriage, to, to be branded with mental health, any form of condition would still be regarded as a shameful thing for them, erm whereas others are far more open, far more accepting, far more open to discussion and to look at ways around how to support their girls, so, so we get both extremes here. But has the overwhelming majority moved in the right direction? I like

Shame: girls/ children represent Honour

Shame: girls/daughters holders of Honour

Shame: Shame can be brought to oneself/ family by engaging in particular behaviours, or being labelled as having mental health problems

Shame: having a condition is Shameful for some, not all

to think they have but we have still got a section who are very stubborn and they are still gona take more time to deal with and how they're gona, I guess they are, in that community literacy levels are still very low, educational levels are still low as well but as that generation moves on I think slowly, I would hope that changes will be brought about. That by the way is the community that I talk about that still has their girls married at 17, 16, they still hold onto that notion

R: what is that community called?

E: it's the pathan, it's the kind of afghani, afghanistani erm heritage kind of community, still prescribe to really outdated, what we would describe as outdated views erm, they're cultural, they're not religious, they are really cultural views that they hold onto but if you look at erm, the overwhelming, the Bangladeshi community, the Pakistani community or the Somali community they're very much different in that respect, erm I spoke about. We went out once for a meal and it was quite late in the evening and a group of our Somali girls walked into the restaurant they bought whatever they wanted and they were out, but, but, and for us to be out at that time on their own is quite a big thing but they were able to do that and there was no issue there, so that just shows how different their communities are, whereas the community I mentioned, they would never do that, they would never allow their girls to be out on their own, so that's their

Shame: cultural not religious

R: even in my experience, when I was at school my dad wouldn't let me, I mean now it's different but erm when I was at school it was this idea that we need to protect girls

E: yeah that's it

R: how would you define shame, what's your definition of it?

E: what's the definition of shame? Erm… I think it's, shame is based upon the notion that you, all conform to what community you have agreed to and you fall well below the standards basically. So for example, erm the idea that your, your girl has gone and had a boyfriend basically and in that community the idea that you shouldn't be having boyfriends, you should stay single till the point of getting married, that's what that community has agreed to be the standard that they all kind of follow and you've now gone beneath that because you've now gone below that standard, you are then… they feel that they cannot hold their head in society in that group. And that's what the, for me that's the concept of shame basically

Shame: results in conforming to societal, standards of behaving

Shame: deviating from standards results in Shame being brought on family and damage to social standing of the family

R: so how does that relate to family honour?

E: family honour… erm well it goes back to that because they, they hold their head in society or in the community because their children follow what they, what that group has agreed to be the, the kind of standards by which they live their life. Because now they've fallen beneath that their standing in society, in the community has now fallen and that's the concept of this honour thing now, that they cannot do that and they seek some sort of retribution and unfortunately as we know, that retribution is in the form of their girls being killed, murdered basically, or attacked or what not. (Phone rings) and I think that's my understanding of honour and shame that you are, because your, your child in this case has made it impossible for you to now go out and be who you are

Shame: Shame damages family Honour, may result in negative consequences for the individual e.g. Honour based violence

Shame: children's actions have implications for the parents

and have this, this your name has been blemished because of the actions of your daughter, and it tends to be more the girls unfortunately in the community that we belong to and the girls have said this many many times that our brothers will go out and they'll have girlfriends and their fathers know that, they'll sell drugs on the streets of Birmingham and their father's know that, their mothers know that as well. They'll wear what they want to wear clothing wise, erm they will do everything that they are prohibited from doing

Shame: gendered, daughters hold responsibility for Honour

R: why do you think that there is that difference?

E: it's that, its because is essentially the cornerstone of, the honour basically. The boys are not.

Shame: Girls hold Honour

R: sounds like girls hold this honour

E: absolutely, absolutely I mean I know that, I'm from that culture which holds the concept so I can empathise, I don't believe in that anymore, but I very much know, I understand where it comes from historically, culturally but they really still hold onto that and erm, not all of them but certain sections of the community really do hold onto that belief and I think in, I mean I would hate to think what would happen if one of their daughters was to become pregnant for example, outside of marriage or or, I mean I told you about putting them into mainstream school when they don't belong in mainstream schools, having physical deformities

Shame: cultural construct, historically located

R: so do you think that's about shame and honour?

E: of course it is, of course it is, I mean we have a child in school who, was… for all intentions and purposes that girl was unfit to be in this school, we had to take her on because her parents were adamant that she came here and until we got to the stage that we just couldn't look

after her and she had to leave us and the simple reason was that because they wanted her to become married in the future and become someone else's responsibility, the idea that they feel that their responsibility is to prepare her for marriage and then their responsibility is then taken away and it becomes the responsibility of their husbands and their husbands family. Its, it's quite sad in a way. But they do have that belief erm and that's why we see kids in here who aren't getting the support that they need because they don't want them to have that support because they're scared that it's gona get out into the community then its gona affect their chances of marriage in the future.

Shame: related to marriage prospects for girls

R: what do you think the girls think about this idea of shame and honour, what do you think they feel about it?

E: well I do know, I do know, because having the discussions I think that, like I said I think it's changing now because they watch mainstream tv and they know it's not shameful to do things that their parents would think are shameful, but they don't share that same, they are rebelling towards that, they are you know they are rebelling in terms of dress sense as well, erm the way our girls dress now and I don't mean uniform wise but you can pick those nuances in the uniform as well, I mean when you look at non-school uniform day and what the girls choose to wear is far more different to what it used to be, so the idea of wearing shalwar kameez as your kind of traditional kind of clothes, it's completely moving away from that, you know they'll come in jeans, they'll come in hoodies, they'll come in things which I know that their parents would have, you know might have done, might have had a massive disgust about that

Shame: Girls demonstrate resistance

you're dressing in a way that's not, that's shameful basically, that doesn't subscribe to those norms that, that they have in that community setting, they do it now

Shame: implications for dress sense – upholding norms of society

Appendix 11: Analysis of data

This example is based upon an excerpt from a transcript (Appendix 10) and reflects how this section of the text was analysed.

1. Transcripts were analysed and all references to *how Shame and Mental Health was constructed* (implicit and explicit) were highlighted	See Appendix 10 for highlighted references to the objects within the text
2. Highlighted excerpts from the transcripts were grouped under 'initial discourses'	**Initial discourses** **Mental health:** o Different to the norm in society o Irrational, erratic behaviour o Deficit within the individual o Mental health 'conditions' **Shame:** o Girls represent Honour of the family o Having a relationship or being labelled with a MH condition- Brings Shame o Conformity to socio-cultural standards and expectations = honourable o Deviation from standards= shameful o Deviation results in negative consequences for the individual o Actions of daughters reflect on parents and family o Shame and Honour linked with marriage prospects of girls
3. Through review and continuous interrogation of the data these initial discourses merged into dominant discourses discussed within the analysis and non-dominant discourses were removed	**Reworked discourses** **Mental Health:** o Mental health as an abnormality o Mental health as an illness **Shame:** o Shame has implications for Honour o Shame is gendered o Shame regulates behaviour **(NB. These discourses are relevant to the excerpt from the transcript found in Appendix 10).**

	Initial discourses	Rationale for the merging of discourses	Reworked discourses
Mental Health	○ Different to the norm in society ○ Irrational, erratic behaviour	These two discourses were based upon the notion that there are particular behavioural norms within society and therefore deviation is considered an 'abnormal'	**Mental health as an abnormality**
	○ Deficit within the individual ○ Mental health 'conditions'	Difficulties are viewed as an internal problem within the individual such as an 'illness' or a 'disease'	**Mental health as an illness**
Shame	○ Girls represent Honour of the family ○ Having a relationship or being labelled with a MH condition brings Shame ○ Conformity to socio-cultural standards and expectations is Honourable	These discourses are based upon the notion that there are particular ways of being which are deemed 'Honourable' as they maintain the status quo and deviation from these results in damaged Honour by bringing Shame	**Shame has implications for Honour**
	○ Shame and Honour are linked to the marriage prospects of girls ○ Actions of daughters reflect on parents and family	Gender is constructed in particular ways which results in girls have particular socio-cultural expectations placed upon them.	**Shame is gendered**
	○ Deviation from standards is Shameful ○ Deviation results in negative consequences for the individual	Shame prevents deviant behaviours and enables 'honourable' behaviours.	**Shame regulates behaviour**