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**Influences on Polish Migrants' Responses to
Distress and Decisions About Whether or Not to
Seek Psychological Help**

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ABSTRACT

INTRODUCTION

Since the expansion of the EU, several hundred thousand people from Eastern European countries have migrated to the UK, the majority of whom are Polish. Although no studies examining utilisation of mental health services by Polish workers in the UK could be found, research suggests that their knowledge of how to access health services is low, while rates of emergency psychiatric treatment are relatively high. The broader migrant literature suggests that migrants can perceive a cultural mismatch between themselves and services, find it difficult to access services due to logistical barriers, and often prefer to seek help from other sources. The current study sought to explore Polish migrants' responses to distress, with a focus on views about accessing psychological services.

METHODS

A cultural psychology framework using Charmaz's social constructionist method of grounded theory was adopted in the design of the research. Field work was conducted within the Polish community, and semi-structured interviews took place with Polish community members and key informants. Utilising data from a range of sources allowed for triangulation of the data, and credibility was further enhanced by member checking. Data were analysed using guidelines outlined by Charmaz supported by NVivo software.

RESULTS AND DISCUSSION

Participants' responses to distress were congruent with their sense of identity and the norms of the social groups with which they identified. Polish cultural values emphasising family closeness, traditional gender roles and discomfort with difference influenced participants' help-seeking strategies. The majority of participants preferred to seek help from a close inner circle of family and friends, at least in the first instance. Participants from working class rural backgrounds appeared to adhere more strongly to traditional values and often saw psychological services as irrelevant to them, whereas seeing a therapist was viewed as fashionable for those from urban, middle-class social groups. Disappointment with Scottish primary care services led to reluctance to approach the NHS for help with emotional difficulties, while those who were satisfied with their treatment were open to this possibility. Private services were preferred in Poland, which could result in preferences for seeking help from private Polish therapists in Scotland. This may also allow problems to be contained within the broader Polish community in line with Polish cultural values.

CONCLUSIONS

Clinical psychology services in Scotland may not be well-placed to meet the needs of Polish migrant workers. NHS services should attempt to be more responsive to the needs of migrant groups in order that they are not discouraged from seeking help if required. Furthermore, it may be helpful to find ways of working with other organisations which migrants feel more comfortable approaching.

SYSTEMATIC REVIEW

ABSTRACT

Background.

Research indicates that rates of service utilisation in migrant groups are low, although levels of distress appear to be high compared to those of the populations of host countries.

Objectives.

To review literature examining influences on migrants' decisions about help-seeking in response to distress.

Methods.

Systematic procedures were used for study selection and data extraction and analysis. Data was extracted from the MEDLINE, EMBASE, PsycINFO, Science Direct and SAGE databases. Inclusion and exclusion criteria were developed, and studies selected accordingly. Results of quantitative studies were summarised on the basis of variables associated with attitudes towards help-seeking. Qualitative studies were examined for common themes using the constant comparative method.

Results.

There was considerable heterogeneity in the results of quantitative studies. However, acculturation appeared to impact on help-seeking attitudes, and migrants appeared willing to seek help only if this was congruent with their explanatory models of distress. There was a suggestion that female gender, higher educational levels, and

higher socioeconomic status appeared to be associated with more positive attitudes towards help-seeking, at least in some migrant groups. Further, it seemed possible that social networks facilitated help-seeking in cultures where emotional expression was valued. Three major themes emerged from the qualitative literature: cultural mismatch between service providers and participants; logistical barriers; and preferences for other sources of assistance.

Conclusions.

These findings highlight the importance of considering cultural factors when exploring migrants' help-seeking decisions. Further, it appears that existing services may not meet migrants' needs, resulting in preferences for alternative sources of assistance.

Keywords.

Immigrants, help-seeking, psychological, attitudes

Research Highlights.

- Migrant help-seeking attitudes are influenced by cultural factors.
- Inappropriate services, logistical barriers, and alternative preferences prevent service use.
- There are consistencies in the qualitative, but less in the quantitative, literature.

INTRODUCTION

This chapter reviews the literature on attitudes towards seeking psychological help in migrant populations. As migrant attitudes are thought to be shaped by both the dominant social values of their country of origin and the values of the host country (Berry, 1997), any investigation of these constructs should be grounded within a cultural context. Cultural clinical psychology provides an appropriate theoretical framework for considering these issues, and will be briefly discussed in relation to the experience of migration. A systematic literature review was conducted in order to better understand factors that influence migrant attitudes to seeking psychological assistance. The findings of this review will be the main focus of the chapter.

Cultural Clinical Psychology and the Experience of Migration.

Cultural psychology is concerned with the ways in which social, cultural and political factors shape human experience. Straub and Weidemann (2006) describe culture as a flexible and interactive system where institutions, traditions and social norms develop over time as a result of human interactions. In turn, individual behaviour is moulded by these social structures and values. From this perspective, culture is not seen as fixed, but as socially constructed. Much (1995) highlights that in contrast to cross-cultural psychology, which assumes that innate, universal norms exist and can be uncovered by cultural comparisons, cultural psychology focuses on how meaning is constructed and expressed within a given society. As meanings are grounded within cultures, they cannot be understood without exploring the cultural context (Bruner, 1990).

Psychology as a discipline has been criticised for developing models based on Western understandings of social norms, and has been accused of 'culture blindness' (Kazarian & Evans, 1998, p.9) due to its failure to adequately consider cultural factors in research and theory development. Straub and Weidemann (2006) note that cultural psychology as a discipline stands in contrast to the nomological stance of many other areas of psychology, and is predominantly interpretive in nature. Further, it represents a move away from reductionist, individualistic, cognitivist traditions within psychology, and asserts that individuals behave in an interactive manner which must be contextualised within the broader sociocultural milieu (Zielke, 2006).

Straub and Weidemann (2006) warn against attempting to understand different cultures without fully considering the impact of one's own perspective and values on interpretations of perceived cultural differences. This is of particular relevance to conducting research with migrant populations. Ewing (2005) suggests that much of the clinical literature on migrant populations authorises the medicalised discourse of the host culture as scientific truth, while marginalising the experiences and perspectives of migrants themselves. Therefore, migrants' lived experiences should be taken as a starting point in attempting to understand notions of distress and associated behaviours within any given culture.

Migration and Emotional Wellbeing.

A literature review by Lindert *et al.* (2008) suggests that migrant populations are at least as likely to experience mental health problems as non-migrants, and are at

increased risk of suicide and psychosis. The reasons for this are unclear. However, research indicates that migrants may experience lower socioeconomic status, social isolation, and prejudicial treatment, all of which increase the risk of experiencing distress in migrant and minority ethnic groups (Dalgard & Thapa, 2007; Karlsen & Nazroo, 2002; Tinghög *et al.*, 2007). A Swedish study found that rates of psychiatric illness and psychosomatic complaints in respondents born in Poland and other Eastern European countries were approximately double those of respondents born in Sweden (Blomstedt *et al.*, 2007), and a review by Carta *et al.* (2005) concluded that migrants from Poland in the UK are one of the three migrant groups most likely to be hospitalised for schizophrenia.

Despite this, it appears that migrants display low levels of services utilisation. A study by Spencer *et al.* (2007) indicated that only 33 per cent of Eastern Europeans surveyed knew how to register with a GP in the UK. The literature consistently suggests that migrants are less likely to utilise available health services than native populations, and when they do, pathways to care are likely more likely to involve police and emergency services (Lindert *et al.*, 2008). Decisions about whether to seek help are likely to be determined by a complex array of factors. The following systematic literature review of the migrant literature seeks to explore the influences on migrants' attitudes towards seeking psychological help.

METHODS

Guidelines from *Clinical Psychology Reviews* were adhered to in the conduct of the systematic review. A systematic search strategy was undertaken to identify relevant

papers. Studies were assessed for quality using criteria developed from existing literature. Data from quantitative studies were summarised in relation to a number of key variables associated with help-seeking attitudes. Results of qualitative studies were integrated using the constant comparative method (Glaser & Strauss, 1967).

Search Strategy.

Greenhalgh's (2010) guidelines on literature searches were used. Databases searched included: EMBASE 1980 to 2008 Week 52; PsycINFO 1806 to December Week 4 2008; and MEDLINE 1950 to November Week 3 2008. The following search terms were used:

1. 'migrant\$1' or 'immigrant\$1'
2. 'mental' or 'psychological' or 'psychiatric' or 'psychopathology' or 'emotion\$' or 'well-being' or 'wellbeing' or 'distress'
3. 'utili?\$' or 'help seeking' or 'help-seeking' or 'access' or 'barrier\$'
4. 1 and 2 and 3.
5. Remove duplicates from 4
6. Limit 5 to English language
7. Limit 6 to human
8. Limit 7 to humans

This search returned 731 records.

The same search strategy was used in the ScienceDirect database. A search of the SAGE database (from January 1879 to July 2009) was conducted using the following search terms: 'migrant' or 'immigrant' or 'migrants' or 'immigrants' AND 'mental' or 'psychological' or 'psychiatric' or 'psychopathology' or 'emotional' or 'well-being' or 'wellbeing' or 'distress' AND 'utilise' or 'utilisation' or 'utilize' or 'utilization' or 'access' or 'barrier' or 'barriers' in keywords. Three further articles were identified, but were not thought to be relevant: two did not examine attitudes towards accessing mental health services, and one involved older migrants.

Abstracts were screened for potentially relevant papers using the inclusion and exclusion criteria. When it was unclear whether studies fitted the inclusion and exclusion criteria, papers were obtained and their relevance assessed. References of included papers were checked for potentially relevant studies; only one of the 36 identified was directly relevant. It was not possible to access two papers which may have been relevant, although it was considered unlikely that they would be.

Searches were sporadically rerun to identify papers which had been published subsequent to the original search. Twenty-five further papers were identified using this method, three of which were included.

Of the original 731 papers identified in the electronic search, 79 papers were considered potentially relevant upon reading the abstracts. Upon reading the full papers, 29 did not meet the inclusion and exclusion criteria. A further 19 studies, all unpublished dissertations, could not be accessed. This left 31 relevant papers.

Combined with the papers identified through other methods, this led to a total of 35 papers being included in the review.

Inclusion and Exclusion Criteria.

Moher *et al.* (2009) provide 'Preferred reporting items for systematic reviews and meta-analyses'; a flowchart was developed following their recommendations and is shown in Figure 1. Inclusion and exclusion criteria were as follows.

Inclusion Criteria.

Included studies met the following criteria:

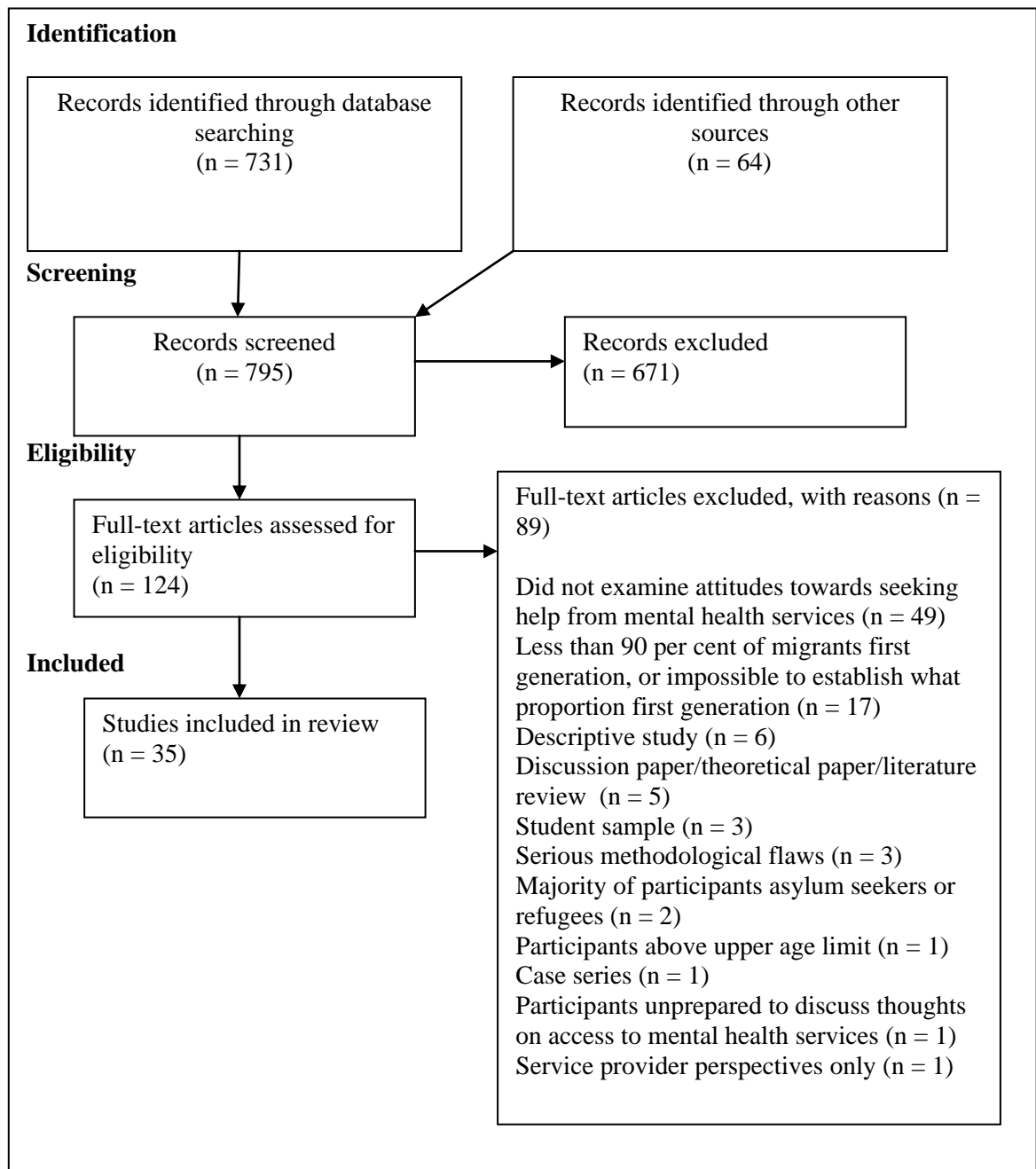
1. Qualitative or quantitative studies examining migrant attitudes towards seeking professional help for distress.
2. English language.
3. At least 90 per cent of the migrant group were first generation.

Exclusion Criteria.

The following types of papers were excluded:

1. Literature reviews, reflective papers, theoretical papers, and comments on the literature.
2. Case studies, case series, and reports of interventions or services for migrants.
3. Quantitative studies providing descriptive data only.

FIGURE 1: FLOWCHART OF INCLUDED STUDIES



4. Studies where the majority of participants were children or adolescents, older adults (i.e. over 65 years)¹, asylum seekers or refugees².
5. Studies which did not report whether migrants were first generation and did not report length of residence data, meaning that it was impossible to establish what proportion of participants, if any, were first generation.
6. Studies with obvious methodological errors³.
7. Studies which focused exclusively on domestic violence, substance abuse, or somatic symptoms.

Characteristics of included quantitative and qualitative studies are presented in Tables 1 and 2.

Critical Appraisal of Quantitative Studies.

Many tools exist for evaluating the quality of intervention studies (e.g. Higgins & Green, 2009). However, van Gerwen *et al.* (2009) highlight that there is a lack of consensus on how cross-sectional studies of attitudes should be evaluated. Therefore, quality criteria were adapted from Greenhalgh (2010), Pettigrew and Roberts (2006), and relevant systematic reviews of quantitative studies of attitudes (Besenius *et al.*, 2010; Glaser & Bero, 2005; Purewal & van den Akker, 2009).

¹ This was due to the fact that older adult migrants are likely to have a different profile to the migrant group under investigation in this thesis.

² Refugees and asylum seekers were considered to be likely to differ from migrant workers, in that it is more likely that they would have had trauma histories, and their reasons for migration were likely to be different (Lindert *et al.*, 2009). This is likely to have an impact on their service needs and use. However, an exception was made for Djuretic *et al.* (2007) due to the potential cultural similarities between their participants and the migrant group examined in this thesis.

³ Examples include questionnaires being inappropriately scored (Khanideh, 2007), or describing the participants as migrant community members when this was not actually the case (Shattell *et al.*, 2008).

Table 3 presents quality ratings for the included studies. The main methodological problems in the studies reviewed were inadequate description of inclusion and exclusion criteria, and a lack of representativeness and generalisability. In part, this is because it is often unfeasible to gain a representative sample in hard-to-reach populations, and methods such as convenience and snowball sampling provide the best opportunity to recruit a relevant sample (Faugier & Sargeant, 1997). However, caution is required in applying these findings to other migrants from the same cultural groups, and they cannot necessarily be considered applicable to other migrant groups. Another common problem was that all studies used at least some measures for which psychometric properties were not established. In some instances, this may have been because appropriate measures have not yet been developed for use with particular migrant groups, necessitating a degree of flexibility. However, in several studies, measures constructed ad hoc involving single items or very few items were used with little consideration of their psychometric validity. Kline (2000) highlights that reliability increases with test length, and recommends that scales should contain no fewer than 10 items.

Given the relatively small number of quantitative studies meeting the inclusion and exclusion criteria, none were excluded on the basis of quality. Furthermore, a sensitivity analysis revealed that if the study with the poorest methodological quality had been excluded, valuable information would have been lost and the diversity of migrant groups included in the review would have been restricted.

Critical Appraisal of Qualitative Studies.

Quality criteria for qualitative studies were based on suggestions from Charmaz (2006), Flick (2007), Glaser and Strauss (1967), and Mays and Pope (2000). Further discussion of relevant issues in evaluating the quality of qualitative research can be found in the Methodology chapter. Table 4 presents quality ratings for the included studies. One of the most important problems identified in the qualitative literature was a lack of transparency in research methods. With one exception, the only studies with sufficiently transparent methods were doctoral theses, probably because the authors had more room to explain their methods of analysis. Nonetheless, the lack of detail provided in the majority of published studies makes it difficult to form firm conclusions about the veracity of analyses. Furthermore, few authors reflected on their own role in the process, therefore it is difficult to establish the extent to which their own perspectives and values influenced their analysis. Only three studies took measures to ensure participant involvement in the research process, and few used triangulation methods. However, it was felt that the latter two issues affected the quality of the data to a lesser extent than the former.

Due to the heterogeneity of samples and methods, no studies were excluded on quality grounds in order to represent the depth and breadth of the literature. Instead, a sensitivity analysis was conducted to determine whether the results of the review would have been different had strict quality inclusion criteria been adhered to (Pettigrew & Roberts, 2006). With the exception of Jirojwong and Manderson (2001) and Martinez Pincay and Guarnaccia (2007), it was felt that studies with a

quality rating of four or less did not make a significant contribution to the analysis. All studies scoring five or above made a significant contribution.

Methods of Synthesis for Quantitative Studies.

Given the diversity of variables investigated and measures used, it was not considered feasible to attempt a meta-analysis of the quantitative studies. Instead, variables which were shown to be significant in at least one study were compared across studies, with a view to identifying consistencies and inconsistencies, and potential reasons for this.

Methods of Synthesis for Qualitative Studies.

Dixon–Woods *et al.* (2007) highlight the importance of making methods explicit in the synthesis of qualitative research, including a description of characteristics of papers, and methods of searching, appraisal, and synthesis. The constant comparative method was used in the synthesis of qualitative studies; Glaser and Strauss (1967) consider that this method can be appropriately applied in the examination of existing literature. When reading studies, notes were made on the major themes identified and any important points discussed in relation to the data. These notes were then examined for themes which were consistent across studies. Themes were colour coded in the notes, while making reference to the original papers to ensure that the reported findings corresponded to the themes in question. This process led to the identification of three key themes. Other minor themes were also found: however, some of these corresponded to the results of only a minority of studies, and it was felt that in general, they could be incorporated into the three major

themes. Results are presented by discussing the main themes and providing illustrative quotes. Similar methods of synthesising and presenting the results of qualitative studies have been utilised in systematic reviews of diverse topics such as experiences of living with HIV/AIDS (Barroso & Powell–Cope, 2000), older adults' and relatives' experiences of acute care settings (Bridges *et al.*, 2010), and women's experiences of domestic violence (Kearney, 2001).

TABLE 1: CHARACTERISTICS OF INCLUDED QUANTITATIVE STUDIES

Authors	Relevant research objectives	Participants	Age Mean (SD) ⁴	LOR ⁵ Mean (SD)	Gender	Methods
Barry & Grilo (2002)	To examine cultural, psychological, and demographic correlates of participants' willingness to use psychological services	170 East Asian migrants in the USA	28.4 (6.0)	7.5 (6.3)	52 per cent male	Questionnaire study; convenience sampling; correlations and regression analysis
Barry & Mizrahi (2005)	To examine associations between guarded self-disclosure and willingness to seek psychological services.	<i>Same sample as Barry & Grilo (2002)</i>	<i>Same sample as Barry & Grilo (2002)</i>	<i>Same sample as Barry & Grilo (2002)</i>	<i>Same sample as Barry & Grilo (2002)</i>	Questionnaire study; convenience sampling; correlations and regression analysis
Bassaly & Macallan (2006)	To determine relationships between attitudes towards seeking psychological help, cultural identity, and resilience	100 Polish migrants in the UK	Modal age group: 26–35 years	Modal LOR: 1–3 years	17 per cent male	Questionnaire study; convenience and snowball sampling; regression analysis
Beckwith (2005) <i>Unpublished doctoral dissertation</i>	To explore factors behind participants' attitudes towards seeking professional psychological help	94 Soviet Jewish migrants in the USA	55.65 (16.58)	14.24 (5.81)	44 per cent male	Questionnaire study; convenience sampling; regression analysis
Cabassa (2005) <i>Unpublished doctoral dissertation</i> Cabassa and Zayas (2007)	To examine how participants' perceptions of depression, attitudes towards treatment, and subjective norms influence intentions to seek help for depression	95 Hispanic migrants attending a primary care clinic in the USA	30 (10)	6 (5)	25 per cent male	Questionnaire and vignette study; convenience sampling; bivariate analysis, correlations, regression analysis

⁴ NB: If means and SDs not reported, ranges given instead.

⁵ LOR = length of residence

Authors	Relevant research objectives	Participants	Age Mean (SD)	LOR Mean (SD)	Gender	Methods
Derry (1996) <i>Unpublished doctoral dissertation</i>	To determine the relationship between demographic variables, traditional values, help-seeking behaviour	54 South Asian migrants in the USA	42.3 (14.9)	Not reported	42 per cent male	Questionnaire study; convenience sampling; correlations and t tests
Fruchtbaum (1995) <i>Unpublished doctoral dissertation</i>	To examine how gender and causal attributions of distress affect help-seeking attitudes	222 Soviet Jewish migrants in the USA	43.7 (13.6)	Not reported	39 per cent male	Questionnaire and vignette design; convenience sampling; MANOVAs, regression analysis
Fung & Wong (2007)	To examine the relationship of casual beliefs, perceived service accessibility, and attitudes towards seeking mental health services	1,000 South East Asian migrants in Canada	42.0 (11.4)	9.3 (6.5)	100 per cent female	Questionnaire study; convenience sampling; regression analysis
Knipscheer & Kleber (2001) – Study 1	To investigate whether migrants would consider consulting agencies for mental health care when they experience distress	292 Surinamese migrants in the Netherlands	34.9 (10.5)	17.3 (8.5)	56 per cent male	Structured interviews; purposive sampling; logistic regression analysis
Knipscheer & Kleber (2005)	To investigate migrant attitudes towards consulting agencies for mental health care when confronted with distress	292 Moroccan and Turkish migrants in the Netherlands	36.4 (11.0)	17.5 (7.8)	63.4 per cent male	Structured interviews; purposive sampling; logistic regression analysis
Mo <i>et al.</i> (2007)	To examine the relative contribution of acculturation and enculturation to the likelihood of help-seeking from mental health professionals	131 Chinese marriage migrants in Hong Kong recruited from community service agencies	35.6 (7.4)	2.0 (2.2)	100 per cent female	Questionnaire design; cross-sectional sampling; regression analysis

Authors	Relevant research objectives	Participants	Age Mean (SD)	LOR Mean (SD)	Gender	Methods
Sheikh (2000)	To investigate the relationships between gender, acculturation, and attitudes towards seeking psychological help	158 South Asian migrants in the USA	35.8 (14.2)	11.75 (8.26)	48.1 per cent male	Questionnaire study; convenience sampling; t tests and regression analysis

TABLE 2: CHARACTERISTICS OF INCLUDED QUALITATIVE STUDIES

Authors	Relevant research objectives	Participants	Age Mean (SD) ⁶	LOR ⁷ Mean (SD)	Gender	Methods
Ahmad <i>et al.</i> (2004a)	To investigate health promotion strategies and factors associated with the uptake of health messages	22 Chinese and 24 Indian migrants (latter may be the same as those in Ahmad <i>et al.</i> , 2004b)	33.5 (18–69)	1.8	100 per cent female	Focus groups; convenience sampling; constant comparison (Strauss & Corbin, 1996 ¹⁰)
Ahmad <i>et al.</i> (2004b)	To elicit experiences and beliefs about major health concerns	24 South Asian migrants to Canada	34 (18–69)	1.5 years	100 per cent female	Focus groups; convenience sampling; constant comparison (Strauss & Corbin, 1996 ⁸)
Ahmed <i>et al.</i> (2008)	To identify factors facilitating or hindering help-seeking	10 immigrant new mothers of various nationalities with post-partum depression in Canada	Early 20s to late 40s	Less than five years	100 per cent female	Semi-structured interviews; purposive sampling; constant comparison method of analysis (Glaser & Strauss, 1967)
Bassaly & Macallan (2006)	To explore attitudes toward seeking and receiving psychological help	3 Polish migrants in the UK	32	3–32 years	100 per cent female	Semi-structured interviews; convenience and snowball sampling; thematic analysis (Aronson, 1994; Leininger, 1985)
Blignault (2008)	To examine cultural variables, knowledge and attitudes towards mental health services, and perceived barriers to mental health care	9 Chinese migrants using mental health services, 13 Chinese migrant community members, 1 carer, 11 service providers	Patients: 36 Community members: 46	Patients: 11 Community members: 7	Patients: 89 per cent female Community members: 69 per cent female	Semi-structured interviews; convenience and snowball sampling; thematic analysis (Gifford, 1998)

⁶ NB: If means and SDs not reported, ranges given instead.

⁷ LOR = length of residence

⁸ This appears to be a typographic error: it is likely that they meant Strauss and Corbin (1998).

Authors	Relevant research objectives	Participants	Age Mean (SD)	LOR Mean (SD)	Gender	Methods
Chiu <i>et al.</i> (2005)	To gain an understanding of how immigrants diagnosed with serious mental illness make treatment choices with respect to spirituality; to understand the treatment choices and needs of women from different immigrant groups.	15 Chinese and 15 Indian immigrants to Canada	Chinese: 44 Indian: 48	Not reported	100 per cent female	Purposive sampling; idiosyncratic methods of analysis
Djuretic <i>et al.</i> (2007)	To explore factors that might explain differences in levels of mental distress among forced and elective migrants	13 refugees and 6 voluntary migrants from the former Yugoslavia in the UK	20–69	11 (3–15)	36 per cent male	Focus groups and individual interviews; purposive sampling; framework analysis method (Richie & Lewis, 2003)
En-Nabut (2007) <i>Unpublished doctoral dissertation</i>	To examine the lived experiences and perspectives on seeking counselling	6 Arab Muslim migrants to the USA	27.8 (5.7)	10.1 (3.3)	100 per cent female	Semi-structured interviews; purposeful sampling; phenomenological analysis (Van Manen, 1990)
Fruchtbaum (1995) <i>Unpublished doctoral dissertation</i>	To examine preferences for mental health assistance, and whether causal attributions of distress affect help-seeking attitudes	12 Soviet Jewish migrants	Males: 44.8; Females: 45.2	1–12 years	50 per cent male	Qualitative analysis of open-ended questions (no further detail given)

Authors	Relevant research objectives	Participants	Age Mean (SD)	LOR Mean (SD)	Gender	Methods
Guo (2003) <i>Unpublished doctoral dissertation</i>	To explore cultural, contextual and family parameters to the experience of depression	8 migrants from China to Canada with depression seeking psychiatric help	42.5	1–30 years	100 per cent female	Interview drawing on narrative (Merton <i>et al.</i> , 1956) and dynamically oriented (Benjamin, 1993; McWilliams, 1999) interview techniques; convenience sampling; idiosyncratic method of data analysis drawing on Coffey & Atkinson (1996), van Manen (1998) and Moustakas (1994)
Hussain (2006)	To examine reasons for low voluntary uptake of statutory mental health services	33 Pakistani migrants to the UK	55–62	Not reported	48 per cent male	Semi-structured interviews; purposive sampling; constant comparative analytic method (Silverman, 2000)
Jirojwong & Manderson (2001)	To examine personal, social, and psychological adaptation	139 Thai marriage migrants in Australia, 6 resource people	38 (19–65)	2 months to 29 years	100 per cent female	Structured interviews; accidental and snowball sampling; content analysis
Li & Browne (2000)	To explore barriers to accessing mental health services, formal and informal sources of help, and past experiences of interacting with health professionals	60 Asian migrants to Canada	41–43 ⁹ (12.2)	13 (9.79)	Approximately equal numbers of males and females	Semi-structured interviews; convenience and snowball sampling; content analysis
Martinez & Carter–Pokras (2006)	To investigate health issues and barriers	34 Latinos in the USA	46 (21–90)	11 (2–53)	15 per cent male	Focus group design; convenience sampling; idiosyncratic analytic methods

⁹ The paper states, ‘The mean age within each group ranged from 41–43 years old (SD=12.2).’ (p. 146)

Authors	Relevant research objectives	Participants	Age Mean (SD)	LOR Mean (SD)	Gender	Methods
Martinez Pincay & Guarnaccia (2007)	To investigate cultural understanding of mental health and depression and barriers to care	94 Latino migrants to the USA	20–71	< 1 year to > 20 years	19 per cent male	Focus group design using vignettes; convenience sampling; content analysis
Patel (2003) <i>Unpublished doctoral dissertation</i>	To examine help-seeking attitudes and behaviours	Indian Hindu migrants to the USA	Early 30s to 50s	2 months – 14 years	33.3 per cent male	Semi-structured interviews; purposeful sampling; discourse analysis (Gee, 1999)
Reitmanova & Gustafson (2009a)	To explore perspectives on access to and utilisation of primary mental health services	8 migrants to Canada from 8 countries on 4 continents (no further details given)	Early 30s to mid 40s	3 to 10 years	25 per cent male	Semi-structured interviews; convenience and snowball sampling; idiosyncratic analytic methods
Reitmanova & Gustafson (2009b)	To examine perspectives on availability and access to support services for mental health	<i>Same sample as Reitmanova & Gustafson (2009a)</i>	<i>Same sample as Reitmanova & Gustafson (2009a)</i>	<i>Same sample as Reitmanova & Gustafson (2009a)</i>	<i>Same sample as Reitmanova & Gustafson (2009a)</i>	Semi-structured interviews; convenience sampling; content analysis
Shin (2002)	To examine help-seeking behaviours related to depression	57 Korean migrants in the USA; 13 community leaders	Migrants: 48.3 (27–67) Community leaders: 47.6 (18–76)	Migrants: 19.5 (4–34) Community leaders: 11.7	46 per cent male	Focus groups and individual interviews; convenience sampling; idiosyncratic analytic methods (Fullilove, 1998)

Authors	Relevant research objectives	Participants	Age Mean (SD)	LOR Mean (SD)	Gender	Methods
Tabora (1994) <i>Unpublished doctoral dissertation</i>	To examine knowledge and beliefs about mental illness and community resources influencing help-seeking behaviour and utilisation patterns	14 Chinese migrants to the USA and two key informants (also Chinese)	46.6 (10.4)	12.07 (8.73)	100 per cent female	Qualitative study: focus group design, purposive sampling, constant comparison method (Corbin & Strauss, 1991)
Tabora & Flakerud (1997) <i>(Same study as above)</i>	To examine beliefs about emotional distress and their effects on help-seeking behaviours	<i>Same sample as Tabora (1994)</i>	<i>Same sample as Tabora (1994)</i>	<i>Same sample as Tabora (1994)</i>	<i>Same sample as Tabora (1994)</i>	Focus groups; convenience, network, and purposive sampling; constant comparison method (Corbin & Strauss, 1991)
Whitley <i>et al.</i> (2006)	To examine under-use of mental health services	15 West Indian migrants in Canada	Not reported	Not reported	27 per cent male	Qualitative design using McGill Narrative Interview (Groleau & Kirmayer, 2004); purposive sampling; idiosyncratic methods of analysis
Wong (1998) <i>Unpublished doctoral dissertation</i>	To investigate needs and preferences for assistance, coping strategies, and facilitators of access to mental health services	12 Chinese migrants to Canada	Only ranges reported (lowest: under 35; highest: 46–55)	5.5 (1.4)	100 per cent female	Qualitative naturalistic inquiry paradigm (Lincoln & Guba, 1985), purposive and snowball sampling, grounded theory analysis (Glaser & Strauss, 1967)
Wu <i>et al.</i> (2009)	To explore perceptions of barriers to seeking mental health services	27 Korean migrants to the USA (15 community members and 12 services providers)	Community members: 59.9 (7.3) Service providers: 44.6 (11.2)	Community members: 25.8 (7.4) Service providers: 20.7 (9.4)	100 per cent female	Qualitative focus group design; convenience sampling; content analysis (Miles & Huberman, 1994)

TABLE 3: QUALITY ASSESSMENT OF INCLUDED QUANTITATIVE STUDIES

Authors	Adequate description of methods of sample selection	Description of inclusion and exclusion criteria	Adequate description of participants	Representativeness/generalisability	Reliable and valid measures ¹⁰	Adequate sample size ¹¹	Evidence of appropriate analytic methods	TOTAL
Barry & Grilo (2002)	0	0	1	0	1	1	1	4
Barry & Mizrahi (2005)	0	0	1	0	1	1	1	4
Bassaly & Macallan (2006)	1	0	0	0	0	0	0	1
Beckwith (2005)	1	1	1	0	1	1	1	6
Cabassa (2005); Cabassa & Zayas (2007)	1	0	1	0	1	1	1	5
Derry (1996)	0	0	1	0	0	1	1	3
Fruchtbaum (1995)	0	0	0	0	Unclear	1	1	2
Fung & Wong (2007)	1	1	1	0	1	1	1	6
Knipscheer & Kleber (2001)	1	1	1	0	0	1	1	5
Knipscheer & Kleber (2005)	1	1	1	0	1	1	1	6
Mo et al (2007)	1	1	1	0	1	0	1	5
Sheikh (2000)	1	0	1	0	2	1	1	6
TOTAL	8	5	10	0	9	10	11	53

¹⁰ 2 = Yes; 1 = Some but not others; 0 = No.

¹¹ Calculated using G*Power3 if data not supplied in paper.

TABLE 4: QUALITY ASSESSMENT OF INCLUDED QUALITATIVE STUDIES

Authors	A	B	C	D	E	F	G	H	I	J	TOTAL
Ahmad <i>et al.</i> (2004a)	1	1	1	0	1	1	0	1	1	0	7
Ahmad <i>et al.</i> (2004b)	1	1	1	0	1	1	0	1	1	0	7
Ahmed <i>et al.</i> (2008)	1	1	1	0	1	1	1	0	0	0	6
Bassaly & Macallan (2006)	1	1	1	0	1	Couldn't tell	0	0	0	0	4
Blignault (2008)	1	1	1	0	1	1	1	1	0	0	7
Chiu <i>et al.</i> (2005)	0	0	1	0	1	1	1	0	0	0	4
Djuretic <i>et al.</i> (2007)	1	1	1	1	1	1	1	0	0	1	8
En-Nabut (2007)	1	1	1	1	1	0	1	0	0	1	7
Fruchtbaum (1995)	0	1	0	0	0	1	0	0	0	0	2
Guo (2003)	1	1	1	1	1	0	1	0	0	1	7
Hussain (2006)	1	0	1	0	1	1	1	1	0	1	7
Jirojwong & Manderson (2001)	0	1	0	0	1	1	0	1	0	0	4
Li & Browne (2000)	1	1	1	0	1	1	1	0	0	0	6
Martinez & Carter-Pokras (2006)	0	1	0	0	1	1	0	1	0	0	4
Martinez Pincay & Guarnaccia (2007)	0	1	1	0	1	1	1	0	0	0	5
Patel (2003)	1	1	1	0	0	0	1	0	0	0	4
Reitmanova & Gustafson (2009a)	1	1	0	0	1	1	0	0	0	0	4
Reitmanova & Gustafson (2009b)	1	1	0	0	1	1	0	0	0	0	4
Shin (2002)	1	1	1	0	1	1	1	1	0	0	7
Tabora (1994); Tabora & Flakerud (1997)	1	1	1	1	1	1	1	1	1	0	9
Whitley <i>et al.</i> (2006)	1	0	1	0	1	1	1	0	0	1	6
Wong (1998)	1	1	1	1	1	0	0	0	0	1	6
Wu <i>et al.</i> (2009)	1	1	1	0	1	1	0	1	0	0	6
TOTAL	18	20	18	5	21	18	13	9	3	6	131

A. Description of sample selection; B. Sufficient description of participants; C. Systematic method of data analysis; D. Sufficient transparency; E. Credible results; F. Well-integrated findings; G. Analytic commentary; H. Triangulation; I. Participant involvement; J. Researcher reflexivity

RESULTS

Quantitative Studies.

There was considerable heterogeneity in included variables, measures employed, and results between quantitative studies. This section discusses concepts examined in the quantitative literature, before providing a synthesis of results and discussion of implications for future research.

Concepts Examined in the Quantitative Literature.

Many quantitative studies examined demographic variables which, with the exception of gender, are self-explanatory. However, some concepts are specific to the migrant literature and are briefly described below.

Acculturation.

Redfield *et al.* (1936) describe acculturation as:

those phenomenon which result when groups of individuals having different cultures come into continuous first-hand contact with subsequent changes in original culture patterns of either or both groups (p.149).

Early models of acculturation suggested that immigration would either result in a 'melting-pot' of cultures, where the cultural traditions of host and migrant societies would merge organically (Park, 1928, p.883), or would require migrants to adopt the principles of the host culture for successful integration (Gordon, 1964). However, these theories have been criticised for being overly simplistic and failing to account for power dynamics within society (Berry, 1997; Padilla & Perez, 2003). More recent models such as Berry's (1997) suggest that acculturation involves

identification with both the host culture and culture of origin, which may vary across different domains of life. Most studies investigating acculturation have followed this principle and measure identification with both host culture and culture of origin, using indicators such as language, food and entertainment preference, pride in one's cultural identity, and identification with cultural values. The term 'enculturation' is sometimes used to describe identification with heritage culture (Much, 1995).

Explanatory Models of Distress.

The way in which distress is viewed and expressed varies across cultures. In a meta-analysis of studies investigating the role of culture on emotional expression, van Hemert *et al.* (2007) found that emotions were expressed more freely in cultures with looser social norms imposing fewer restrictions on behaviour. Bentall (2003) discusses cultural differences in how voice hearing is conceptualised: for instance, voice hearing is valued in some African cultures, and those who hear voices are elevated to the roles of healers and shamans. Further, in some Native American cultures, hearing voices is thought to represent communication from ancestors, and is considered normal. This stands in stark contrast to the stigmatising attitudes attached to such phenomena in Western cultures (Johnstone, 2000).

In addition, a vast array of 'culture-bound' syndromes, or patterns of expressed distress specific to particular culture groups, have been described. Some examples are *koro*, a phenomenon experienced by Chinese males who believe that their sexual organs are shrinking (Garlipp, 2008); *amok*, a display of uncontrollable murderous rage observed in Malaysia (Lucas & Barrett, 1995); *latah*, an exaggerated startle

response associated with involuntary vocalisations in Indonesia (Tanner & Chamberland, 2001); *brain fog*, a perception that the brain is being overworked in Nigerian students, leading to fatigue and a range of cognitive and perceptual impairments (Prince, 1985); and *ataque de nervios*, an expression of distress in Hispanic cultures occurring in response to a stressful event, involving uncontrollable crying, screaming, and often pseudoseizures (Guarnaccia *et al.*, 2003). Orbach (2009) highlights that eating disorders were once mainly exclusive to Western cultures where thinness is seen to represent beauty and positive personal attributes, but are increasing in the developing world with spreading Westernisation. This highlights how culture shapes the ways in which distress is expressed and communicated. Several of the studies included in the systematic review examined participants' models of distress, for instance by examining the extent to which they endorsed biological, psychological, social, and spiritual causal models.

Gender.

Although gender was measured as a dichotomous variable in the studies reviewed, feminist and social constructionist theorists have argued that gender identity is socially constructed rather than biologically determined. Kimmel (2004) points out that gender roles differ drastically across cultures, and are shaped by socialisation processes reflecting dominant cultural norms. Although the majority of cultures across the world assign more power to men than women, this is not always the case. Further, there is considerable variation in what is considered to constitute masculinity and femininity, and in behaviours which are deemed gender appropriate

across cultures. This is important to bear in mind when examining results in relation to gender across studies conducted with different migrant groups.

Synthesis of Results.

It is difficult to draw definitive conclusions from the quantitative literature given the diversity of variables investigated and measures employed. Inconsistencies between studies may be explained, at least in part, by differences in measurement and cross-cultural variation. Nonetheless, some findings are suggestive of factors which may play a role in attitudes towards help-seeking. Dependent and independent variables measured in the quantitative studies are summarised in Appendix A; further details of the measures used can be found in Appendix B.

Acculturation.

Of the seven studies measuring acculturation, five found a positive association with attitudes towards help-seeking on at least some dimensions of this construct. Derry (1996), Mo *et al.* (2007), and Sheikh (2007) found that acculturation was associated with more positive attitudes towards help-seeking. Fung and Wong (2005) found that identification with Canadian culture predicted Attitudes Towards Seeking Professional Psychology Help Scale (ATSPPHS; Fischer & Turner, 1970) scores in Taiwanese and Korean groups, but not in participants from China, Hong Kong, or Vietnam. However, Bassaly and Macallan (2006) found that conformity, measuring identification with British values, predicted perceiving greater stigma in relation to help-seeking, and greater doubts about being accepted for treatment in Polish migrants. Beckwith (2005) failed to find an association between acculturation and

help-seeking attitudes: the reasons for this are unclear. However, he used a measure which compared Russian/Jewish culture with American culture. Given the age range of participants in his study, it is likely that many would have chosen to leave the Soviet Union due to religious persecution (Chiswick, 1993); therefore, attitudes towards Russia and attitudes towards Judaism may represent different dimensions, which may have confounded his results.

Barry and Grilo (2002) found that interdependent self-construal, thought to be characteristic of Eastern cultures (Markus & Kitayama, 1991), was inversely associated with attitudes towards seeking psychological help. However, they found no association between identification with heritage culture and help-seeking attitudes; similarly, no relationship between these variables was found by Mo *et al.* (2007) or Fung and Wong (2005). In contrast, Bassaly and Macallan (2006) found that identification with Polish culture inversely predicted total scores, recognition of need for psychological help, comfort in disclosing problems, confidence in psychological services, and expectations of being accepted for psychological treatment on a modified version of the ATSPPHS.

Cabassa (2005; Cabassa & Zayas, 2007) found no association between acculturation and help-seeking attitudes. However, he categorised participants as having either a bicultural or unassimilated identity, which may be an over-simplification. Similarly, Bassaly and Macallan (2005) found that bicultural identification was not associated with attitudes towards help-seeking. However, Barry and Grilo (2002) found that

having a bicultural identity was positively associated with attitudes towards help-seeking.

Therefore, while acculturation appears to be important, there seems to be cross-cultural variation in whether identification with host or heritage culture is more influential in determining help-seeking attitudes. In Asian cultures, it seems that adopting, at least partially, some of the values of the host country leads to greater amenability to seeking psychological help, whereas identification with heritage culture is less important. In contrast, adhering to Polish cultural values was negatively associated with help-seeking attitudes, and adopting the host culture's values led to increased perceptions of stigma and doubts about being accepted for treatment.

English Fluency.

English fluency was positively associated with attitudes towards help-seeking in Barry and Grilo's (2002) study, although it is unclear how this was measured. No other studies examined this variable. Beckwith (2005) found no association between language spoken at home and attitudes towards help-seeking: however, only 8.5 per cent of participants in his study spoke English at home, which may have prevented a statistical association from being found. As language was a frequently cited barrier to help-seeking in several descriptive quantitative studies (Cabassa, 2007; Kung, 2004; Tabora & Flaskerud, 1997), fluency in the host country's language may be associated with help-seeking attitudes, although further research is warranted.

Length of Residence.

Of the six studies measuring length of residence, two found an association with attitudes towards help-seeking in different directions: Barry and Grilo (2002) found that more positive attitudes towards help-seeking were associated with shorter length of residence, while Knipscheer & Kleber (2001) found that they were associated with longer residence. No further studies found an association between these variables (Beckwith, 2005; Derry, 1996; Knipscheer & Kleber, 2005; Mo et al, 2007). However, although Mo *et al.* (2007) and Barry and Grilo (2002) studied similar cultural groups, length of residence may have been less relevant in the former study as participants migrating from China to Hong Kong are likely to have faced fewer cultural barriers than those migrating to America. However, the reasons for length of residence having differential effects on Surinamese and East Asian migrants are unclear.

Age.

The majority of studies examining the relationship between age and help-seeking attitudes found no significant association (Beckwith, 2005; Cabassa, 2005; Cabassa & Zayas, 2007; Derry, 1996; Fung & Wong, 2005; Knipscheer & Kleber, 2001, 2005; Mo et al, 2007), the only exception being Barry and Grilo (2002), who found willingness to seek help increased with age. As countries of origin overlapped between this study and Fung and Wong's (2005), the positive relationship found in the former is unlikely to represent a culturally-specific association between age and help-seeking attitudes. However, this discrepancy could reflect age-specific attitudes towards help-seeking. In the most recent *British Social Attitudes* survey, Anderson

et al. (2009) found that participants aged 25 to 59 held more positive attitudes towards help-seeking from a therapist than those aged under 25 or over 60. As the majority of participants across studies reviewed fell into this middle range, age effects may not have been detected. The fact that Barry and Grilo's (2002) study also included younger participants may explain why this study alone found age effects.

Explanatory Models of Distress.

In studies investigating the association between explanatory models and help-seeking attitudes, there was a suggestion that attributing distress to psychological causes was associated with more positive attitudes towards help-seeking. Fruchtbau (1995) used an adapted version of an unpublished questionnaire by Narikiyo (1991) to measure help-seeking preferences. However, she included personal coping strategies such as positive thinking and adjusting to the situation under psychological types of help, and helping oneself under psychological sources of assistance. Seeking professional psychological help and coping on one's own appear quite distinct, and combining them may have confounded her analysis. Nonetheless, she found that preferences for psychological assistance were predicted by attributing emotional difficulties to psychological or spiritual (but not physical or social) causes. Fung and Wong (2005) found that attributing emotional problems to stress predicted ATSPPHS scores in participants from Hong Kong, but not in those from China, Taiwan, Korea, or Vietnam. Attributing distress to supernatural causes inversely predicted ATSPPHS scores for participants from Hong Kong and Taiwan, but not for participants from other regions. Physiological attributions were unrelated to help-

seeking attitudes across groups. This suggests that causal explanatory models may vary across cultural groups, possibly as a function of cultural values.

Cabassa (2005; Cabassa & Zayas, 2007) found that participants were more likely to seek help from health services if they labelled a problem presented in a vignette as depression. This makes logical sense, and suggests that people may be more likely to seek help from sources which are congruent with their perception of their difficulties. Therefore, if problems are not considered to be psychological in origin, people may be more likely to seek help from alternative sources, such as family or traditional healers. In support of this, Fung and Wong (2007) investigated the impact of perceptions of the appropriateness of services to migrants' needs, and found a positive association with attitudes towards help-seeking in all participants except those from Hong Kong. Therefore, it seems likely that migrants across cultural groups may feel more inclined to seek help if services are perceived as culturally congruent and in line with their culturally determined conceptions of distress.

Severity of Distress.

Across studies, levels of distress and resilience did not appear to make a significant contribution to help-seeking attitudes (Bassaly & Macallan, 2006; Cabassa, 2005; Cabassa & Zayas, 2007; Knipscheer & Kleber, 2005; Mo et al, 2007). The only exception was that Barry and Grilo (2002) found that higher levels of somatisation and obsessive-compulsive symptoms were negatively correlated with willingness to seek psychological help. The finding that participants with higher levels of somatisation are less willing to seek psychological help is unsurprising: in a review

of somatisation literature, Mai (2004) proposes that patients who present with medically unexplained symptoms are reluctant to be treated by mental health services. The lack of a relationship between severity of distress and help-seeking might be explained by the fact that the studies reviewed all included community samples who had not necessarily sought help from psychological services, and whose levels of distress are likely to have been lower than in clinical samples. Furthermore, migrant groups have been found to be less likely to access services voluntarily (Lindert *et al.*, 2008), therefore seeking psychological help may still seem undesirable even when problems are severe.

Gender.

Women appeared to be more amenable to seeking psychological help than men in three studies (Barry and Grilo, 2002; Beckwith, 2005; Derry, 1996). However, Derry (1995) provides two different p values ($p = 0.15$ and $p < 0.05$) of the association between gender and help-seeking attitudes at different points in her thesis, leading to difficulties in interpreting her data. Sheikh (2000) found that more positive attitudes towards help-seeking were associated with more liberal attitudes towards women, suggesting that traditional gender roles may impede access to services. Six papers reporting on five studies found no association between gender and help-seeking attitudes (Cabassa, 2005; Cabassa and Zayas, 2007; Fruchtbaum, 1995; Knipscheer & Kleber, 2001, 2005; Sheikh, 2000). Two further studies included only female participants, therefore gender differences could not be explored (Fung & Wong, 2005; Mo *et al.*, 2007). Consistent with reviews of general population literature by Galdas *et al.* (2005) and Möller-Leimkühler (2002), this suggests that if gender

differences are to be found, women are likely to hold more positive attitudes towards psychological services than men. It seems unlikely that differences across studies are purely attributable to cultural factors: Beckwith (2005) and Fruchtbaum (1995) both investigated attitudes towards help-seeking in Soviet Jews, but obtained different results in relation to gender. Nonetheless, it is noteworthy that participants in two of the studies which found gender differences were from Eastern cultures, which have been characterised as promoting differentiated, hierarchical gender roles (Guo, 2003; Hussain, 2006).

Social Support.

Beckwith (2005) found a positive relationship between social support and attitudes towards help-seeking. Using a measure of subjective norms based on the Theory of Planned Behaviour (Fishbein & Ajzen, 1975), Cabassa (2005; Cabassa & Zayas, 2007), found that believing that family members would approve of help-seeking was positively associated with intentions to seek help, while friends' attitudes were unrelated. Mo *et al.* (2007) found that social support was unrelated to help-seeking attitudes. The scales used by Beckwith (2005) and Mo *et al.* (2007) are conceptually similar, suggesting that social networks may play different roles in help-seeking attitudes across cultural groups.

A review by Gudykunst (1998) suggests that people from Eastern cultures are more interpersonally reserved than those from Western cultures and are less likely to disclose personal information to others. In contrast, Langman (1997) suggests that discussing difficulties with others is an integral part of Jewish culture. Similarly,

family relationships in Hispanic culture have been characterised as being warm and intimate (Marín, 1993). Examining East Asian migrants, Barry and Grilo (2002) found that a lesser desire for interpersonal distance was associated with more positive attitudes towards help-seeking, and Barry and Mizrahi (2005) found that measures of self-concealment and conflict avoidance inversely predicted willingness to seek psychological help, although they found that desire for privacy was unrelated. Taken together, these findings suggest that when social networks are supportive of emotional expression, help-seeking may be viewed positively. In contrast, in cultures where emotional expression is discouraged, seeking psychological help may be less appealing

Education.

Both Knipscheer and Kleber (2005) and Mo *et al.* (2007) found that higher educational levels were associated with more positive attitudes towards help-seeking; however, Fung and Wong (2005) and Cabassa (2005; Cabassa & Zayas, 2007) found no association. Examination of these papers suggests that participants in Fung and Wong's (2005) had relative high levels of education while Cabassa's (2005; Cabassa & Zayas, 2007) participants had relatively low levels, which could have resulted in failure to detect education effects. However, as it is not clear how Knipscheer and Kleber (2005) measured educational levels, these comments are merely speculative. Cabassa *et al.* (2007) suggest that participants who are more highly educated are more likely to be familiar with Western models of distress, and to seek help accordingly.

Socioeconomic Status.

Mo *et al.* (2007) found an association between higher socioeconomic status and more positive attitudes towards help-seeking, but this was not replicated in other studies (Beckwith, 2005; Cabassa, 2005; Cabassa & Zayas, 2007; Knipscheer & Kleber, 2005). This is rather surprising, as several descriptive quantitative studies of migrants in the USA have found that costs of treatment present a major barrier to seeking treatment (Cabassa, 2007; Kung, 2004; Tabora & Flaskerud, 1997). However, participants in Beckwith's (2005) study were of relatively high socioeconomic status, and those in Cabassa's (2005; Cabassa & Zayas, 2007) had relatively low annual incomes, which may have prevented an association from being found. As health services are publicly funded for those on social benefits in the Netherlands (Schut & Van de Ven, 2005), socioeconomic status may have had less bearing on attitudes towards help-seeking in Knipscheer & Kleber's (2005) study.

Conclusions.

The most consistent finding in the studies examined was that acculturation appears to be associated with help-seeking attitudes, although the relevant importance of identification with host and heritage cultures may vary across different cultural groups. It is unclear what contribution length of residence makes to help-seeking attitudes, and further research is warranted. There was a suggestion that greater English fluency, higher socioeconomic status, and higher educational levels were associated with more positive attitudes towards help-seeking; however age did not appear to play a major role. It appeared that in some cultures, particularly Asian ones, women may be more amenable to seeking psychological help than men. The

data suggested that participants are likely to seek psychological help only if this is compatible with their explanatory models of distress, and if services are viewed as culturally congruent. However, severity of distress did not appear to predict help-seeking attitudes across migrant groups. Findings regarding social networks were intriguing, and suggest that strong social networks may encourage psychological help-seeking in cultures where emotional expression is socially acceptable, but may be less important in cultures where it is not valued.

Qualitative Studies.

Three main themes were identified in the qualitative literature: cultural mismatch between services and participants; logistical barriers; and preferences for assistance from alternative sources. Table 5 illustrates which studies contributed to each of the themes.

TABLE 5: CONTRIBUTION OF INDIVIDUAL STUDIES TO FINAL THEMES

Study	Cultural Mismatch	Logistical Barriers	Other Preferences
Ahmad <i>et al.</i> (2004a)	✓	✓	x
Ahmad <i>et al.</i> (2004b)	✓	✓	✓
Ahmed <i>et al.</i> (2008)	✓	✓	✓
Bassaly and Macallan (2006)	✓	✓	✓
Blignault <i>et al.</i> (2008)	✓	✓	✓
Chui <i>et al.</i> (2005)	✓	✓	✓
Djuretic <i>et al.</i> (2007)	✓	✓	✓
En-Nabut (2007)	✓	x	x
Fruchtbaum (1995)	x	x	✓
Guo (2003)	✓	x	✓
Hussain (2006)	✓	x	✓
Jirojwong and Manderson (2001)	✓	x	✓
Li & Browne (2000)	✓	✓	✓
Martinez and Carter-Pokras (2006)	✓	✓	✓
Martinez Pincay and Guarnaccia (2007)	✓	✓	✓
Patel (2003)	✓	✓	✓
Reitmanova & Gustafson (2009a)	✓	✓	✓
Reitmanova & Gustafson (2009b)	✓	✓	✓
Shin (2002)	✓	✓	✓
Tabora (1994); Tabora and Flakerud (1997)	✓	✓	✓
Whitley <i>et al.</i> (2006)	x	x	✓
Wong (1998)	✓	✓	✓
Wu <i>et al.</i> (2009)	✓	✓	x

Cultural Mismatch Between Services and Participants.

Language and communication difficulties were commonly reported barriers to help-seeking in the literature reviewed. Service providers were rarely able to speak the languages of participants' countries of origin, and difficulties in accessing interpreters were described. Some participants described a lack of adequately translated information in their native languages. Unsurprisingly, Djuretic *et al.* (2007) found that migrants from the former Yugoslavia to the UK who were fluent in English had less difficulty in accessing services. Thai participants in Jirojwong and Manderson's (2001) study expressed the view that lack of proficiency in the English led to difficulties in explaining feelings and expressing emotions.

To see a counsellor, we are going to have to use complicated and emotional terms, and we don't know them [in English]. Using Thai [language] is better because it provides a deeper understanding. To speak in a way that allows others [to] understand in depth [luuk sueng] what you say, it has to be in Thai. If I am desperate, I will seek help from others [non-Thais] (p.177).

Communicative styles also differed between cultures, leading to problems in communication between service users and providers. Jirojwong and Manderson's (2001) Thai participants were unaccustomed to direct Western styles of communication and were uncomfortable with this. Furthermore, in some Eastern cultures, distress is communicated through subtle cultural idioms which do not readily translate into English and may be misinterpreted by providers unfamiliar with these cultures. It has been suggested that Chinese people are more likely to somatise their distress than those from Western cultures (Kleinman *et al.*, 1978). However, Chinese people understand complaints of heart problems as expressions of emotional distress, while Western clinicians might interpret them as representing somatisation.

Participants perceived that service providers were often uninformed and insensitive to their cultural beliefs and values. For instance, in some cultures, life is interpreted through the prism of traditional gender roles, as described in the following quote from Wu *et al.* (2009).

[Mainstream medical services] are not appropriate for Korean American women because of language, because of different culture. For example, for domestic violence and family issues, their family and cultural background is different. If you approach it from a Western egalitarian view, sometimes it doesn't fit with this Korean American family structure. Korean culture is strong and very hierarchical. Husband has a lot more power. You can put that woman in danger (p.82).

Without a sufficient understanding of such issues, service providers risk alienating migrants by providing advice which is culturally incongruent. Participants' conceptualisations of distress were often in line with their cultural values, which differed from Western models of distress. In general, participants across cultures appeared to attribute distress to psychosocial factors such as life events rather than to organic or intrapsychic causes. Participants who held such views sometimes rejected medication as an appropriate strategy for dealing with distress and were reluctant to approach mental health services as they felt that this was what they were likely to be offered, as discussed by a West Indian participant in Whitley *et al.*'s (2006) study.

What he [the Doctor] going to do for me? He going to find me a nice husband, going to pay my rent? What's he can do? He can't do that, so he's going to make happy taking pill! No! (p.207)

Particularly in Hispanic and West Indian cultures, talking solutions were preferred. However, discussing problems is strongly discouraged in many Eastern cultures, particularly those with a tradition of Confucianism, where emotional control is valued in order to maintain harmonious, hierarchical interpersonal relationships. This appeared to be associated with a high tolerance of emotional distress, which was seen as an inevitable part of life. Holistic views of mind and body are also common in these cultures, and distress is thought to result from imbalances within this system, such as between hot and cold elements. For instance, angry feelings are thought to result from excessive heat in the body; an appropriate remedy is thought to be avoiding spicy and fatty foods to restore emotional equilibrium. From this perspective, having separate services for physical and emotional difficulties could be difficult to understand. Furthermore, the Muslim participants in Hussain's (2006)

study believed that their difficulties were a punishment from God for their sins, and that the appropriate course of action in resolving their difficulties was to accept their fate and to attempt to regain God's favour. In many cultures, there is no tradition of psychotherapy, meaning that it is viewed as irrelevant and culturally incongruent, as described by one of Wong's (1998) Chinese participants.

... we were brought up in a different culture (in which counselling is foreign). It is hard to verbalize your problems to others. You were taught that those problems were shameful. When small, mother would say, 'ugly things should not go out of the family gate' (p.162).

Expectations of providers' responses to distress were also determined by cultural norms, which were often incongruent with Western therapeutic practices. For instance, Hispanic participants in Martinez Pincay and Guarnaccia's (2007) study expected that if they unburdened themselves and shared their difficulties, providers should respond in a warm and emotional manner. Similarly, the East Asian participants in Chiu *et al.*'s (2005) felt that a connectedness and bond with a healer was essential for effective treatment, while Wong's (1998) Chinese participants felt that relationships should be informal and friendly. This could lead to a perception of being misunderstood or rejected by therapists working from models which emphasise therapeutic distance and boundaries, such as psychodynamic therapy. Many participants expressed dissatisfaction with previous contacts with service providers, and participants in a few studies felt that they had been treated in a discriminatory manner by healthcare staff due to their ethnicity.

Cross-culturally, many participants expressed concerns about stigma. Participants in En-Nabut's (2007) study were concerned that a therapist might be judgemental

towards their difficulties or think that they were 'crazy' (p.100). Worries about confidentiality were often expressed, and participants in some studies were uncertain whether service providers could be trusted in this respect.

Logistical Barriers.

Difficulties in accessing information about services presented a frequently cited barrier to help-seeking. Li and Browne (2000)'s study of Asian migrants found that considerably fewer participants knew how to access mental health services than general health services, and perceived greater barriers in accessing them. Participants in some studies relied mainly on informal social networks to gain information about services. Other sources of information included outreach advertising (such as subway advertising and brochures at clinics), children's social workers, and mass media.

No one is providing information like where and how and when to seek this information for immigrants and foreigners. There is a lot of job to do to provide the basic information regarding mental health where, when, how ... I think there is the potential for this subject and also for mental health providers. When you ask me where I can go, I don't know except to my family doctor (Reitmanova & Gustafson, 2009a, p.619).

Differences in healthcare systems between countries also appeared to lead to confusion in some instances, and participants were dissatisfied when they perceived healthcare systems to be less efficient and responsive than in their home countries. This could discourage them from seeking help for emotional difficulties. Participants from the former Yugoslavia in Djuretic *et al.* (2007)'s study highlighted the difficulties they faced in navigating the UK health system, in particular the role of the GP as a 'gatekeeper' (p.752).

In North American studies, costs of treatment provided a major barrier for many participants, often due to lack of health insurance, and could lead to delays in seeking help. Other issues raised included worries about illegal immigration status being discovered; concerns about entitlement to treatment; difficulty in accessing interpreters; lack of a private sector; difficulties in accessing services due to inconvenient locations; lack of transport; inconvenient opening times; difficulties with child care; long waiting times; insufficient time in healthcare consultations; and disinterested healthcare staff.

Preferences for Other Sources of Assistance.

Self-reliance was strongly valued by many participants across cultures, as illustrated by a Korean participant in Shin's (2002) study:

Because I thought I needed to take care of my own problems, I didn't ask for help when I was really low. When something happens, I avoid interaction with people until I resolve the issue alone. I do not want to make trouble. My mother always said, 'Even between parents and children, there are some things that are better not to discuss. Don't say everything on your mind. It's better to try to resolve it alone' (p.465).

Participants utilised a range of individual coping strategies to cope with their problems, including yoga; Tai Chi; meditation; gardening; exercise; walking; shopping; cooking; art; music; singing; writing; reading; returning to work or education; changing their environment; keeping busy; bearing it; trying to forget; crying; letting go of the past; valuing the present; thinking positively about future; appreciating what one has; and substance use. Ups and downs were viewed as a normal part of life by participants in some studies.

Family and friends were often the preferred source of assistance; again, this was the case for participants across cultures. As a Soviet Jewish participant in Fruchtbaum's (1995) study put it:

Family and friends are very important. Support is very important. Person can practically never deal with psychological problems by himself. You have to be super strong person to deal with [psychological problems] by yourself (p.125).

Particularly in Eastern cultures, help-seeking was often limited to immediate family, at least in the first instance, primarily due to fears about stigma and the potential for damage to the family's reputation if others in the community discovered a family member's problems. In some studies, a number of participants described visits to their home country as a strategy for dealing with emotional distress. Relationships with family and friends were generally seen as protective of emotional well-being. In Hussain's (2006) study of Pakistani Muslims in the UK, women were permitted to confide in the oldest woman in their household, but it was considered a sign of weakness for men to confide in anyone apart from religious healers. In other studies, participants from various cultures were as happy to speak to close friends as to family members, and sometimes preferred this as they felt that friends would be more likely to understand their difficulties. However, friends were sometimes seen as being too busy to help or unable to intervene. In some instances, participants found it helpful to talk to others who had experienced similar difficulties: for example, some participants talked of the benefits of meeting other immigrants at English as a Second Language classes, and participants in Ahmed *et al.*'s (2004) found meeting other new mothers particularly helpful:

My friends have been really really great with me. I have mostly other Latin American women who are my family friends, who are mostly also mothers, and they help me by, you know, meeting us in the park or coming to the playground, and I am able to talk to them and share stories ... (p.300)

Some participants in Eastern cultures used traditional medicines, such as traditional Chinese medicine and ayurvedics, to help with emotional difficulties. This was often in conjunction with Western medications, sometimes to combat side effects. Western medications were described as being strong and fast-acting but as having side effects, whereas Chinese medicine was viewed as slower-acting but effective.

Spirituality appeared to be important to participants in a number of studies. This could involve praying, or asking for God's help or forgiveness. In Hussain (2006) and Whitley *et al.*'s (2007) studies, participants viewed distress and its relief as determined by God, therefore interventions adopting a medical model were viewed as irrelevant and inappropriate. Across studies, talking to religious leaders was generally seen as socially acceptable and was not associated with fears of repercussions. However, in some studies, concerns were expressed that religious leaders would have to give advice in line with religious doctrine which was not necessarily in participants' best interests. An Indian participant in Chiu *et al.*'s (2005) study described the helpfulness of her faith in overcoming mental health problems:

It is only because of my beliefs in religion that I am all right. Medicine has helped me but mostly it is because of the religion and my belief in God that I am okay. When I read Gurbani [Sikh scripture] my mind goes towards the guru

[God] then my mind does not go to any other place and I feel better, even better than after taking the tablet (p.647).

In many studies, seeking help from mental health services was reserved for severe problems where the person was unable to perform their social roles, and/or where their problems were visible to others. Shin (2002) presents a four-stage model of help-seeking strategies. First, migrants would attempt to resolve their difficulties on their own through methods such as self-reliance, prayer and faith. When this failed, they would seek help within their family units. Help-seeking attempts might then proceed to formal sources, such as traditional medical practitioners, GPs, social service providers, and ministers. Only as a last resort and after considerable efforts to resolve their problems through other channels would help be sought from mental health services.

Conclusions.

The qualitative literature indicated considerable similarity in migrants' responses to distress and help-seeking decisions across cultures. A common problem was perceived cultural mismatch between participants' and services providers, in terms of language and a lack of understanding of participants' culture. Logistical barriers to accessing services were often identified, including lack of information, costs of services, and difficulties attending services. Many participants preferred to seek help from sources other than mental health services.

SUMMARY AND CONCLUSIONS

Overall, the results of qualitative studies were more consistent than those of quantitative studies. Comparative analysis of results across quantitative studies would be facilitated by the adoption of similar measures. The Attitudes Toward Seeking Professional Psychological Help Scale (Fischer & Turner, 1970) has been used in a number of studies, and appears to be a promising instrument. Most studies have measured acculturation along two dimensions – identification with host and heritage culture – and consistent adoption of this method would aid the synthesis of data from different studies. It would also be helpful for future quantitative research to include variables which have been found to have a significant association with help-seeking attitudes in previous studies to determine whether these findings are replicable within cultural groups, and whether the relative importance of these variables varies across cultures. Sophisticated statistical techniques such as structural equation modelling might be helpful in this regard.

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THESIS AIMS

PRINCIPLE RESEARCH QUESTION

What influences Polish migrants' decisions about whether or not to seek psychological help?

SECONDARY RESEARCH QUESTIONS

1. What are migrants' experiences of coming to the UK?
2. How have participants experienced their contacts with health services in Scotland?
3. How do participants conceptualise distress?
4. Is there a relationship between these factors and responses to distress, and if so, what is the nature of this relationship?

METHODOLOGY

Charmaz's (2006) social constructionist method of grounded theory was chosen to investigate the research questions, as it was considered to fit well with a cultural psychology framework. This chapter discusses the rationale for selecting this method, and its application in the current study.

RATIONALE FOR A QUALITATIVE SOCIAL CONSTRUCTIONIST MODEL

Qualitative research methods grew out of the anthropological tradition, where researchers commonly spent considerable periods of time in the field observing and speaking to participants, such as in Mead's (1977) seminal study of gender relations in the Trobriand Islanders. Barbour (2008) and Robson (2002) note that qualitative research has been increasingly adopted in psychology in recent years, and is now generally considered a 'respectable and acceptable' (Robson, 2002, p.163) research endeavour. Both of these authors emphasise that qualitative and quantitative research methods address different questions. Barbour (2008) considers that qualitative research can help to explain the relationships between aspects of experience by examining participants' accounts. She notes that qualitative research is concerned with processes, understandings, and beliefs, which can help to explain actions and events. Further, Kvale (1992) considers that qualitative methods allow the researcher to gain information about culturally situated, socially constructed meanings.

There are many different approaches to qualitative research with divergent underlying philosophical and theoretical rhetoric and associated methods (Barbour,

2008; Robson, 2008). Starks and Trinidad (2007) compare three major schools of qualitative research: phenomenology, discourse analysis, and grounded theory. They consider that phenomenology is characterised by the notion that an essential reality exists which can be discovered through examining participants' lived experiences. Discourse analysis focuses on linguistic processes and how they are used to achieve certain ends. Finally, grounded theory is based on the principle that meaning is negotiated and understood through social interactions. A decision was made to use grounded theory methods in the current study. Phenomenological methods were rejected on the grounds that the underlying propositions clashed with a social constructionist conception of culture. Although discourse analysis appeared philosophically compatible with the aims of the study, it was considered that complications might arise in applying a method which primarily focuses on language use to participants whose first language was not English.

Grounded theory was originally described by Glaser and Strauss in *The Discovery of Grounded Theory* (1967), written partly in reaction to their perception that much sociological research of the time was not conducted in a systematic manner. Grounded theory methods attempted to redress this balance by providing codified procedures for qualitative research allowing the systematic development of theories which closely reflected data from which they were constructed. It is important to note the authors' training and the time and place in which grounded theory arose. Glaser aimed to develop rigorous methods for systematically coding qualitative data, in response to criticisms that qualitative data was unreliable and subjective. On the other hand, Strauss had trained at the Chicago School of Sociology, and had been

greatly influenced by thinkers in the symbolic interactionist tradition such as Mead, Cooley and Blumer (Charmaz, 2006). Thus in its original conception, grounded theory represented a perhaps rather unlikely marriage between positivist approaches and symbolic interactionism. The word 'discovery' in the title of their book has profound positivist implications: that an external reality exists waiting to be revealed through structured investigations.

Since its original conception, grounded theory has evolved in different ways, with Glaser and Strauss each developing their own versions, and other researchers refining the method in yet other directions. Glaser's (1978, 1992, 2004) approach is arguably the less active of the two methods, and involves developing modifiable concepts from data with the expectation that a theory will emerge from the inter-relationships between categories. In contrast, Strauss and Corbin (1990, 1998) provide detailed guidelines about how the researcher should interrogate the data to arrive at a theory. Boychuk Duchscher and Morgan (2004) discuss Glaser's objections to the manner in which Strauss and Corbin (1990, 1998) developed the method, which he felt was overly prescriptive and forced data into a theoretical model rather than allowing the theory to emerge organically. They consider that the level of specification in some of Strauss and Corbin's (1998) procedures makes them reductionist to the point that they could interfere with the researcher's understanding of the data. Nonetheless, both versions of the method are grounded in positivist discourse. For instance, Glaser's (1978) description of 'coding families' (p.74) could be argued to reify abstract theoretical concepts, while Strauss and Corbin (1998) use terms such as 'hypotheses' (p.135) and discuss modelling data along dimensions.

Furthermore, both approaches could be criticised for underplaying the researcher's role in the research process. Implicit in Glaser's (1978, 1992, 2002) accounts is an assumption of objectivity on the part of the researcher: that if the researcher is patient, the theory will reveal itself. Strauss and Corbin (1990) do address the issue of the researcher's values, promoting a technique which they call 'waving the red flag' (p.91) to assist the researcher to see how their own cultural values may prevent them from seeing beyond what is obvious in the data. There is an implication here that if the researcher is able to identify their own biases, they should be able to overcome them and achieve greater objectivity. However, from a social constructionist perspective, it should be recognised that the researcher has a key role in the research process, and that their individual and cultural characteristics will influence their interactions with participants, what data is obtained, and how this is analysed. Rather than trying to eradicate these issues – which would be impossible – adopting a reflective stance on how they feed into the research process may be more helpful.

An alternative, and explicitly social constructionist, approach to grounded theory has been developed by Charmaz (1995, 1999a, b, 2006, 2008). Charmaz (2006) considers that as we are part of the social world under study, theories are constructed through interactions between researcher and participant, and through the interpretations which researchers bring to data via their prior experiences and values: thus, it is an explicitly interpretative approach. This method considers the study of action to be central, examines process, and aims to reach an abstract interpretative understanding of data using flexible procedures. The migrant literature reviewed

strongly suggests that culture frames people's decisions about what action to take in response to distress. Thus, Charmaz's (2006) approach to grounded theory appeared best suited to the current study.

METHODS EMPLOYED

Field Work.

The idea of this thesis sprang from an informal conversation when a colleague mentioned that there was a large community of Polish migrant workers in Forth Valley. However, this did not seem to be reflected in referral patterns to Adult Clinical Psychology, leading to a process of preliminary investigations into the possible reasons for this. Barbour (2008) suggests that conducting pilot work in the field can help the researcher to familiarise themselves with a new area of study and assist the development of interview schedules.

A community education worker assisting Polish migrants served as the first point of contact, and provided an invitation to join the Scottish Migrants Network, and introductions to Polish community organisations and professionals offering assistance to migrants. Initially, informal meetings were held with a range of professionals: their views were sought on issues facing Polish migrants in Scotland and possible reasons why they might not be presenting to psychological services. Various Polish community events were attended where it was possible to speak informally to Polish community members generally and about relevant issues. Throughout the research process, Scottish Migrants Network meetings, conferences about migrant issues, and Polish events were attended in order to network with others

in the field. This provided invaluable contacts and allowed discussion of ideas with others with experience of the issues in question. Unstructured field notes were kept of impressions gained through these interactions.

Nonetheless, the field work was not without its difficulties. As an 'outsider' within the Polish community, access to certain cultural practices was limited, not least due to the fact that I do not speak Polish. This process was helped when working with interpreters who were well known and trusted within the Polish community, and were able to act as cultural brokers. Fowler (2002) describes similar experiences in her work with older African American women, despite being of the same ethnicity (although of higher socioeconomic status). She highlights that minority groups may be reluctant to participate in research due to scepticism of researchers' motives, possibly due to past negative experiences with health services. She overcame her initial recruitment problems by 'hanging out' (p.35) with potential participants at social occasions linked to the church, sharing personal information to overcome her 'outsider' (p.31) status, and enlisting the help of nurses linked to the church who were already trusted by potential participants. To an extent, a similar approach was adopted in the current study.

Interviews.

A semi-structured interview schedule was developed in line with recommendations from Barbour (2008), Charmaz (2006), and Robson (2002) to cover the areas which the literature and initial field work had identified as being potentially relevant (see Appendix C). It included open-ended questions covering four main areas of interest with additional prompts to elicit discussion of relevant issues. Language which was overly complex, verbose, leading or biased was avoided. The interview schedule started with simple, non-threatening questions, and moved onto more sensitive topics as the interview progressed to create a situation where participants felt optimally comfortable. The interview schedule was used flexibly so that any interesting areas that arose in the course of the interview could be pursued.

Potential participants were provided with the Participant Information Sheet (Appendix D) and were given at least 24 hours to decide whether they wished to participate before interviews were arranged. Consent forms (Appendix E) were filled out before the interview commenced, with the assistance of an interpreter when necessary. Interview locations were decided by participants: five were interviewed in their homes, one at a Polish event, one in a café, and two at the Adult Clinical Psychology Department. Interviews were recorded using a Sony ICD-MX20 digital voice recorder with participants' permission, and lasted for an average of 1 hr and 12 min (range: 36 min to 2 hr and 4 min).

Sampling.

A convenience sample of participants was recruited through networks developed in the course of the research and by snowball sampling, whereby existing participants were asked if they knew anyone else who might be interested in taking part in the study. This method has been widely used in research involving hard-to-reach populations, such as recreational drug users (e.g. Boys *et al.*, 2001), sex workers (e.g. Potter *et al.*, 1999), and people with HIV/AIDS (Magnani *et al.*, 2005). Several studies have also used this method to recruit migrant populations (Bassaly & Macallan, 2006; Blignault *et al.*, 2008; Jirojwong & Manderson, 2001; Knipscheer *et al.*, 2000; Li & Browne, 2000).

Theoretical sampling procedures were also used; this technique is a key component of grounded theory methods (Charmaz, 2006; Glaser & Strauss, 1967). Quantitative methods generally seek to recruit a sample which is maximally representative of a larger population in order to allow findings to be generalised beyond the sample (Robson, 2002). The goals of qualitative research are different, and demographic characteristics of participants are less important than what their accounts can add to the developing theory (Glaser & Strauss, 1967). Although theoretical sampling has been described as a process of selecting participants whose experiences are likely to be particularly relevant to the research (Barbour, 2008; Cutliffe, 2000), more importantly, the method involves seeking data to develop the properties of emerging categories as the research progresses (Charmaz, 2006; Glaser & Strauss, 1967). In this way, the questions asked of participants may change over time. Questions which seem irrelevant, or which relate to categories which are already saturated, may be

dropped, while new questions may be introduced to develop areas of interest which arise from the data.

As the research progressed, the interview schedule was adapted in accordance with these principles. It swiftly became apparent that some participants were uncomfortable when directly questioned about emotional issues. Therefore, in subsequent issues, this topic was approached more sensitively and indirectly by enquiring about general social attitudes in Poland before asking about personal experiences. Further, the first few participants talked extensively about health services for physical conditions, but were less comfortable discussing mental health services. As the categories relating to physical health services became saturated after approximately five interviews, fewer questions were asked about this in subsequent interviews and the focus was shifted to mental health services earlier in the interviews. Several hunches emerging from the data were also followed up as the research progressed. For instance, an impression was gained that few migrants in Forth Valley came from major Polish cities, therefore questions were asked to investigate whether there were factors that made Forth Valley a particularly attractive destination for migrants from rural areas. In addition, participants from urban and rural areas appeared to hold different attitudes in relation to distress: the reasons for this were examined in later interviews.

Transcription.

In deciding how to transcribe data, Tilley (2003) recommends that researchers should consider how much detail is necessary for the purposes of the study. Some analytic

systems, such as discourse analysis (Potter & Wetherell, 1987), are primarily concerned with how participants use language, and in this instance, a detailed method of transcription may be necessary (Bucholtz, 2007). However, O'Connell and Kowal (1999) highlight that the application of detailed systems of transcription can decrease the readability of transcripts without adding much analytic value. As the focus of the current study was participants' descriptions of their experiences, it was considered that a straightforward method of transcription would be the most appropriate.

O'Connell and Kowal (1999) describe several features which are common to many systems of transcription, some of which were adopted in the current study. When colloquial pronunciations were used, these were transcribed phonetically (e.g. 'it's not gonna' rather than 'it's not going to'). Paralinguistic features such as laughter or crying were transcribed, although not using any formal coding system: laughter was simply transcribed as '*laughs*'. Brief pauses were indicated by a comma, while pauses of more than three seconds were indicated by an ellipsis in brackets: '(...)'. In the Results and Discussion section, sections of text cut from quotes were indicated by an ellipsis: '...'. Although tone of voice was generally not transcribed, this was done if it was particularly relevant, for instance, if the participant was impersonating someone else in a narrative. Bailey (2008) considers it justifiable to omit details of speech such as false starts, repetitions, overlaps, and encouraging noises, as this can make text appear cluttered and participants seem inarticulate or uneducated. This was considered of particular relevance to participants in the current study as English was not their first language.

Given that Bailey (2008) considers transcription to be an interpretive act which forms the first step in data analysis, it was considered important to transcribe the interviews personally. Interviews were transcribed as soon as possible after they had taken place. Frequently, interesting and subtle points arose in the course of transcription which were not apparent at the time of the interview, and memos (see below) were written on thoughts about the interviews during transcription. Following Dunne & Quayle (2002), transcripts were numbered by line, and each participant was assigned an identifying code letter (starting C for community members and K for key informants). In this way, alphanumeric labels were created to allow the participant and transcript lines to be identified when examining segments of the text. For interviews conducted through an interpreter, for practical reasons (particularly the fact that I do not speak Polish), only English language was transcribed. It is acknowledged that this means that some of participants' exact words and meanings may have been lost in the process.

Interpreters.

Three interpreters were involved in the research. The first, who was involved in two interviews, had a Polish parent and was bilingual in Polish and the language of her country of origin as well as speaking fluent English. I had met her several times while at migrant events and discussed the research with her. She had a social science degree, was experienced in research methods, and expressed an interest in participating in the project as it was in line with her own academic interests: she therefore had an excellent understanding of what was required. Unfortunately, she

moved out of the area during the course of the research. The second interpreter was also identified through personal contacts. She was self-employed as a professional translator and interpreter, and was involved in one interview. Both professional interpreters were paid £30 per interview for their services: this was self-funded. Additionally, one participant requested that a colleague be present during her interview to assist if required. This interpreter was second generation Polish, and English was his first language. In practice, the participant needed minimal support from him, and he was not present for the full interview.

Participants in the interviews conducted through interpreters were recruited by the interpreters and were already acquainted with them. After the interpreters had expressed an interest to work on the project, they identified people who were keen to participate through their social networks, and went through the Participant Information Sheet with them. Although the BPS (2008) warns that using interpreters who are known to participants can lead to complications, in the current study, the opposite seemed to be true: having a trusted person from their own community present appeared to put participants at ease.

Smith (2004) highlights the difficulties in working through interpreters given the essentially linguistic nature of qualitative research. He suggests weighing up the relative advantages and disadvantages of including and excluding non-English speaking participants, and proceeding if the gains outweigh the costs of not speaking the same language. Further, he advises that researchers should be aware that interpreters may edit responses in the course of interpreting. In the current study, it

was decided that excluding participants who did not speak English would be discriminatory, and would make it impossible to gain a comprehensive picture of the views of Polish community members in Forth Valley. It is possible that some information may have been lost in translation in one interview. Other interviews appeared to be interpreted accurately, although there was no way of verifying this for certain.

BPS (2008) guidelines were adhered to in working with the interpreters. Where possible, I sat in a triangular formation with the participant and interpreter. Eye contact was made with participants as frequently as felt comfortable. In line with Tribe's (2005) recommendations, interpreters were asked to interpret in the first person, and to interpret what participants said as closely to their exact words as possible. A debriefing period of 10 minutes was allocated after the interviews, where interpreters provided contextual information on the interviews and were able to reflect on the process. They reported that they had found the interviews interesting, and did not appear to be emotionally affected by the content.

Ideally, for interviews conducted through interpreters, participants' words should ideally have been transcribed in Polish and translated into English in order to preserve meaning. Unfortunately, financial limitations meant that this was not possible. Therefore, I transcribed the translated words spoken in English by interpreters. It is acknowledged that this adds a layer of analysis. Together with the potential for some information to be lost, interpreters may have transformed the content of participants' words in line with their own perceptions. This means that

these transcripts may be of a poorer quality than interviews conducted in English. Nonetheless, interpreters spoke fluent English while participants' levels of fluency varied, therefore some interviews conducted in English may also have been compromised by participants' difficulties in finding words to express themselves.

PARTICIPANTS

Community Members.

Table 6 gives details of participant demographic characteristics: in many respects, the sample was fairly homogeneous. Cutliffe (2000) considers that recruiting a focused sample of similar participants can be advantageous, as this allows social processes which are common to members of a social group to be uncovered. Nonetheless, there are several points worth noting about the sample composition, as at a glance, it might appear that the sample it could be split into smaller subgroups. For instance, the sample comprised two men, two single mothers, two childless clinical psychologists, and two professional people while the majority of participants were working class (some of these categories overlapped). Some of these characteristics appeared to be more important than others in shaping accounts.

TABLE 6: PARTICIPANT DETAILS

Participant	Age	Gender	Job classification ¹²	Length of Residence	Relationship status	Children	Conducted through interpreter?
C1	32	Female	7	11 years	Married	Yes	No
C2	28	Male	5	5 years	Married	Yes	No
C3	35	Female	6	2 years	Single	Yes	Yes
C4	40	Female	8	2 months	Married	Yes	Yes
C5	31	Female	8	2 years	Married	Yes	No ¹³
C6	40	Male	6	6 years	Married	Yes	Yes
C7	39	Female	2	2 years	Single	Yes	No
K1	32	Female	2	1 year	Married	No	No
K2	28	Female	6	4 years	Married	No	No

Men were under-represented relative to official statistics since few men were willing to participate in the research. Addis and Mahalik (2003) suggest that discussing sensitive personal issues may conflict with internalised social norms about masculine identity, which may have led to men being reluctant to participate. While the male participants held some similar attitudes, there was also a great deal of consistency between their accounts and those of female participants, and differences between the two men. In particular, while both held traditional attitudes to an extent, C2 identified more strongly with Polish culture in a similar manner to C1 and C5, while C6 appreciated many aspects of Scottish culture and was happy to take advantage of them. C2 also felt that life was more stressful for men than women, while C6 acknowledged that both men and women could face difficult challenges.

The two single mothers were very different. C3 had become pregnant while in Scotland and had experienced financial hardship and doubts about her future as a result. In contrast, C7 was comfortable with her status as a single mother, possibly

¹² Job classifications follow the Office for National Statistics Socioeconomic Classification (2005).

¹³ This interview was conducted predominantly in English, but an interpreter was present for most of the interview to provide assistance if the participant struggled to understand anything.

due to being more financially secure and from a middle-class background where single motherhood was less stigmatised.

In certain respects, the key informants were similar in that they were from middle-class backgrounds and had trained as clinical psychologists in Poland. However, while K1 had continued to practice in Scotland, K2 had not. Furthermore, K1 expressed few critical opinions about either Polish or Scottish culture, whereas K2 identified difficulties created by aspects of both. Furthermore, clinical psychologists were deliberately recruited as key informants through theoretical sampling to enhance the research (see below).

There were similarities between all participants, but also differences between them in respects which it is not easy to quantify. For instance, both K4 and K7 had children with disabilities, but their experiences varied dramatically in terms of the nature of the disabilities and the impact on their respective families. This appeared to relate to differences in social class, an issue which is addressed in the Results and Discussion section. In line with Charmaz's (2006) social constructionist method of grounded theory, categories were developed which emerged from and were grounded in the data rather than imposing pre-determined demographic categories.

Few middle-class or single people participated in the current study, although this reflects demographic characteristics of Polish community members in Forth Valley more generally (Falkirk Council, 2009). Nonetheless, the experiences of people with

these characteristics may have differed from those of participants in the current study.

Key Informants.

Gilchrist (1992) describes key informants as individuals with an inside knowledge of a particular cultural group who often have a formal social role in the community of interest. Historically in anthropological research, this role was often filled by the translator, who could introduce the researcher to others from their community and act as a cultural broker. Gilchrist (1992) and Marshall (1996) consider it important that key informants should be able to reflect on their culture. In this manner, they may differ from other participants, who may be able to describe their experiences, but without necessarily providing any reflective analysis. Key informants may be involved as collaborators in the research, and can help the researcher to expand, modify and clarify their interpretations. Tabora (1994; Tabora & Flakerud, 1997) used this technique in her study of Chinese migrants in America. She identified two professional women with experience in mental health who she considered to be more acculturated than the community members in her study, in order to gain additional insight and clarify information provided by community focus group participants. These participants reviewed the findings of the study and participated in discussions about them, and were also interviewed about their own experiences.

Two Polish clinical psychologists living within the UK were identified as key informants through personal contacts. It was thought that they would be privy to insider perspectives both of Polish culture and clinical psychology, and have first-

hand experience of Polish people's attitudes towards clinical psychologists. Furthermore, it was anticipated that they would be able to contrast health, political and social systems in Scotland and Poland, and reflect on how these differences might impact on Polish migrants' attitudes towards seeking help in Scotland. Key informant interviews focused on the emerging themes, their own experiences of clinical psychology training and practice in Poland and Scotland, their reasons for migration, experiences of migration, and reflections on Polish and Scottish culture in relation to attitudes towards clinical psychology and help-seeking.

DATA ANALYSIS

Coding.

In grounded theory, analysis is conducted throughout the research process (Charmaz, 2006; Glaser & Strauss, 1967). The constant comparative method is central to this endeavour, and involves searching for incidences of similar phenomena within interviews and between participants. This allows for consideration of similarities and differences in how participants describe their experiences (Charmaz, 2006).

Initial coding.

Initial coding is the first stage of the analytic process. Charmaz (2006) suggests that initial codes should be considered provisional, and should help the researcher to discover pertinent issues which may be worthy of further exploration in subsequent interviews. Line-by-line coding was used in the current study to facilitate picking up the subtle nuances of the data. A line was taken to be a unit of meaning, either a sentence or phrase. Charmaz (2006) recommends developing codes which stick

closely to the data and reflect action. In this respect, initial codes began with a verb to reflect the action described by participants in each line of speech. Transcripts were printed off with a wide margin on the left hand side in which initial codes were written. Box 1 shows the initial coding from an excerpt of C3's interview.

BOX 1: INITIAL CODING

<p>Feeling uncertain about exactly what doctor said</p> <p>Requesting a prescription of calming pills</p> <p>Knowing that pains are related to stress and difficulties in life</p> <p>Having a rocky life at times</p> <p>Knowing the reason for the chest pains</p> <p>Asking for calming pills for chest pains attributable to stress</p> <p>Doctor disagreeing; refusing to prescribe calming pills</p> <p>Not remembering exactly what doctor said</p> <p>Thinking doctor may have offered a referral to another specialist</p> <p>Receiving no specific help</p>	<p>P: I am not even sure what exactly he said, but my request was to prescribe me some calming pills, because I know that these pains are related with the stress I have and with my life, it is quite rocky at times, so I kind of knew what was the reason for it, that's why I asked for those calming pills, but the doctor disagrees to prescribe them to me. And I don't remember what exactly said, but he might have asked me if I want a referral to another specialist, but there was nothing specific, no specific help I have received.</p>
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Focused coding.

Charmaz (2006) describes focused coding as the second major phase in coding. Codes at this stage are more conceptual than initial codes, and allow larger segments of data to be synthesised. In this phase, the most significant or frequent codes from the initial coding phase can be used to sift through large amounts of data. It is necessary at this stage to decide which codes have the most analytic value in categorising the data. Focused codes are developed by comparing data and considering how data fits with existent codes. A colour coding system was used to conduct focused coding. Sections of text which related to the same codes were marked in the relevant colour. After each interview, the coding system was revised, and a list of focused codes was typed and printed to serve as a guide for coding the subsequent interview. Strauss and Corbin (1990, 1998) have suggested the use of axial coding – the process of asking particular questions of the data – to map data along dimensions at this stage. However, following Glaser (1992), it was felt that this might force complex meanings into a particular type of structure, which seemed inconsistent with a social constructionist approach. Therefore, this procedure was not used. Box 2 shows the focused coding for the same excerpt as above.

BOX 2: FOCUSED CODING

<p>Trusting own judgement about problems</p> <p>Linking physical symptoms to emotions</p> <p>Trusting own judgement about problems</p> <p>Feeling that Scottish doctors are reluctant to prescribe medication</p> <p>Finding that GPs do not necessarily take ownership of patient care</p> <p>Considering good advice and specific help important</p>	<p>P: I am not even sure what exactly he said, but my request was to prescribe me some calming pills, because I know that these pains are related with the stress I have and with my life, it is quite rocky at times, so I kind of knew what was the reason for it, that's why I asked for those calming pills, but the doctor disagrees to prescribe them to me. And I don't remember what exactly said, but he might have asked me if I want a referral to another specialist, but there was nothing specific, no specific help I have received.</p>
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Theoretical coding.

In contrast to a positivist stance where theory seeks to explain causality, Charmaz (2006) presents a method for constructing grounded theories which seek to understand the phenomena of interest through a process of interpretation. Experience is considered to be complex and indeterminate, and relationships between concepts interactive and processual. Theory should be grounded in data, and should seek to contextualise participants' experiences in light of broader cultural conditions.

Charmaz (2006) suggests that theory development should start with sensitising concepts exploring issues such as power and difference, moving towards an inductive analysis which theorises the connections between participants' immediate environments and larger social structures.

The final stage of analysis which allows for the development of a grounded theory is theoretical coding. Glaser (1978) describes how codes begin to cluster together into 'coding families' of related concepts at this stage. Although he provides a range of different types of theoretical codes, these were not used in this study as it was considered that these could force the data conceptually: a process to which Glaser (1992) himself objects. Charmaz (2006) describes this stage of analysis as a sophisticated level of coding, where relationships between categories are weaved together through the process of constant comparison. Categories which are most meaningful, prominent, and have the greatest degree of explanatory power are raised to the level of theoretical concepts. Theoretical codes integrate categories and specify the relationships between them. For instance, they may highlight the context and conditions in which phenomena are evident, and how categories interact with each other. The emergent theory should provide a parsimonious integration of concepts which allows for a coherent understanding of the relationships between categories (Charmaz, 2006).

Theoretical codes were built from related categories formed by the relationships between focused codes. For instance, the theoretical code 'Cultural Norms' was constituted by the categories 'Catholicism', 'Gender Issues', 'Rejection of Difference',

and 'Urban–Rural Class Divide': these categories appeared to be the most important influences on cultural values. In turn, the 'Rejection of Difference' category was built from the following focused codes: 'Highlighting Discrimination Towards Particular Social Groups'; 'Being Assigned a Stigmatised Identity as a Result of Contact with Services'; 'Discussing Historical Antecedents of Discriminatory Practices'; 'Viewing Emotional Expression as Culturally Acceptable'; and 'Judging Reasonableness of Behavioural and Emotional Reactions'. The theory on decisions relating to seeking psychological help reflected the interaction between the four theoretical codes identified.

Memos.

Throughout the analytic process, detailed memos were produced documenting thoughts about the data as they occurred. Peters and Wester (2005) emphasise the importance of memo writing as a process which forces the researcher to reflect and to explicate their analytic ideas and decisions. Further, Charmaz (2006) highlights that memos aid the development of conceptual categories with broad explanatory power by allowing comparisons and connections in the data to be noted, reflected upon and developed. An excerpt from a memo is shown in Box 3, written after coding the first two interviews.

BOX 3: EXCERPT FROM MEMO

From the data gathered so far, help-seeking from formal services is seen as alien to Polish culture, as are Scottish attitudes towards depression. Talking openly about one's problem is taboo, with the possible exception of doing so within close confiding relationships, and there is a hint that in these situations, help sought is of a more practical than emotional nature. There appears to be a degree of empathy, where friends and family can offer appropriate support, but without directly discussing emotions. Alien systems are rejected, provoking anger in participants, who justify their feelings by identifying themselves strongly with migrant, in particular Polish, communities. Both Polish culture and Polish health systems are viewed as being superior to Scottish ones. This type of downward social comparison and group identification may allow self-esteem to be maintained in the face of challenges such as downward occupational mobility (in some instances) and rejection/?racism from the host culture. Perhaps the strong rejection of materialistic values compensates for a relatively low level of income.

Theoretical Sufficiency.

Glaser and Strauss (1967) describe theoretical saturation as the point at which new properties of a category cease to arise. However, it could be argued that the concept of theoretical saturation has an air of finality about it. This appears to conflict with Glaser's (1978) notion that theories should be modifiable in the light of new information. A useful alternative definition is provided by Morse (1995), who views theoretical saturation as the point at which researchers have enough data to build a comprehensive and convincing theory. She suggests that saturation will be most easily achieved if theoretical sampling is used to select a culturally cohesive sample that shares the characteristics defined by the research topic. Similarly, Dey (1999)

has proposed the concept of theoretical sufficiency as an alternative to saturation, which refers the point at which the researcher has developed categories suggested by the data with adequate explanatory power. In an empirical investigation of theoretical saturation in the context of a study with African women at high risk of acquiring HIV/AIDS, Guest *et al.* (2006) found that 73 per cent of codes were identified within the first six transcripts, with 92 per cent of codes identified after 12 interviews. Following this, any new codes reflected nuances in the data rather than fresh concepts.

In the current study, several categories – particularly those concerning physical health services – appeared to saturate at around the fifth interview. Subsequent interviews confirmed these initial findings and did not contribute any novel insights. Categories relating to attitudes towards mental health services took longer to saturate, probably due to the greater complexity of the issues concerned. Although relevant cultural issues were hinted at in early interviews, it was not until the final three interviews that these issues were discussed in depth and the categories relating to broader cultural influences impacting on attitudes towards seeking psychological help were filled out. However, by the final interview, there appeared to be enough consistency and depth within the data for theoretical sufficiency to be achieved.

Software.

NVivo 8 (QSR, 2008) software was used to assist in the analysis of the data. Several authors have expressed concerns about the use of computer assisted qualitative data analysis software (CAQDAS). In particular, authors such as Peters and Wester (2007) have suggested that CAQDAS may be used as a substitute for a sound understanding of the analytic procedures which it aims to support. However, CAQDAS also has several distinct benefits. It can assist in the mechanical aspects of analysis, increasing the rate at which data can be accessed, retrieved and viewed, and making it far easier to manage large volumes of data (Hunter *et al.*, 2005; Thompson, 2002).

Therefore, in the current study, NVivo 8 was used rather like an electronic filing cabinet for data. The initial stages of coding were completed by hand, and interviews were imported into NVivo 8 after focused coding had been completed. Data were then coded using the manually developed focused codes. After each interview had been coded within NVivo, the coding structure was reviewed. On occasion, codes were found which were equivalent, and were collapsed together. Codes which appeared to relate to similar concepts were coded in a hierarchical structure using the tree node function. Few other features in NVivo were used, as this was considered unnecessary. However, occasional text search queries were run to look for particular words which appeared to relate to conceptual ideas. For example, some participants appeared to use 'we' and 'us' language when defining their identity: it appeared that this related to maintaining a strong Polish identity in some instances, and it seemed of interest to observe if and how other participants

used such language. This process would have been extremely laborious to conduct manually. The coding stripes function was used on occasion to investigate the overlap between codes: this was helpful in considering which codes linked together, and identifying instances where codes contained such similar data that it was more appropriate to collapse them together. Memos were occasionally written in NVivo, mainly to describe coding decisions. More lengthy reflective memos were written by hand in a journal, partly because this was where field notes and memos were recorded during manual coding, and partly because it was easier to access and read these memos subsequently. When using NVivo 8, transcripts were frequently revisited to contextualise coded data. Thus, NVivo 8 was used to organise data as a support to the conceptual analysis process and the generation of theory.

ENSURING QUALITY IN QUALITATIVE RESEARCH

Silverman (2006) highlights that a criticism which has historically been levelled against qualitative methods is that they lack methodological rigour. Some authors, such as Lincoln and Guba (1985), have attempted to translate quantitative standards of rigour into qualitative terms. However, Whitemore *et al.* (2001) suggest that such translations may be misleading, as there are fundamental differences in the types of questions which each of these methods seek to explore, meaning that it is inappropriate to directly compare them. For instance, in contrast to positivistic quantitative methods, qualitative methods are essentially interpretive, do not claim to be objective, and do not have generalisability as a goal. To this end, they emphasise the importance of describing the links between research questions, methods, and underlying philosophy.

The concepts most commonly invoked when evaluating the quality of quantitative research are reliability and validity. Reliability refers to the degree to which evidence is stable or replicable, while validity denotes whether findings accurately represent what they purport to (Coolican, 2004). Within a social constructionist paradigm, social processes are considered to be determined by contextual historical and sociocultural factors (Gergen, 1973). Therefore, it is not reasonable to expect that identified phenomena should remain stable over time and across situations, making reliability in its traditional sense a somewhat redundant concept. In quantitative research, validity is often established through the empirical measurement of variables of interest using demonstrably accurate techniques while controlling for the influence of extraneous variables (Flick, 2007; Kline 2000). As qualitative research is concerned with contextualised subjective experience, if this concept is to be applied to it, there is a need for it to be redefined. Bruner (1990) suggests that validity is essentially subjective anyway, and depends upon how plausible a reader finds the researcher's conclusions.

Various alternative standards have been proposed for assessing qualitative research (e.g. Charmaz, 2006; Denzin, 1970; Flick, 2007; Lincoln & Guba, 1985). A common theme underlying literature pertaining to quality standards for qualitative research is a concern with methodological rigour and credibility of findings: namely, has the researcher used an appropriately rigorous method in their analysis, and provided a sufficiently detailed description of it, for the results which they present to appear as a reasonable interpretation of the data to the reader? Although several

checklists for assessing the quality of qualitative research are now available, Flick (2007) cautions against their use due to the inherent difficulties in developing universal criteria and standards for studies employing diverse methods. Instead, he advocates considering more general principles of what constitutes good qualitative research.

Such considerations are apparent in the earliest writings on grounded theory. Glaser and Strauss (1967) suggest that theories should 'fit and work' (p.5). This refers to the fact that the theory should emerge from the data and should closely reflect it, and should be able to predict and explain relevant phenomena (Glaser & Strauss, 1967; Lombard & Kirkevold, 2003). However, the notion of prediction is adjunctive to positivism and does not fully acknowledge the changeability of social phenomenon. In this regard, Glaser (1978) added the criteria of modifiability, emphasising that theories should be flexible in the light of new data. Glaser and Strauss (1967) also suggest several criteria for theoretical credibility, including explaining the theoretical framework, describing data vividly using quotes and examples, using a codified procedure allowing readers to understand how the theory developed from the data, and ensuring that the theory is well-integrated and clearly presented.

Charmaz (2006) offers further criteria in relation to her social constructionist grounded theory method. She suggests that the value of qualitative studies may be assessed by reference to their credibility, originality, resonance, and usefulness. To achieve credibility, the researcher should have achieved intimate familiarity with the topic in question, should be able to substantiate their claims by recourse to the data,

and should provide enough evidence for the reader to independently assess the veracity of their claims. Originality refers to the extent that the research provides new insights of theoretical significance. Resonance is achieved if categories portray the fullness of the studied experience, reveal both implicit and explicit taken-for-granted meanings, draw links between individual lives and broader social forces, and make sense to participants. A theory can be considered useful if it has practical applications and contributes to the knowledge base.

A great deal of academic attention has been devoted to developing practical methods to achieve these principles. Mays and Pope (2000) suggest a number of criteria for ensuring methodological rigour in qualitative research, including triangulation, member checking, transparency, and reflexivity. The next section will discuss these methods and how they were applied in the current study.

Triangulation.

The term 'triangulation' was originally introduced by Denzin (1970), who described the ways in which different methods and types of data could be used to enhance the completeness of theory construction. Mays and Pope (2000) describe triangulation as a process of comparing the results from different methods of data collection, or from two or more data sources, to allow the researcher to gain a more comprehensive impression of the area under investigation. However, Flick (2007) cautions that triangulation should not be seen as a way of falsifying, correcting or validating data obtained from different sources or using different methods: rather, it is a way of gaining of a fuller picture of the phenomenon under study.

In the current study, triangulation was achieved through using both field and interview methods, conducting interviews with both community members and key informants, and through comparison of collected data with existing literature. A common theme in grounded theory literature, as highlighted by Cutcliffe (2000), is that literature reviews should not be conducted until data collection is complete. However, Glaser and Strauss (1967) state that existing texts 'lend themselves wonderfully to the comparative method' (p.53). Without conducting a prior literature review, it would be impossible to establish whether the research was likely to add anything to the existing literature. Furthermore, NHS ethics boards require a certain degree of familiarity with existing literature before they will approve projects. In the current study, a systematic review of the literature allowed familiarity with themes which seemed potentially significant to the current study. Backman and Kyngäs (1999) consider that knowledge of existing literature is not necessarily problematic, but suggest that researchers should 'bracket' (p.148) this information in order to remain open to emergent themes. Therefore, while themes in the literature were compared with themes emerging from the data, precedence was given to the latter.

Member Checking.

Member checking, which has also been described as respondent or communicative validation (Flick, 2007; Mays & Pope, 2000), involves providing participants with research findings and adjusting the emergent theory to fit with their comments (Flick, 2007). Lincoln and Guba (1985) consider that member checking is a valuable technique for establishing credibility. This strategy was employed in two ways in the

current study. Firstly, prior to interview, key informants were provided with an account of initial themes emerging from formal analysis of the first four interviews, with reflections on the subsequent three interviews incorporated. It was considered that providing this data would help with theory development, as any biases or misconceptions could be identified before the theory was formalised.

Secondly, once analysis was complete, both key informants and one community member were sent the theory for comment as they had expressed an interest in doing this. Flick (2007) cautions that member checking can be somewhat problematic as the research may go beyond participants' viewpoints. However, it was considered that this concern might be overcome somewhat in the current study since two of the participants involved in member checking were psychologists familiar with psychological theories and constructs. Member checking can be thought of as one way of achieving the concept of resonance described by Charmaz (2006). Two participants responded – their emails included the following comments, supporting the robustness of the theory.

I agree with your conclusions – the types of narratives sound very familiar (K1).

I would only say that most of your findings hit home and in my opinion represent an accurate account of Polish migrants' approaches to the issues raised (K2).

The importance of involving the people who services aim to assist in research has been highlighted by both professionals and service users (e.g. Tait & Lester, 2005; Wallcraft & Bryant, 2003). The service user movement can be dated back to the 1970s, when current and former psychiatric patients formed groups to protest about

the dehumanising practices which they had been subjected to by the psychiatric system (Brown, 1984). Lindsay *et al.* (2007) highlight that EU, UK and Scottish policy initiatives from the late 1990s onwards have emphasised the need for service user involvement in planning services. One means by which this can be achieved is involving service users in research, not only as participants but as co-researchers. For instance, Williams and Simons (2005) describe a project where people with learning disabilities were involved as paid employees in researching others' with learning disabilities views on direct payments, an initiative allowing service users to purchase support services from providers of their choice. In the current project, it was not possible to achieve this level of service user involvement. However, conducting initial field work in the local Polish community to identify relevant issues prior to beginning interviews, and employing member checking procedures in the construction of theory, allowed a degree of community member involvement in the direction of the research.

Transparency.

Yardley (2000) defines transparency as the degree to which all relevant aspects of the research process are disclosed, by detailing every aspect of the data collection process and coding procedures, presenting data excerpts, and explicating the role of external influences and researcher characteristics within the research. Transparency in the current study is demonstrated by describing the procedures used in sampling and coding, and providing examples of coded text.

Several authors have suggested that creating an audit trail can be a useful method for increasing transparency (Bowen, 2007; Bringer *et al.*, 2004; Whitemore *et al.*, 2001). Bowen (2009) highlights that an audit trail systematically and chronologically documents what a researcher has done, how they did it, and how interpretations were arrived at. He considers that this can attest to the internal coherence of data and the trustworthiness of the research. An audit trail was created by several procedures employed in the current study. Firstly, a reflective log was kept in which thoughts on the field work were noted along with impressions of interviews, reflections on the emerging analysis, and coding decisions. Secondly, using CAQDAS is a way of maintaining an audit trail (Bowen, 2009; Bringer *et al.*, 2004). In this respect, memos were made about coding decisions, such as when different codes were merged together. Thirdly, after each interview was analysed, a document detailing the coding structure was printed out so that the evolution of the coding system could be tracked. Finally, minutes were taken from each academic supervision meeting to track conversations which guided the analytic process and the resulting decisions. These were also shared with the academic supervisor for further discussion.

Reflexivity.

Reflexivity refers to the researcher's sensitivity to their own role in the research process by considering the influence of their prior assumptions and experience. Nicolson (1995) highlights that the process of research involves the interaction of researchers, participants, and existing discourses, and as such, researchers should reflect upon these processes and make them explicit. Particularly in a post-modernist

research paradigm where it is acknowledged that an ultimate truth is unattainable, it is vital that researchers are able to critically evaluate both the data they are analysing and what they as individuals bring to it (Whittemore *et al.*, 2001). Reflexivity involves an openness to the data, including ambiguities within the data and instances which contradict the researcher's existing and developing ideas, and an awareness of how one's own attitudes and values interact with the research process. In this way, interpretations of the data which reflect the researcher's taken-for-granted assumptions about the world can potentially be avoided, or at least, the reader can decide how these ideas may have influenced the researcher's interpretation of the data. Interpretations should be continually checked against the data to establish whether they are in fact borne out by it (Whittemore *et al.*, 2001). Mays and Pope (2000) recommend disclosing personal and intellectual biases to enhance the credibility of findings. Further, they advise that researchers should consider the effects of their personal characteristics on the data collected.

In this respect, my role as a middle-class Scottish woman, with the dual role of researcher and trainee clinical psychologist, may be relevant. There are differences between Polish and Scottish culture, one of the most obvious being that Scotland is a more secular society (Glendinning & Bruce, 2006; Wróbel, 2005). This may have relevance to the research process given that the majority of Polish people are Catholic while I am atheist. The reluctance of men to participate in the study may have been related in part to the fact that I am a woman: further, Williams and Heikes (1993) found that male respondents framed their answers to interview questions differently depending on researcher gender. It is also important to consider power

dynamics in the research process (Nicolson, 1995; Parker, 1994). While the majority of participants appeared to be from working class backgrounds, I am training as a middle-class professional. As recent media debates on immigration in the lead-up to the general election have indicated, Polish people are a visible minority group in British society and are subject to hostility from the native population (Popova, 2010). All of these factors are likely to have led participants to project certain characteristics onto me and to make assumptions about my position (Parker, 1994). Additionally, my left-wing, feminist political values, and the social constructionist theoretical position taken in the research, are likely to have framed my understanding of participants' accounts.

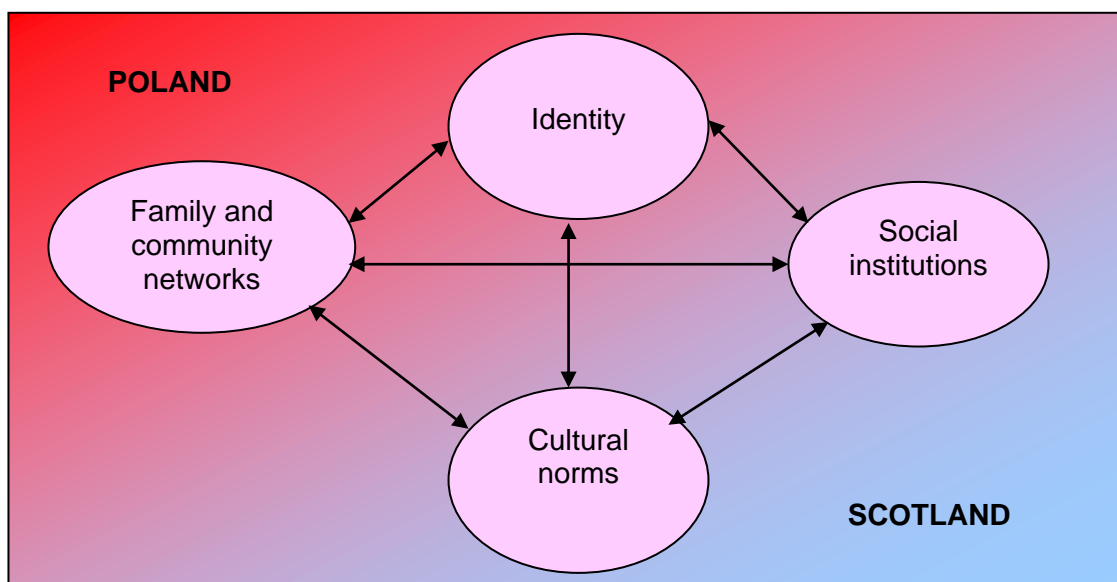
ETHICS

The study was reviewed by the University of Edinburgh Doctorate in Clinical Psychology ethics panel and the NHS Research Ethics Committee for Fife and Forth Valley. Copies of letters of ethical approval are included in Appendix F.

RESULTS AND DISCUSSION

This section discusses the categories which create the theoretical codes of identity, social institutions, family and community networks, and social institutions. The theory suggests that the interaction of these factors determines migrants' help-seeking decisions. Figure 2 provides a graphical representation of the theory. The following section presents the results of the study and discusses their relevance from a social constructionist cultural psychology perspective. For reasons of space and cohesiveness, generally only one quote is provided per category. However, in order to enhance transparency, a detailed breakdown of the coding structure is shown in Appendix G, and supplementary quotes are provided in Appendix H.

FIGURE 2: INFLUENCES ON POLISH MIGRANTS' HELP-SEEKING DECISIONS



DEFINING IDENTITY

Participants defined themselves through their relative identification with, and rejection of, Polish and Scottish culture. Identity was constructed on an ongoing basis through interactions with others, reflections upon values, and enactment of cultural norms. This theoretical code comprised the following categories: Identifying with Polish Culture; Rejecting Scottish culture; Rejecting Polish Culture; Appreciating Benefits of Life in Scotland; and Making Help-Seeking Decisions in Line with Identity.

Participants who identified strongly with Polish culture provided accounts which characterised Polish communities as being close-knit, mutually supportive, and holding shared goals and values. Polish people were described as holding traditional values emphasising conformity, family loyalty, and egalitarian relationships between workers. Participants who appeared to hold traditional values tended to view such social systems positively and appeared to feel a sense of unity with others in the Polish community.

People are sticking to their, you know. I don't know what the thing about Scottish people, but well if we are organising our parties obviously people come and then they you know they have great fun and get help and that but yeah, have plenty of Polish people that I just met through [organisation]. You know, they are good friends of mine but they're the same probably (C1 362–366).

These participants were most likely to view Scottish culture as problematic and to reject the values which they felt it embodied. Scottish people were described by some participants as being irresponsible, materialistic, and decadent, and primarily motivated by self-advancement and immediate gratification.

I've heard a lot of time, cover your own back. Make a good party ... if you've got a problem, help yourself ... If you say that to a Polish migrant worker ... you've done something wrong, he'll try and help you ... but if you say to somebody from Scotland, he go to manager ... Because he feel he catch a point ... That's the difference between immigrant worker and between people who living here from they're born (C2 491–502).

However, others were keen to point out that Polish people were not all the same and to distance themselves from other migrant groups. These participants were able to reflect upon aspects of Polish culture which they found troublesome and wholly or partially rejected. Some appeared to bring liberal values with them and to develop these further in Scotland. Poland was sometimes described as a more dangerous, chaotic and corrupt society with higher rates of crime, less social protection for its citizens, and hostile communication.

... if you go to the tax office let's say, you are on that person's mercy. If she has a bad day, you're not gonna get anything ... It's again not very, like quite chaotic what are the people's roles ... something about not having structure, the expectations are very blurred. And it's quite a corruptive country as well, so that's very stressful as well in a lot of ways ... Very often police officer comes to you and you didn't do anything, but he still wants the bribe (K2 785–801).

These participants expressed appreciation of the benefits which life in Scotland afforded them. Scottish society was seen by some to offer more freedom and flexibility in work, and less interference and judgement from outsiders in personal lives.

... if you started in a new workplace here, I think there's much more flexibility around what your ideas and your involvement and your suggestions ... (K1 610–612).

... they kind of behave probably similar to people that the locals now. They would not mind, they wouldn't be interested in an unhealthy way in anything that was going on (C6 161–163).

Participants' help-seeking decisions were congruent with their sense of identity: those who identified with traditional values tended to reject psychological services as a potential source of assistance. In contrast, those who identified less strongly with these values were more open to the possibility. If seeking help was congruent with the norms of a person's social group, they were open to seeking help. In contrast, this was ruled out as an option if it clashed with the dominant social values of a particular social group, or was seen as something which only outgroup members did.

... That's actually quite in fashion now. Especially among my friends ... as I say, well probably most my friends are university educated people (C7 796–798).

... I haven't any reason to go to see and I never been interest with this, I have, even nobody from my friends probably (C2 278–280).

The processes by which participants defined their identities as migrants in a foreign culture were consistent with symbolic interactionist theory. Authors such as Cooley (1964), Mead (1934), and Blumer (1969) have suggested that identity is constructed through interactions with other people and social institutions, considerations of how we are perceived by others, and enacting cultural practices. My impression from interacting with participants was that some appeared to live their lives in accordance with traditional Polish social norms without directly reflecting upon them, suggesting that cultural values can operate at an implicit, subconscious level. A degree of awareness of cultural values is necessary in order to take a position on them and to deliberately define one's identity in relation to them. Moving to a different country appeared to cast Polish culture in a new light, and illuminated aspects which may

have previously been invisible. If Polish values were thrown into relief by attributes of Scottish culture which were perceived negatively, participants appeared to define their identity more strongly in line with traditional social norms, sometimes through connecting with Polish communities in Scotland. These participants frequently used 'we' language when talking about Polish people, which appeared to reflect an attempt to validate their opinions and present them as being representative of their community's views.

In contrast, becoming aware of the disadvantages of Polish culture through living in Scotland seemed to lead others to construct their identity in a way which minimised their connection to such values. However, even when Polish values were rejected, they were still influential in shaping people's lives: identity was still defined in relation to them, even if contradictory or opposing stances were adopted. Therefore, a sense of Polishness appeared to pervade all aspects of participants' lives.

This suggests that identity construction may be more complex than models of acculturation presented in the migrant literature suggest. Models such as Berry's (1997) propose that migrants identify with various aspects of their culture of origin and host culture resulting in a more or less acculturated identity. However, people do not become culturally Scottish when they migrate, even after considerable periods of time. The literature suggests that successive generations of migrants become increasingly acculturated, with traditional values becoming more diluted with each generation due to interacting with the host country's values (Rimbaut, 1997). However, for first generation migrants, the influence of the values of their country of

origin is likely to be pervasive. Even if they reject some of these values and adopt Scottish practices, they remain aware of what it is that they are rejecting, and Polish norms subtly influence their behaviour.

FAMILY AND COMMUNITY NETWORKS

Identity was primarily defined through relationships with others. A feature of all participants' accounts was the central role which family played in their lives. The majority of participants' lives appeared to be built around family units and relationships with the broader Polish community in Scotland, sometimes through community organisations. This theoretical code comprised the following categories: Migrating With or to Join Significant Others; Socialising Mainly with Other Polish Migrants; Depending on Others to Navigate Life in Scotland; Prioritising Children's Well-Being; Viewing Relationships as Protective of Emotional Well-Being; Containing Problems within Small Social Units; Describing Negative Effects of Close Relationships; and Attributing Closeness of Relationships to Sociohistorical Factors.

The majority of participants had migrated with friends or family, or to join significant others who had migrated earlier. In some instances, the husband migrated to Scotland first and the wife and children joined him once he had settled and established a life for himself. Others migrated with friends or had come to join them. Having pre-established social networks was seen to be helpful in adapting to life in Scotland.

... maybe there are extreme extremes when situations that you know, people just don't have no-one around here. But usually if some people are coming with someone, friends or family, or are coming to stay with someone other, it's easier to start (C1 356–359).

The majority of participants socialised mainly with other Polish people in Scotland. Three participants were actively involved in Polish community organisations, one of which provided a drop-in service run by Polish people to offer advice on issues such as employment rights. Others spoke of meeting Polish people at language classes which gave them access to the Polish community in Scotland. The tendency to socialise with other Polish people appeared to be at least partly attributable to language barriers rather than a desire to avoid contact with Scottish people, although an implicit preference for socialising within the Polish community was sometimes apparent.

... At first, we were very separate from other people because of the language barrier and not meeting many people, it was mostly work and then home. Recently, it has become a bit more open with, I've been meeting people and the language barrier is slowly starting to disappear, we're starting to communicate. But we don't really need too many contacts where the family and friends. Mostly Polish people. We're mostly spending time with Polish people ... (C6 43–48).

These informal supportive networks enabled participants to access advice and information on services and social institutions, which allowed them to navigate life in Scotland while simultaneously creating cohesion within the community. Without this support, some participants reported that they would have had to return to Poland.

... if I didn't have the Polish people who would help me, I would have decided to go back to Poland at the moment when I found out that I was pregnant ... if people wouldn't have the support or help, they wouldn't know where to start or what would be the first door where to look for help ... (C3 84–91).

Reflecting family values, migrants prioritised their children's well-being above their own needs. Polish parents appeared to take an involved approach with their children, and saw their role as being to impart cultural values to their children and to ensure that they behaved well. These values in themselves were often geared towards preparing the child for adult life in line with Polish social norms emphasising family relationships. Children's health and well-being was given priority by Polish parents, and they were more likely to approach services to seek help for their children than for themselves.

... everything what children feel inside they can't manage with it. It is like a, like mark on the psychology. And I'm always talk to parents who can't cover something like that, you must speak with children, you must help them. Because they keep inside a lot of aggressive behaviour and if it don't appear now, it appeared maybe after school, yes like that. And I am sure that the children, they should be very, very professional. We need to take a very, very professional, take care of them (C5 664–670).

Relationships with others appeared to act as a buffer to the stresses faced by participants. Close relationships were described with immediate family members, long-term friends, and neighbours in Poland. Particularly for women, close relationships appeared to provide a forum for disclosure and emotional expression as well as practical support. In contrast, men seemed to gain practical help and support from these networks but did not appear to discuss their feelings with others, with the possible exception of very close male and female friends in some instances. Having children was seen to protect against distress, both in terms of keeping busy and as a comfort. Participants appeared to prefer to seek help within these networks in the first instance, and perceived them as protective of emotional health.

... Here in Scotland, the way I help myself is to talk with my eldest daughter. We have a very good relationship. It's more of a close friends relationship rather than mother–daughter. So we can talk about any topic really. She does know there are limits to it, but we do get along very well and this possibility to talk to her about anything helps me a lot (C4 333–337).

Problems appeared to be contained within small social units formed by close family and friendship networks in both Poland and Scotland, which served as the first port of call when difficulties arose and provided practical, financial, and emotional support. Social relationships within Polish communities were characterised as being somewhat extreme in nature, with people quickly welcoming others into their social group and being very friendly, but being reserved, distant and sometimes hostile to people outside this inner circle.

They kind of, they keep themselves to themselves and keep your distance unless they're knowing well. Cause then they become real kind of, very kind of, sometimes too much, you know. They'll take you in and feed you and give you drink and you know, 'You're part of the family now!' You know. So from there, you suddenly get there. There's not much in between (C7 1439–1444).

Several participants described attempting to assist others who they perceived to have problems by approaching their family members and occasionally others who were involved in their lives. There was a sense that it would be embarrassing to the person if they were to discover that these conversations had taken place or if issues were raised directly with them, leading to a degree of secrecy. Furthermore, gossip was identified as a problem in small Polish communities, leading to a cautiousness of disclosing personal information to anyone outside one's inner circle due to the potential for damage to social identity. Being unable to look after elderly relatives

and those with learning disabilities or emotional problems was considered shameful. Seeking outside help for such difficulties might reflect a rejection of one's family, or a family's inability to cope, which could be viewed negatively by the rest of the community.

... even if you see that person can, has some problem with their mental health, you try help in around way ... you don't want to say that person directly, 'You've got a health problem.' You don't want hurt her or his. I say in the Eastern Europe citizens I think all of this area, it's a very private ... Try and speak with somebody who can know better than me. Or than any member of family. I think this way it's the best. You don't want announce yourself in this (C2 296–310).

... I don't think anybody can imagine their parents could be in a care home. There is no such, it would be something shameful ... (K2 1341–1342).

On occasion, closed social networks were seen to breed conformity, as there was a perceived obligation to live in accordance with family wishes due to the degree of emotional investment from others.

... one of the reasons why I left Poland was that I didn't want to feel so dependent on others. And you are in a lot of ways because you, from one side they help, but from the other you cannot like sort of get out of there, you know, you need to listen to them in a lot of ways. You know that they interfere with your life quite a lot. And that's the price (K2 252–255).

A key informant suggested that the tendency to develop extremely close social networks of family and friends might be an artefact of Polish history, where oppression led to mutual support, while at the same time creating paranoia and fear of the consequences of gossip.

... there is a social structure, there is like lots of helpfulness, you know, that people help each other. And that comes from probably all that oppression again,

you know, like you had to rely on others, but at the same time there is like is some kind of slight paranoid attitudes, you know, what people are gonna to say to whom ... (K2 874–878).

Two participants differed from the rest of the sample in that their social networks included Scottish people; one appeared to have a mixed group of Scottish and Polish friends, while the other described herself as socialising mainly with Scottish people. These participants appeared to form friendships reflecting shared interests and values rather than Polish identity; they identified less strongly with Polish culture and rejected aspects of it. Both were recruited through personal contacts, whereas the majority of other participants were recruited through people encountered professionally with links to the Polish community.

The preference to depend on family and friends for assistance is consistent with the broader migrant literature: across cultures, people appear to prefer to turn to their significant others rather than approaching professional services unless difficulties are severe (Anderson *et al.*, 2009; see Systematic Review chapter). However, some of the reasons for the preference to seek help within close social networks may be specific to Polish culture.

Firstly, Poland is a predominantly Catholic country (CSI, 2010); the central role which family played in participants' lives is consistent with Catholic theology. Rubio (1997) notes that Catholic teaching emphasises moral duties such as loving one's family, obeying the church's teaching on sexuality, and lifelong intimate partner relationships. Family life is considered in a communal context where people are encouraged to help others in society. Therefore, families play a central role in

Catholic Poland, and communities (at least in rural areas) are likely to be built up around smaller family units. Participants appeared to have created similar social networks in Scotland, while maintaining close links to their family members in Poland.

Secondly, the close ties which participants formed with their inner circles might reflect important functions which family and friendship networks served in the communist era, allowing occupational advancement, procurement of black market goods, and protection from betrayal to the authorities (Kawalek, 1992; Pawlik, 1992; Stan, 2006). Pawlik (1992) notes that as people felt that they were being exploited by the state, they felt justified in stealing goods from their workplaces and putting minimal effort into their jobs. Shortages of basic goods were common, therefore items stolen from workplaces would be redistributed on the black market through close networks of family and friends. Under communist rule, the secret police developed a large network of informers, including members of the clergy (Stan, 2006). In this climate, people were unlikely to know who could be trusted and who might report their activities. Therefore, developing very close relationships with a small number of others seems sensible in this context.

The greater willingness to approach services for children's difficulties may also reflect cultural values. Seeking professional help outside one's social network may be incongruent with a desire to maintain a competent, adult identity in line with Polish cultural norms and to avoid bringing shame on the family should one's problems be publically revealed (Knab, 1986; Winstead, 1984). In contrast, children

appeared to be viewed as vulnerable, impressionable, and in need of protection in Polish society, therefore seeking help to assist them may be seen as more socially acceptable.

CULTURAL NORMS

Catholicism.

Catholicism appeared from the field work to be an important force in the Polish community. This led to the construction of the code 'Enacting Catholic Practices'. However, only one interview participant explicitly discussed the role of Catholicism. Nonetheless, Catholic values were implicit in many others' accounts, suggesting that they subtly influenced participants' daily interactions. This led to the construction of the second code, 'Holding Implicit Catholic Values'.

Many examples of the ways in which migrants from the Polish community engaged in Catholic practices emerged from the field work. For instance, I discovered that the demand for religious services in Polish was such that a priest was recruited from Poland. Catholicism and church attendance were mentioned frequently at many of the Polish events attended; migrants appeared to respond positively to being identified as regular churchgoers by Scottish speakers. The impression gained was that attending church helped to create a sense of cohesion within the Polish community, and provided a forum for people to meet others in similar circumstances.

The participant who explicitly discussed Catholicism during the interviews felt that Catholicism is so embedded in Polish culture that people may not reflect on its

influence. This could explain why no further participants discussed this issue, as this may have seemed like stating the obvious to them. Alternatively, they may have been reluctant to talk about their religious beliefs due to an assumption that I did not share their values.

I think like that is quite reasonable to think that they have it such a big, such deeply inside them that they would not even think where it comes from, you know. It comes from your mum, or it comes from your teacher, everybody follows the same, so you don't think in categories of what, you know, in this bigger complex (K2 1124–1128).

From other accounts, it appeared that Catholicism may have asserted a subtle influence in terms of an emphasis on family values and morally responsible behaviour. Although participants did not explicitly link this to religion, their accounts seemed consistent with the teachings of Catholic theology.

... they think they must help the parents. They won't go with their friends for example to some pubs or some parties, so they need the money. If they go for a party, they lose that money, they can't help the parents. Or for example, if they, you see the teenagers got the absolutely different way of thinking. They must, they want show other people how they are good ... (C2 215–220).

Catholicism is central in Polish life: 90 per cent of the Polish population identify themselves as Roman Catholic (CIA, 2010). The importance of Catholicism in Poland is likely to be linked to historical forces. Under the communist regime, religious expression was suppressed, a paradoxical consequence of which was that Polish people identified Catholicism strongly with Polishness and fought to preserve it (Wróbel, 2005). Catholicism has such a central role in Polish society that the Polish constitution was amended to reflect its Christian heritage after heated debates

between liberal factions and the Catholic church (Zubrzycki, 2001). Martin (1985) suggests that in societies such as Poland where Catholicism has been associated with threatened nationhood, social institutions and leisure activities develop to defend religious norms, resulting in close-knit communities with explicit social rules. All participants' accounts implicitly reflected these values, particularly in their discussions of family, community, and appropriate behaviour.

Identification with the Catholic faith may also help to explain many participants' reluctance to access psychological services. Worthen (1974) highlights that Catholic doctrine and the principles of psychotherapy are not necessarily compatible. Catholic theology implies that distress results from sins, and that repentance through confession to a priest and a willingness to accept the consequences of sinning is an appropriate response. Thus, guilt is seen as a necessary and even desirable aspect of life. In contrast, psychotherapy seeks to alleviate distress, and often focuses on the individual rather than the social. From a Catholic perspective, this egocentric focus could be viewed as selfish and counterproductive. Many studies in the broader literature found that migrants often preferred to resolve their difficulties through spiritual avenues rather than approaching psychological services (see Systematic Review chapter). However, the impression gained from the interview data was not that participants sought help from religious sources in the first instance; rather, that their help-seeking strategies were consistent with Catholic values.

Gender Roles.

Gender norms were apparent in all interviews, in terms of participants' descriptions of the roles which men and women were expected to fulfil, and their accounts of their own social situations. This category comprised the following focused codes: Being Expected to Enact Polish Gender Norms; Having Access to Professional Careers for Women; Describing Domestic Abuse in Poland; Experiencing Stress, Disadvantage and Stigma as a Result of Gender Norms; Coping Through Gendered Practices; and Feeling Liberated from Social Pressures in Scotland.

The majority of participants were married, and appeared content to conform to traditional gender roles. Men were described as generally acting as the primary breadwinners, with women taking responsibility for taking care of the home and children.

... the general way things are, the women have children, and they naturally tend to stay at home and look after, especially if there's more children, you know, stay and look after the house. So obviously men have got to go out and find employment, find work and provide for them (C6 249–252).

Marriage and the family played a central role in the lives of Polish women. Women were expected to marry and produce children while in their 20s; failure to do so was viewed in a stigmatising manner. Furthermore, they were expected to maintain a slim and attractive appearance and were seen as responsible for the health of their relationships. As such, they were blamed for marital breakdowns regardless of the underlying reasons and their social status was damaged as a result.

... the woman is sort of made responsible for the fact that the father or the partner left her. Like, and that's why there is so much pressure on the woman. The woman is, in the marriage should be the best cook, and the best mum, and she should still should look beautiful and work (K2 424–427).

Women were often expected to work as well as take care of domestic duties, and professional careers appeared to be open to middle-class women. Participants gave examples of female acquaintances working in professional roles in Poland, sometimes in fields traditionally reserved for men.

... she specialised in foreign marketing ... she's kind of climbed the ladder, she's on the top there, she's not going to climb, but she's the director and she can't go any higher (C7 805–810).

Thus, gender biases appeared to operate mainly at a personal rather than an occupational level in Poland. Although women could progress professionally, at home, their position was subordinate. In support of this, many people with whom I spoke during the field work reported that domestic abuse was rife in Poland; a few participants also described this.

... her problems developed because of her husband being alcoholic. And lots of nasty things were happening in the house (C4 296–297).

Along with the stigma experienced by women who did not conform to traditional gender norms, stress and disadvantage could result from these roles for both men and women, and distress was often explained in this context. For instance, seeking help from mental health services following divorce was viewed as understandable for women. For men, failing to provide for their families was viewed as something which could result in emotional problems.

... the man has got more responsibility for that side of well family life, to provide. Of course, there are situations in which the man stays at home and the woman would go, would have a better job offer. And it would be better for her to go and work. But the man can feel belittled by this situation. Because of the stereotype that man should be the head of the family, the breadwinner and all that (C6 257–263).

Coping strategies in relation to distress appeared to be highly gendered. Female participants utilised a combination of individual and social coping strategies, such as engaging in enjoyable and soothing activities, and emotional expression either individually or through talking to friends and family. Nonetheless, they tended to restrict their discussions of relationship problems to a close inner circle, possibly due to fears of being viewed as inadequate wives or mothers if the broader community was aware of their difficulties. For men, it appeared that there could be considerable stigma attached to discussing one's problems. The impression gained from male participants was that when faced with difficulties, they did not engage in any coping strategies per se, but felt that they simply had to push on through their problems. Substance use and acting out emotions were presented as primarily male coping strategies by female participants. Although it was noted that women sometimes coped through substance use as well, primarily in a solitary fashion, this coping strategy appeared to be utilised more frequently by men.

I knew here a Polish person who is working just with Scottish person. And the Scottish person, the Scottish man bullying him. Very, very hard. But this Polish man has a family here. And you understand that he is very closed inside ... But when he back to home, he start to be a very angry for his family. He start a push a children, he hit once at his wife ... it is because this Scottish man bully him very hard at work. And he is very nervous. And all aggression which one he has inside, he pushed everything at home (C5 449–462).

For a minority of women, migrating to Scotland had been a liberating experience which allowed them to reflect on the pressures on women in Poland and to develop their identities in directions of their choosing. Gender roles appeared to become less important: although it was noted that changes resulting in migration could lead to relationship breakdowns, this appeared to have a different meaning in the Scottish context, as women were able to feel good about themselves outside the dictates of gender norms. Women who took advantage of the increased freedoms offered by Scottish society viewed them positively.

... they get here and they feel free. They don't need to worry about it, you know. Then don't worry how you look, how you are, you know, how you are dressed, you can dress whatever in here, and go to work like that, and nobody's going to tell you you're a freak ... (K2 1260–1263).

The gender divisions observed in the Polish community are likely to be linked to historical and sociocultural factors. Bystydzienski (2001) states that feminism was belittled by the communist regime, and that the Catholic Church in Poland continues to support the maintenance of women's traditional gender roles. Participants' accounts of women's roles are consistent with the findings of research by Triandafyllidou (2006), who describes the dual roles of Polish women in undertaking paid work while simultaneously taking responsibility for domestic duties.

The gendered differences in coping strategies observed in the current study are similar to findings in the migrant literature more broadly, and also in community studies in the UK. For instance, the most recent British Social Attitudes report found that women were more comfortable discussing their emotions than men (Anderson *et*

al., 2009). Where gender differences in attitudes towards help-seeking have been found in the migrant literature, they have suggested that women may be more comfortable seeking psychological help than men (see Systematic Review chapter). Addis and Mahalik (2003) suggest that men may be less likely than women to seek psychological help due to internalised gender norms about masculinity which emphasise the need for self-reliance and emotional control. The possibility that Polish men have fewer coping strategies available to them than women may indeed make them more vulnerable to the effects of stress, but also less likely to seek assistance to cope with this. This could mean that men may not receive any assistance until their problems develop into a crisis.

Rejection of Difference.

From participants' accounts, it appeared that standing out as being different could have damaging social consequences in Poland, resulting in rejection and discriminatory treatment. Although participants generally distanced themselves from such practices, implicit prejudices were evident to a greater or lesser degree in many interviews. The focused codes comprising this category included: Highlighting Discrimination Towards Particular Social Groups; Being Assigned a Stigmatised Identity as a Result of Contact with Services; Discussing Historical Antecedents of Discriminatory Practices; Viewing Emotional Expression as Culturally Acceptable; and Judging Reasonableness of Behavioural and Emotional Reactions.

Several participants alluded to or explicitly discussed institutional and discrimination towards particular social groups in Poland. These participants were generally those

who held less traditional values or were able to appreciate the benefits Scottish culture; participants who were more closely affiliated with the Polish community in Scotland tended not to raise these issues. Groups described as facing prejudicial treatment in Poland included gay people, people with disabilities, the elderly, teenage mothers, single mothers, childless women over a certain age, and single women.

In Poland the case is that disabled people are not really on the streets. They normally stay in their houses. They don't participate in social life as much. They're very intimidated and very closed and there is not much of acceptance in the public for them. If people on the streets see someone disabled, they make some nasty remarks. They make fun of them. They are not educated in that way to respect them. And it's very difficult for disabled people to do really anything, it's pretty much impossible to get jobs (C4 218–229).

... I'm 28 and in Poland, it happens still although I'm not there that they would be asking, 'Why you still don't have children?' for example. And if I did, if I don't have children and I reach 30 you would start being stigmatised in a lot of that, you're like a bit weird or you're a bit, something's wrong with you (K2 364–368).

Discrimination towards those who had contact with mental health services was also described. Participants highlighted that mental health problems were considered a 'gentle' or 'private' subject in Poland. Negative consequences of contact with mental health service were described in terms of being socially ostracised and assigned a stigmatised identity, and possibly employment difficulties.

I think that they avoid going to there ... there is a negative, very old-fashioned, is like a phobia between going to them. To go to them is some of joke for Polish people ... I think that in our country, we don't have a more, a lot of understanding to people who they've got really a mental problem. For us, we're like very old-fashioned, and the people, they are for example just kind of like, oh, they are stupid or something like that (C5 354–368).

A few participants reflected on the potential historical antecedents of these types of attitudes, and highlighted that certain social groups were persecuted by the Nazi

regime during World War II and under the subsequent communist regime. Furthermore, having attention drawn to oneself by observable differences could be dangerous in these circumstances.

... I've heard some theory that basically what happened during the war, all the weak people didn't survive so for then at least one generation, there was no really mental illnesses, learning disabilities or anything like that because they were all killed (K2 725–728).

However, emotional expression did not necessarily appear to be judged negatively in Polish culture. It was suggested that due to the prevalence of distress due to trauma following World War II, the stresses associated with economic difficulties, and the development of a work culture in the communist era where people did not value their jobs, public expression of distress in Poland is so common that it is perceived as normal.

... quite a lot of people later on would be distressed because now I'm thinking about it, because they were interrogated, because the person was like I don't know, your husband was taken away and never came back, you know, like loads of these kind of quite serious and horrible situations happened, you know. So people weren't, I would say they weren't focused so much about somebody who was a bit sad or cries ... (K2 739–745).

Judgements about emotional distress were based on how reasonable it was considered to be in the circumstances. Distress which was considered reasonable was generally attributed to life stresses and social factors, such as divorce, pressures at work, and poverty.

They all had problems which were mainly resulting from the fact that they were, they did not have work. They did not have enough money ... (C6 104–105).

It is possible that Polish history may have led to a perception of difference as being dangerous. Conditions during World War II and the subsequent communist regime meant that standing out often had grave consequences. For instance, during Nazi occupation, along with the extermination of the Jewish population, many other social groups whose social identity did not conform to Aryan ideals were persecuted and sometimes exterminated, including those with mental health problems and learning disabilities (Mostert, 2002). Although the communist regime did not persecute people to the same extent, oppressive forces continued to operate, and any suggestion of political dissidence or practices perceived by the state as socially deviant could lead to interrogation and harsh penalties (Checinski, 1982). Thus, historically there have been considerable social pressures to conform in Poland. This is likely to have been created, somewhat paradoxically, by both the Polish people's desire to maintain their national identity in the face of attempts to suppress it, and the devastating consequences which could result from standing out under previous political regimes. A likely consequence of this is that intolerance of difference continues to pervade Polish culture today, particularly in rural areas. Schwartz and Bardi (1997) found that compared to people from other European countries, Polish teachers and students held relatively more conservative social values.

There are perhaps two key issues here. Firstly, vulnerable members of society may face persecutory treatment, and social institutions appear to support rather than dissuade this. Research by Kerlin (2005) indicates that social care services in Poland are underfunded, particularly in rural areas, meaning that they are unable to meet the

needs of the populations they serve. Siemieńska and Domaradzka (2009) highlight that the structure of the welfare system is such that few services are provided for people with disabilities, and the burden of care usually falls on families. Furthermore, few initiatives exist to allow people with disabilities to participate in society, for example, through employment. Therefore, people from marginalised social groups in Polish society are likely to be less visible due to their inability to access social resources.

The second issue appears to relate to a deviance from Catholic family values: in particular, women who do not conform to social norms appear to be discriminated against. The fact that gay people also face discrimination suggests that valued social roles are partly defined through reproduction, and that failure to conform to socially sanctioned sexual norms leads to stigma. Foucault (1979) suggests that such views have developed in Western society due to a desire for social control on the part of the bourgeois classes in order to produce a population that conforms to their social goals.

As the interviews progressed, I had the impression that I may have been talking at cross-purposes with some of the earlier participants, and that when I used the word 'distress', participants assumed that I was talking about severe mental health problems, probably due to my role as a Trainee Clinical Psychologist. Therefore, in later interviews, I modified my language to discuss 'everyday stresses', which participants appeared to respond to more positively. The finding that participants attributed distress to social factors is consistent with research into folk psychology

indicating that cross-culturally, distress is conceptualised as an understandable reaction to life events (Read & Haslam, 2004).

Seeking psychological help appeared for some to be associated with an expectation of being distanced socially. Gilbert's (1992) social rank theory proposes that maintaining one's position within one's community has a profound impact on emotional well-being. Being assigned a stigmatised identity could be a strong motivating factor to avoid contact with mental health services.

Urban–Rural Class Divide.

From participants' descriptions, it appeared that there were cultural differences between urban and rural areas in Poland. This influenced migration goals and decisions about where to settle, as well as social attitudes. The focused codes contributing to this category included: Describing Urban–Rural Divide in Poland; Describing Life in Poland as Stressful and Difficult; Migrating for a Better Life; Migrating to Gain Freedom; Thinking Different Demographic Groups Settle in Different Areas; and Employing Help-Seeking Strategies in Line with Social Class and Urbanicity.

Considerable social differences were described between rural and urban areas. In particular, rural areas were described as being more deprived and isolated from the outside world. Participants from urban, middle-class backgrounds described people from rural areas as being closed-minded, while characterising those from urban areas as modern and progressive in their opinions.

... the society is still very much divided into what is in Poland termed as 'Poland A' and 'Poland B'. Poland A would be big cities. And maybe satellite towns around it where they all have access to good work. Good education. Culture ... And it's kind of people will get, tend to get more information but also live in a less, well more open way. More accepting of it. Because they meet more people. They meet people of different races and religions and all that, because they live in a big group of people. And they tend to kind of accept it a bit more. Every day in the street they see things happen. They don't always approve it, but they kind of get used to it ... Whereas Poland B is usually certain areas in the country, especially small villages a bit further removed from cultural centres ... They are poorer ... (C7 714–728).

Life in Poland was described by many participants as being stressful and difficult. In the most part, this related to financial troubles. However, some participants also described Polish culture as being somewhat chaotic, with people communicating in a direct manner dependent on their mood with little regard for social graces, which could make it difficult to conduct everyday business.

... it was always very nervous, and we never knew what was coming, so it was really very, we didn't have, couldn't afford a car. We didn't have lots of things that we would like to have ... I always felt worried and I was always like nervous and I felt helpless not being able to do enough. I worked nine to ten hours a day, sometimes on Saturday as well, it was still not enough (C6 188–194).

... here, if you cope with yourself well, you don't have any problems with the bus driver, with the, I don't know, person in the tax office. Where in Poland, there is more of, life is very stressful in a way ... The people express their emotions... You don't want to go at eight o' clock in the morning to the shop and be shouted (K2 767–776).

Due to these difficulties, the majority of participants reported that they had made a rational choice to migrate to Scotland to improve their situations. In particular, they considered that it was easier to find work in Scotland, that wages were better leading to an improved standard of living, and that their children had greater opportunities.

I think here is easier you see ... Because for example, if you earn own living now, wages. It's £5.73 per hour or something like that. If you're working forty hours per week, you've got that two hundred only have. And if the both of them working, that's a four hundred weekly home budget. So that's absolutely enough to live. So that's, I think the financial, national problem are very low here for immigrants (C2 255–262).

However, not all participants' migration goals were the same. Middle-class participants were more likely to migrate to attain independence and freedom and to escape aspects of life in Poland which they found constrictive rather than for financial reasons. A few participants noted that the pace of life in Scotland was more relaxed, which they saw as having a beneficial impact on their well-being.

... I don't think that most of my friends anybody would mention that reason. Rather it would be more of adventure, change, something. They would be probably complaining about mentality in Poland and different things than the finances (K2 7–10).

... for me, because I moved from a big city, it's how kind of the pace of life, how kind of calm it is. I love driving in this country. Cause in Poland, especially [major Polish city], it's like you know, one for all basically. And it's like, it's a jungle basically (C7 1392–1396).

It appeared from the field work and interviews that different demographic groups might settle in different areas. As Forth Valley contains several factories offering employment to unskilled migrant workers, this may have made it an attractive location for them. Furthermore, it is possible that rural areas in Scotland may appeal due to similarities to the geographical areas in Poland from which migrants originate. An impression was gained that people from urban, middle-class social groups in Poland might be more attracted to urban centres than rural areas.

I think there might be a difference in demographics depending on where the people settle. Eventually. And probably, and also maybe that the people that move with families are more likely to be family orientated, more traditional in their views and in their opinions ... it's also in terms there a lot of jobs opportunities, so that would be the place that they would go to for work (K1 362–372).

Attitudes towards seeking psychological help appeared to vary between participants from urban and rural areas. Psychological service provision in rural areas in Poland was described as sparse, and seeking help was associated with considerable stigma and fears of gossip. In contrast, engaging in therapy was described as being fashionable in middle-class, urban Poland, and even as necessary for self-actualisation.

... people talk about it openly among my friends. And always the people that live in, I think, like Warsaw, Krakow, Wroclaw, Poznań, wherever ... it's kind of maybe a sort of fashion thing, you know. It was kind of, you know, you're not fully yourself if you don't dig deep. And who can help you? A psychologist can find you the real you and kind of get rid of all the baggage ... and I think people now they kind of use it as I kind of, you know, 'You've never, you know, done any therapy. You're all entangled inside and you're not a real person' (C7 827–838).

The suggestion that there might be attitudinal differences between urban and rural Poland is supported by the literature. Rural Poland was badly affected by the communist regime due to poor agricultural planning, which left a legacy of poverty and deprivation (Wróbel, 2005). The introduction of a free market economy following democratic elections in 1989 led to a rapid growth in the private sector and an expansion of industry in urban centres, increasing social mobility (Psimmenos & Kassimati, 2007; Wróbel, 2005). McManus–Czubińska *et al.* (2003) found that people who identified most strongly with traditional Polish values were more likely to be older, poorer, more devoutly Catholic, less politically engaged, and to live in

rural locations. In contrast, those who adopted progressive, dual European–Polish identities were more likely to be younger, middle-class, well-educated, and from urban areas.

Fóti (2009) suggests that the majority of migrants from Poland come to the UK for economic reasons, partially due to high rates of unemployment in their home country: this is consistent with the findings of the research. It seems likely that many of these migrants will be from deprived rural areas of Poland, and consequently may be more traditional in their attitudes, both generally and in relation to help-seeking. Therefore, few Polish migrants in rural areas of Scotland may be inclined to seek psychological assistance.

EXPERIENCES WITH SOCIAL INSTITUTIONS

Experiences with General Health Services.

Participants' prior experiences with general health services in Poland and Scotland shaped their planned future help-seeking behaviour. The focused codes contributing to this category were: Feeling Disappointed with Scottish Health Services; Questioning Health Services' Motives; Avoiding Contact with Health Services Unless Absolutely Necessary; Preferring to use the Private Sector in Poland; Having Access to Services Determined by Social Class in Poland; Describing Corruption in Polish Healthcare System; and Appreciating Benefits of Scottish Health Services.

The majority of participants expressed disappointment with Scottish health services; in particular, they appeared to feel dismissed by GPs. Factors contributing to this

included being given general lifestyle advice and over-the-counter painkillers rather than powerful medications, not being physically examined, and difficulty in obtaining referrals to specialists. Many participants also complained of long waiting times. There was a sense from participants that they felt that health professionals did not listen to them or trust them, meaning that on occasion they had to go to considerable lengths to provide evidence of medical conditions before receiving treatment. This could lead to reluctance to approach health services in future.

... for all different health issues, they give you Paracetamol in Scotland. In Poland, I'm not saying the doctors are more intelligent or more educated, but they use their books more and for each case, they would try to adjust the, or choose the right medication, and it's not really the case that for three different illnesses, they would give you the same drug (C3 388–392).

If you obviously need to see a, some specialist, like a gastrologer or urology or somebody, they give you an appointment, for example, next month or next two weeks. But you know exactly date, you don't need waiting half year or one year. But the people feel more important if doctor said to them, 'Another doctor with the specialist need to see you.' You see, don't give advice like, 'You should eat not fatty things,' or don't even go for an X-ray or something like that (C2 80–86).

For some people, these experiences led them to question health services' motives; opinions were expressed that doctors were motivated by personal gain, and that health services prioritised meeting government drivers over patient care.

... I can think that's the economical things you see, that's the financial things and all the doctors got a huge money here. They use huge money. But that's why here they're doctors. That's why they are doctors. And I think they, the main thing, the main feeling should be, help to patients. Just don't fill your own pocket (C2 558–562).

Participants noted that they and other members of the Polish community in Scotland avoided contact with health services unless absolutely necessary. Sometimes this

was due to being healthy, having a preference to solve problems on their own, or having other priorities. However, for some people, the perception that health providers were unmotivated to help them also contributed to this reluctance to seek help.

... definitely the health services won't be on their mind you know unless something happens again ... They just don't getting registered because they don't need it ... (C1 319–321).

... the people just angry. Angry and try and use own experience in medicine. You see they go to the shop and buy a lot of medicines. And they take it (C2 59–60).

One reason for the perceived inferiority of Scottish services may be that many participants chose to use private services in Poland, where they were able to quickly access specialist help which they found responsive to their needs.

... you can even choose if we need to wait quite long for national system, in the long queue for example, over two weeks, we can choose, is my personal choose, I can go to the private sector and I can get service in immediate next day. Even in the Sunday (C5 182–185).

However, unsurprisingly, access to private services in Poland was determined by social class. Several participants highlighted that medication is expensive in Poland, meaning that poorer people are often unable to fulfil their prescriptions. Additionally, access to services was sometimes determined by personal connections.

... in Poland, we need to pay for everything. And it is, sometimes we need to spend really a fortune. For medicine (C5 199–200).

... I got there only because I knew someone who knew someone who knew him and we were referred, otherwise we would have to wait for probably couple of years to get there (C7 56–58).

Despite the generally positive picture painted of Polish health services, some participants described corruption in the system which could lead to compromised care. They recounted that state healthcare staff expected bribes, meaning that in practice, it was sometimes no more expensive to use the private sector which was perceived to be better quality. Some felt that the pharmaceutical industry had a greater influence on Polish than Scottish doctors and that its presence was more apparent in Poland. Polish doctors were seen as being more vulnerable to the effects of the industry as they were considered to be relatively poorly paid but able to access additional benefits for prescribing certain medications, and by supplementing their incomes through engaging in lucrative sidelines such as homeopathy within their everyday practice in the state healthcare system.

I remember when I was studying there would be pharmaceutical companies that would ... come up with a kind of maybe not therapy, but on activities for groups for certain client groups. But they would also produce a specific medication for it ... They were funding, but they were also by promoting these psychological service, they were also promoting their own brand (K1 555–563).

... there's lots of doctors that also went into the debatable area of ... homeopathy ... there again, most of the homeopathy stuff is quite expensive ... It's a real money business. So again, hmm. You think, do they really believe in that or is there some sort of ulterior motive for that? (C7 482–525).

Although a minority of participants appeared to hold exclusively negative views about the NHS, the majority identified at least some aspects of it which they appreciated. In particular, most participants spoke highly of specialist services, which were seen as validating and responsive to their needs. It was noted that medication was much cheaper in Scotland, meaning that people had access to

treatment which they could not necessarily afford in Poland. Furthermore, a few participants felt that some medications were over-prescribed in Poland and were satisfied with the Scottish system.

... I have to say that the Scottish system is more people-friendly ... from the moment that I explained that I am a single mother and that I will be going home alone with the child, I was offered to stay in hospital as long as I need to regain my strength and to be able independent and look after the baby at home. It would have never happened in Poland (C3 362–369).

... there are cases when antibiotics are being prescribed without really huge need ... the liquid for throat that has been given here in Scotland has helped my daughter, and she did get better ... (C4 70–75).

The literature supports participants' descriptions of the healthcare system in Poland and helps to explain their expectations for treatment. Millard (1995) notes that during the communist era, healthcare provision was inadequate and many doctors supplemented their incomes through private practice. As noted by participants, this meant that corruption and bribery were common in health services, and people often depended upon personal connections to access care. The private sector grew rapidly following the downfall of communism, and may have been accepted more readily by a public eager to embrace private initiatives following decades of inefficient services. The profession of General Practitioner was only introduced in the 1980s, and originally served as a referral gateway to specialists. This meant that the public tended to associate good quality care with high-technology treatment from specialists (Millard, 1995). Again, this is consistent with participants' accounts of their desire to be prescribed medications and referred to specialists, and their dissatisfaction when this did not occur. Participants' descriptions of the use of homeopathy and problems in state services are also supported by Millard (1995), who notes that health services

in Poland are poorly regulated, and that doctors sometimes engage in profitable forms of alternative medicines such as homeopathy to supplement their incomes.

It is interesting that some participants felt that UK health services were structured around monetary and political drivers. In the UK, GPs receive monetary incentives for adhering to policies and meeting government targets (BMA, 2009). There is an implication in the medical literature that investigating symptoms thought to be medically unexplained reinforces difficulties and encourages further help-seeking behaviour (e.g. Page & Wessely, 2003). Further, as GPs are expected to see patients within 10 minutes (Deveugele et al., 2002), it may be difficult for them to provide comprehensible explanations to migrant patients. However, from participants' accounts, it seems that in practice, this is unhelpful to doctor–patient relationships: patients are left feeling that they are not being treated as individuals, and viewing GPs' agendas with suspicion.

Perspectives on Mental Health Services.

Only two participants reported having accessed mental health services directly in Poland, but many had indirect experience through friends who had used them. Although none had accessed mental health services in Scotland, several discussed the impressions they had gained about them. The focused codes which contributed to this category included: Having Little Contact with Mental Health Services; Distrusting Mental Health Professionals due to Associations with Communism; Accessing Mental Health Services in Poland; Viewing Assistance from Mental Health Services as Effective; Discussing Benefits of Therapy; Thinking that

Motivation for Recovery is Greater in Poland due to Fewer Secondary Gains; Thinking that Polish Psychiatrists are Less Likely to Prescribe Medication and Hospitalise People; Discussing Benefits of Scottish System; Viewing Formal Intervention as Necessary in Some Circumstances; and Preferring to Seek Private Therapeutic Assistance.

Some participants appeared to have had little contact with mental health services. This was linked to a lack of service provision in Poland, particularly for poorer people; an impression that fewer people experienced emotional problems in Poland; a preference to resolve problems through other means; viewing contact with mental health services as taboo; and past negative experiences with NHS services.

I think people who can't afford, as I said, the access is a bit more difficult. Because I think the resources are not there. And information is not there (C7 1293–1295).

... I think the first stage, they try help own. On the other one, they can try go to friends and family. And like I say, believe me if they've got some mental problem, they didn't go to Scotland. Doctors. Because if they go to the Scotland's doctors with the tooth pain or stomach pain and they giving them with fatty meals, if he's got with the mental problem, aye. You can think well, whatever that person can think what the doctor can say. So believe me, nobody who's got a mental problem, and has got experience with the Scottish health service don't go (C2 396–403).

On occasion, participants with no experience of mental health services feared that such contact could exacerbate problems. A key informant suggested that a possible reason for distrusting mental health professionals was the role they played in the communist era. She stated that university lectures in the social sciences sometimes

incorporated government propaganda, that some professionals benefited from the regime, and that some were involved in hospitalising political dissidents.

... people would be a little bit mistrustful of psychology and psychologists. Because it might have been viewed as almost as a tool that the government or the party was using to work with certain groups of people that they might find a little bit difficult (K1 481–485).

Nonetheless, the majority of participants were able to describe the services that they or their friends had accessed in Poland. They appeared to have a reasonable understanding of the sorts of services offered by mental health professionals, including addiction centres; services for children with developmental disorders; individual, group and family therapy; medication; and psychiatric hospitals.

They were our neighbours so we knew about the problems and we knew that they had therapy ... they called it psychoanalysis, and they were given some sort of medication ... (C6 113–117).

My son has been diagnosed with ADHD. So I've got a big experience of psychiatrists and psychologists from Poland. And I did courses in behavioural therapy for him (C7 32–34).

Participants who had contact with mental health services generally viewed them positively, and considered that the help received had been effective. Benefits of interventions were generally construed in terms of being able to function again in line with Polish social norms, in particular being able to fulfil family and work obligations.

She became calmer and she became more open for life in a way that before, she would be not interested in anything ... She actually starts to believe that I have to take care of my children, I need to ensure they have a good education and they

have a good future, whereas before she thought that if I was to go away or die, the kids will manage without me. And now she feels more responsible for them and she's trying to improve things in their lives as well (C4 316–323).

Further benefits of seeking professional services as opposed to seeking help within one's social circle were confidentiality and objectivity. A participant who had seen a psychologist in Poland emphasised that by seeking professional help, she avoided the potential for gossip and social repercussions and was able to gain an unbiased perspective on her difficulties, which she found validating.

... I have this comfort that once I told the specialist what's wrong with me, we will never come back to this conversation. It's like you throw your, I don't know, your issues, your feelings to the well, and no echo will come back up. And if you talk about your problems with your friends, you are still around them, they might come back to it, and you might not want it (C3 471–476).

On occasion, people in Scotland were perceived as being less motivated to resolve their difficulties due to the secondary gains which were available to them, which included receiving state benefits and housing, and evading responsibility for their children's problems. In turn, it was suggested that this could lead to people with psychiatric diagnoses becoming trapped in a sick role. In contrast, people in Poland were not seen to relate to psychiatric labels.

... a lot people would be seen as mentally ill, and would start being in the services and would start getting benefits and would get into the loop of you know, benefits, staying in their own flat and doing, not doing much kind of thing. But you know like getting isolated. Which in Poland because you need to, you need to go back to your own environment, you sort of are more determined to actually think on it (K2 289–295).

In line with this, a key informant expressed the opinion that Polish psychiatrists were more reluctant to prescribe psychiatric medication or hospitalise people unless problems were very severe: she was disturbed by what she perceived as Scottish psychiatrists' over-willingness to assign diagnoses and prescribe medication.

... I think that medication for the mental illnesses is overly prescribed from here ... so I think you get like antidepressants quite easily from the GP, if you have any kind of voice, you hear voices, whatever the reason for it is, you get antipsychotic medication, so your appearance changes, you actually look quite ill you know ... Whereas in Poland you won't, you'll get a lot of medication, but only when you have very severe symptoms. Whereas if you get back to normal, you don't (K2 300–308).

However, benefits of the Scottish system were also identified. There was a sense that there was more information available on mental health issues in Scotland and that it was easier to access services at an earlier stage. Furthermore, it was felt that the Scottish system might be better for people with severe difficulties in that they would not have to return to toxic family environments.

I think that like the Scottish system would be probably much better for people with a very serious mental illness ... Maybe sometimes the environment is not great. Or it's the cause of actual distress and that person cannot, you know, cannot start the new independent living (K2 191–198).

The majority of participants felt that there were some circumstances in which it would be necessary or desirable to seek psychological help. Examples given of such situations included: when problems were very severe; when problems were apparent to others; when problems interfered with everyday functioning; and when other attempts to resolve the problem had failed.

If there was any situation in which either I realised or someone told me that I was behaving strangely and I could feel that I had a problem with something, I would definitely go and seek psychologist's advice (C6 269–271).

I would first try to go through it somehow myself, maybe take some pills. And I can handle it as long as I feel I have strength to do so, but then I do understand when the point passes that I am not managing, could have enough time to prove that I am not managing, and then a person wants to go and see the specialist which is probably the last help, the last choice (C3 433–437).

Although some participants noted that they would be prepared to seek NHS psychological services if necessary, one participant reported that she would prefer to seek private services from a Polish counselling organisation. This organisation operates in two major Scottish cities and employs experienced Polish volunteer therapists. Polish therapists in Scotland were also noted to advertise their services in the Polish media. However, a key informant expressed concerns about the quality of services provided by Polish therapists in Scotland due to the lack of regulation and provision of supervision.

... I definitely think I want to use it again and I have heard that in Edinburgh there are some services for Polish people that are being run in Polish language (C3 329–330).

... I know psychologists from Poland quite frequently advertise on the Polish, for example, the Polish forums and the Polish papers ... And I think the people that migrated from Poland and be over here quite frequently would look for these even first for some reason (K1 16–20).

... there is no procedures, there is no, these people don't get supervision, no. It's all quite unstructured again, so I don't find it very professional (K2 1093–1095).

The fact that familiarity led to more positive attitudes towards mental health services is consistent with social psychology literature: Allport (1954) suggests that familiarity can reduce fear and allow for more realistic perceptions. Research

indicates that social services provision is limited in Poland (Kerlin, 2005; Siemieńska & Domaradzka, 2009), therefore many participants, particularly those from rural areas, may be unfamiliar with psychological services. In turn, this may mean that they are less likely to approach them.

Perceptions of the consequences of contact with services may be important in this context. Memories of the corrupt role which mental health professionals sometimes played in the communist era could understandably lead to a distrust of these professions. Psychiatric abuse in the former Soviet Union is well-documented (e.g. Bloch & Reddaway, 1984), and although this appears to have been less common in Poland, there are reports of similar activities having taken place (Rich, 1982; Subcommittee on Human Rights and International Organizations, 1983).

In contrast, some participants seemed to view Scottish people as being overly keen to access services due to the secondary gains available. There appeared to be a perception that Scottish people related more to psychiatric diagnoses, which were promoted by the government and the psychiatric profession. Furthermore, Scottish psychiatrists were perceived as being over-zealous when prescribing medication. Moncrieff (2008) suggests that many Western psychiatrists are susceptible to the influence of the pharmaceutical industry, as endorsing biomedical models and prescribing medication validates their identity and allows them the same status as other branches of medicine. Polish psychiatrists may have different motivations, such as to shed the corrupt identity with which they have historically been associated.

Although participants considered that more information on mental health was available in Scotland, it does not necessarily follow that this has led to Scottish people holding less stigmatising attitudes: Bentall (2009) suggests that anti-stigma campaigns can actually increase stigma. Lincoln *et al.* (2008) highlight that most anti-stigma campaigns present a biomedical model of psychiatric disorders; a review by Read *et al.* (2006) found that holding such views leads to perceptions that people with these diagnoses are dangerous and unpredictable, leading to fear and rejection. Interestingly, Bassaly and Macallan (2006) found that acculturated Polish migrants were more likely to hold stigma-related concerns in relation to seeking psychological help than those who did not identify as strongly with British values. It is possible, therefore, that Polish migrants may be disinclined to access psychological services in Scotland due to fears of the consequences.

This may be one reason why a preference was occasionally expressed to seek help in the private sector, where clients may have greater control over the therapeutic process. Experiences in Poland are also likely to play a role: seeking help from private services was valued, and it is possible that these services are viewed as more acceptable than state services. Furthermore, migrants appeared keen to keep their problems within the Polish community, and seeking services from Polish organisations and individuals may be more congruent with this desire than seeking NHS services. Finally, the greater ease of communication with a Polish therapist is likely to be beneficial. It might be worth NHS services considering joint work with Polish counselling agencies if migrants are more inclined to approach them.

Communication.

Language barriers were highlighted as a significant problem for the Polish community in Scotland. This category comprised the following focused codes: Experiencing Difficulties as a Result of Language Barriers; Communicating through Interpreters; Having Friends Act as Interpreters; Contrasting Scottish and Polish Communicative Styles; and Losing Meaning in Translation.

Many participants discussed the problems created by language barriers for members of the Polish community in their everyday lives. In particular, language barriers made it difficult for people to find out what services they were entitled to and to access information.

... I didn't have a problem with communication and my English, you know, I can speak, I can communicate. But some people I think that's what holds them back, you know. And it's obviously not easy to go to your GP or even, I don't know, family planning centre, any one of those places. Because you know they depend on language, and I think that's the main barrier and will always be (C1 21–26).

While some participants who did not speak English were satisfied with the services they had received, which necessitated communicating through an interpreter, others noted that it could be difficult for people to reveal personal information with an interpreter present.

It wasn't difficult because I always interpreter next to me, but if it would have to be only me and [health professionals], I would never understand (C4 355–356).

... if you've a very private problem, you don't even trust the translator ... if somebody don't speak English, can't go to their doctor and say for example, I've

got some sexuality problem, or a mental problem or something like that ... Not with anybody who sit here and translate (C2 417–425).

Several participants described the use of friends as interpreters. It appeared that this could be more convenient as it was sometimes necessary to wait for professional interpreters to become available. However, on occasion, friends were used due to a desire not to over-utilise resources.

... I do realise it's not fully my country here, I am not Scottish and I wouldn't want to use too much this free interpreter's help, so I would always try to go doctor's visits with some of my friends so that I don't need to use the system and I know that after all it does cost to the government ... (C3 95–99).

Some participants felt that communicative styles differed between Poland and Scotland. Polish communication was characterised as being direct, honest and to the point. Additionally, during the field work, I noticed that Polish community members were assertive and expressed their opinions freely. Some interviewees felt that this meant that communications with strangers could sometimes seem rude. However, interactions within close inner circles were described as being warm and hospitable in nature. In contrast, Scottish communication was viewed as being more polite but more distant. It was felt that this could lead to difficulties in communication between Polish people and Scottish health professionals.

... the way they use language is different. They would speak much more pol-, the way we construct sentences and they, this communicate with others would be very, very polite. Very, they wouldn't necessarily go straight to the subject, they'd be very, they'd go round and round and round the subject ... (K1 259–264).

... I think that like Scottish people have more of structure in terms of social interactions and how you should be behaving and how you shouldn't, whereas in Poland, if somebody screams at you, that's quite normal (K2 231–233).

... maybe that also affects relationship with people with, with like medical services because you know because they don't smile at you very much, and you kind of also come with the kind of reserved approach and it's kind of more difficult to talk then (C7 1450–1454).

It was noted that there was the potential for meaning to be lost in translation, particularly when discussing sensitive subjects and emotions. Furthermore, it was felt that even when people spoke fluent English, it could be difficult to communicate meaning in a second language.

I believe information would be said probably correctly, but you never have this guarantee that all the emotion and the way you say it is being delivered ... it would be better to speak directly, because through interpreter, everything is being said in a more dry way, it's like dry information. And sometimes I wouldn't even concentrate as well knowing that there is another person in the room. So it changes actually the way you (C3 349–356).

... psychology is a funny area really, because although you might speak good English, it might be quite difficult to communicate different, certain emotions, or to communicate certain, feelings in English even though you are able to communicate quite proficiently otherwise (K1 31–35).

The use of friends as interpreters has the potential to lead to problems, as people may be less likely to disclose personal information due to fear of repercussions. Additionally, interpreters who know the participant may have their own opinions about their difficulties which may colour the way that they interpret (Phelan & Parkman, 1995). This could be particularly problematic in therapy, where meaning is central. Watkins (1989) highlights that language is grounded in the history and culture in which it develops. Certain words may have double-meanings which conjure up obvious connotations for a native speaker, but which may be time-consuming and difficult to translate and express in a different language. Also, subtle

cultural idioms may not be clear to someone from a different culture even when both conversational partners are speaking the same language (Bortfeld, 2003). This may be particularly true of emotional communication, as emotions are abstract in nature and construed differently in different cultures (Ovejero, 2000).

Communication styles vary between cultures (Gudykunst & Matsumoto, 1996). The tendency described for Polish people to keep their distance from strangers might relate to historical antecedents, where communication with strangers was potentially dangerous. The suggestion that differences in communicative styles could lead to problems in healthcare communications is supported by a review by Ferguson and Candib (2002), who found that communication between doctors and patients from different cultures was hampered by less empathy on the part of doctors, a lack of rapport, insufficient provision of information, and less patient participation in clinical decisions.

Therefore, communication appears to impact on how and from whom help is sought. The most obvious manifestation of this is the language barrier, but more subtle processes, such as differences in cultural values and communicative style, may also hinder the process of communication.

SUMMARY AND CONCLUSIONS

Polish migrants' decisions about whether to seek psychological help were consonant with their sense of identity, which developed in interaction with cultural norms, community and family relationships, and experiences with social institutions. Approaching services for assistance with emotional problems was incongruent with traditional Polish cultural values, and participants who strongly identified with these values rejected psychological services as a relevant option to them, preferring to deal with their problems on their own or within their social networks. Participants who had more conflictual relationships with traditional Polish cultural values and who identified with social groups where therapy was seen as socially acceptable were more open to this option, although on occasion, a preference for seeking help from Polish therapists in the private sector was expressed. Experiences with health services also impacted on participants' decisions on how to deal with problems; negative experiences were associated with a reluctance to approach services again in future. Therefore, help-seeking decisions are constructed through the interaction of life experiences, relationships, identity, and social norms.

STRENGTHS AND LIMITATIONS

Strengths.

While cultural clinical psychology is a growing field and has spawned much research in North America, few researchers in the UK have explored cultural issues from a psychological perspective. The only previous study of Polish migrants in the UK, by Bassaly and Macallan (2006), provides insufficient detail on methods and has several methodological limitations. The current study builds a richer and more

comprehensive picture of how Polish migrants in the UK perceive psychological services and reach decisions about whether to seek help, and contributes to the wider migrant literature on help-seeking. The results have potential utility in policy decisions and service development when considering how existing NHS services can meet the needs of migrant communities in Scotland.

The methods employed in the study sought to ensure that a rich understanding was gained of the experiences of Polish migrants in Scotland in relation to their help-seeking decisions by incorporating guidelines on best practice in qualitative research to enhance the robustness and credibility of the findings. As initial analysis suggested that different issues may affect Polish migrants in metropolitan urban areas, theoretical sampling outside the main cohort was undertaken to explore these issues further.

Limitations.

To an extent, the study was restricted due to difficulties in accessing relevant participants, an inherent problem for outsiders recruiting from closed social groups. The need to work through interpreters, or to conduct interviews in English with participants who did not speak English as their first language, may have led to difficulties in communicating meaning. The process of conducting interviews through interpreters was necessarily slower, and due to financial restrictions, it was necessary to conclude these interviews within an hour. This was frustrating, as it would have been desirable to expand upon interesting topics raised by participants.

Nonetheless, it was felt that including participants who did not speak English enhanced the research.

REFLECTIONS ON THE RESEARCH PROCESS

The research process was a fascinating, if at times stressful, process and highlighted aspects of Polish culture which I had previously been unaware of and had not reflected upon. I was surprised to find that there were greater cultural differences between myself and the Polish community members who I met in the course of the research than I had anticipated: in my everyday life, I had met many Polish people socially, and had not perceived any significant cultural differences. However, the majority of participants in Forth Valley appeared to represent a different demographic group who I perhaps would be less likely to encounter.

It became apparent that many of the agencies and community members with whom I liaised had different and sometimes conflicting agendas of which I was not always able to gain a clear understanding. At times, I felt that these agencies, and a minority of participants, had certain expectations of me which were not explicitly stated, which felt rather awkward. At the outset of the research, I thought it might be possible to integrate into the Polish community to an extent following the ethnographic tradition (Geertz, 1973). This proved to be more challenging than I had predicted. When I attended Polish cultural events, I was very aware of my role as an outsider. At some events I was politely welcomed, and at others, treated with suspicion. However, it was clear that I was not viewed as part of the Polish community, and as such, only superficial engagement was possible. Furthermore,

probably as a result of my clinical psychology training emphasising professional boundaries (Gutheil & Gabbard, 1998) and my position as a representative of the NHS, I felt somewhat conflicted about appropriate levels of formality, and tended to err on the side of caution. It has been suggested that Polish communication is relatively informal (Boski, 2002), therefore my reserved approach may have created a barrier. On the other hand, I had the impression at times that some Polish community members viewed me in line with a perception of Scottish people as materialistic, decadent, and whimsical. It is possible that they may have rejected me if I divulged more personal information, since as a childless, unmarried, 30-year-old woman whose lifestyle could be viewed as rather bohemian, I could be seen to be flouting valued traditional Polish norms. Having always considered myself as someone with an independent self-identity who rejects many dominant social norms, I developed an increased awareness of the extent to which I too am a product of my culture.

It has been suggested that due to their relatively privileged social position, researchers hold the balance of power in research relationships, particularly when working with people from marginalised social groups (Cotterill, 1991; Lewis, 1973). However, more recently, attention has been drawn to the fact that research is a dynamic process, and that power relationships are constructed by participants as well as researchers. Thapar-Björkert & Henry (2004) suggest that the notion of participants as vulnerable and powerless reflects a rather condescending Western academic perspective which may not reflect participants' experiences of taking part in research, and highlight that the dependence of researchers on participants gives the

latter considerable power. Similarly, Merriam *et al.* (2001) note that the social characteristics which give academics power within their own field may have little meaning to participants.

This was consistent with my experience of conducting research within the Polish community. I found the Polish people I encountered to be assertive in their communication, and many were rather dismissive of the research, as they did not feel that it addressed their central concerns which were of a practical nature. Others offered to participate on the condition that they could structure the research process by setting the topics for discussion and controlling the interview format: these offers were generally politely declined as it was not felt that this would be conducive to answering the research questions. While it is possible that some participants may have viewed me as being in a position of power, my experience was more one of being a relatively powerless outsider in the Polish community.

CLINICAL AND SERVICE IMPLICATIONS

The results of this research have a number of important implications in considering how services might best meet the needs of Polish migrants in Scotland. Firstly, they highlight the importance of considering problems within a cultural context. Secondly, there is a need to consider how clients' experiences with health services more broadly impact on future help-seeking behaviour. Finally, consideration should be given to how services might be adapted to fit with migrants' help-seeking strategies and preferences.

There is much rhetoric promoting the consideration of cultural issues in policy documents (e.g. DCP, 1995), but it is less clear how this translates into practice. Clinical psychologists are encouraged to consider how their own values impact on their therapeutic work through the process of reflective practice, although Lavender (2003) suggests that insufficient emphasis is given to this on UK training programmes. As was clear from many participants' accounts, values often operate at an implicit level outside immediate awareness. The findings of this research indicate that there are important cultural differences between Poland and Scotland, such as the importance of Catholic values and the family. If clinicians are unaware of these factors, there is a danger that they might pathologise aspects of clients' experience through the application of Western models, for instance, by interpreting family closeness as enmeshment. Therefore, when working with clients from other cultural groups, clinicians should acquaint themselves with literature about these clients' culture, and consider how differences between their own and their clients' values might impact on the therapeutic process.

It was clear from many participants' accounts that they found their interactions with GPs unsatisfactory, which discouraged them from seeking help in future. This highlights that the organisational culture within the NHS, with its emphasis on following policy and discouraging over-utilisation of services, may be counterproductive in working with certain cultural groups. In the current study, when explanations were provided for treatment decisions, participants often accepted them. Taking just a little more time to explain decisions to patients, with an awareness that health services operate differently in different countries, could have a

significant impact on GP–patient relationships. Providing training to GPs on working with new migrant groups might be helpful in this respect.

It appeared that many participants did not perceive psychological services as relevant to them. On reviewing the 'grey' literature on working with ethnic minority groups, Moffat *et al.* (2009) suggest health services may need to think more broadly about how they can be helpful to migrant communities. They recommend collaborative working between the NHS and other statutory and non-statutory services through the use of mutual referral pathways. Adopting a community psychology model and moving away from traditional clinical psychology interventions may be helpful in this regard (Holmes, 2010). Since the introduction of Agenda for Change, a consultancy model of clinical psychology has been promoted (BPS, 2007). Working with other organisations to promote the emotional well-being of communities appears to fit well within this context. One means to do this might be to establishing links with Polish counselling services as these appear to be more acceptable to some migrants than NHS services. In return, NHS psychology services could offer to provide supervision and support to these organisations. Current policy guidelines often recommend the use of CBT over other therapies (e.g. Scottish Government & NHS Scotland, 2008). However, both key informants indicated that psychodynamic models are the prominent in Poland. Therefore, Polish counselling services may be skilled in delivering treatments which NHS psychologists are not necessarily qualified in and which may be more acceptable to some clients. Therefore, there is potential for both services to benefit from the skills of the other. Rather than simply assuming that NHS psychology services are appropriate for migrants and that they

should be educated in how to access them, consideration should be given to what migrants actually want and how this might be provided.

RECOMMENDATIONS FOR FUTURE RESEARCH

This study suggests that particular issues may have varying levels of salience for different individuals and migrant groups, even when they share the same nationality. Little research has been conducted into factors influencing help-seeking decisions other migrant groups in the UK; it would be interesting to investigate whether similar or different factors influence help-seeking decisions. Working with interpreters highlighted the advantages of having a co-researcher from the cultural group being studied in terms of gaining access to participants and providing insight into cultural issues. Merriam *et al.* (2001) suggest that insider–outsider research pairings may represent an optimal strategy for cultural research, as this serves to highlight the assumptions and cultural constructs of both.

JOURNAL ARTICLE

This journal article was prepared in accordance with guidelines for the *British Journal of Clinical Psychology*.

ABSTRACT

Objectives

This study aimed to investigate the influences on Polish migrants living in Scotland's responses to distress and decisions about whether or not to seek psychological help.

Design.

A cultural psychology framework using Charmaz's social constructionist method of grounded theory was adopted in the design of the research: this method was chosen due to its relevance to migrant populations.

Methods.

Field work was conducted within the Polish community, and semi-structured interviews were conducted with seven Polish community members and two key informants. Data was analysed using guidelines outlined by Charmaz supported by NVivo software.

Results.

Participants' responses to distress were congruent with their sense of identity and the norms of the social groups with which they identified. Polish cultural values emphasising family closeness, traditional gender roles and discomfort with

difference influenced participants' help-seeking strategies. Participants who felt disappointed with Scottish primary care services felt reluctant to approach the NHS for help with emotional difficulties, while participants who were satisfied with their treatment were open to this possibility. Private Polish psychologist services may be preferable to state services in Scotland in some instances.

Conclusions.

Clinical psychology services in Scotland may not be well-placed to meet the needs of Polish migrant workers. There may a need for services to become more culturally sensitive, and to develop ways of working with community organizations with whom migrants have contact.

Key words: immigrants, Poland, psychology, help-seeking.

INTRODUCTION

A literature review by Lindert *et al.* (2008) suggests that migrant populations are at least as likely to experience mental health problems as non-migrants, and are at increased risk of suicide and psychosis. The reasons for this are unclear. However, research indicates that migrants may experience lower socioeconomic status, social isolation, and prejudicial treatment, all of which increase the risk of distress in migrant and minority ethnic groups (Dalgard & Thapa, 2007; Karlsen & Nazroo, 2002; Tinghög *et al.*, 2007). A Swedish study found that rates of psychiatric illness and psychosomatic complaints in respondents born in Poland and other Eastern European countries were approximately double those of respondents born in Sweden

(Blomstedt *et al.*, 2007), and a review by Carta *et al.* (2005) concluded that Polish migrants in the UK are one of the three migrant groups most likely to be hospitalised for schizophrenia.

Despite this, the literature consistently suggests that migrants are less likely to utilise available health services than native populations, and when they do, pathways to care are likely more likely to involve police and emergency services. Utilisation of psychotherapy appears to be low, whereas proportions of compulsory and secure-unit admissions are higher than for non-migrants (Lindert *et al.*, 2008).

Little research has been conducted into help-seeking decisions by Polish migrants in the UK. However, Winstead (1984) suggests that distress is viewed as an intrinsic part of life in Polish culture, and that seeking help is considered shameful. This is supported by research by Czabala *et al.* (2000), who found high levels of stigmatising attitudes towards mental health issues in the general population in Poland. Knab (1986) reports that family solidarity is valued in Polish culture, and that strong measures are established to ensure conformity and to prevent bringing shame on the family. It has been suggested that these values, together with the stigma associated with expressing distress in Poland, could prevent Polish people from seeking help from professional agencies (Knab, 1986; Winstead, 1984).

METHODS

Field Work.

Barbour (2008) suggests that conducting pilot work in the field can help researchers to familiarise themselves with a new area of study and assist the development of interview schedules. Therefore, informal conversations were held with community members and professionals familiar with the issues of concern, and events for Polish migrants were attended to gain an impression of pertinent cultural factors. Unstructured field notes were kept of impressions gained through these interactions.

Interviews.

A semi-structured interview schedule was developed to cover the areas which the literature and initial field work had identified as being potentially relevant following guidelines provided by Charmaz (2006).

Sampling.

A convenience sample of participants was recruited through networks developed in the course of the research and by snowball sampling. Theoretical sampling procedures were used to develop emerging themes; this technique is a key component of grounded theory methods (Charmaz, 2006; Glaser & Strauss, 1967).

Participants.

Table 1 gives details of participant demographic characteristics: in many respects, the sample was fairly homogeneous. Interviews were conducted with seven

community members and two key informants, who were Polish clinical psychologists living in Scotland.

TABLE 1: PARTICIPANT DETAILS

Participant	Age	Gender	Job classification ¹⁴	Length of Residence	Relationship status	Children	Conducted through interpreter?
C1	32	Female	7	11 years	Married	Yes	No
C2	28	Male	5	5 years	Married	Yes	No
C3	35	Female	6	2 years	Single	Yes	Yes
C4	40	Female	8	2 months	Married	Yes	Yes
C5	31	Female	8	2 years	Married	Yes	No ¹⁵
C6	40	Male	6	6 years	Married	Yes	Yes
C7	39	Female	2	2 years	Single	Yes	No
K1	32	Female	2	1 year	Married	No	No
K2	28	Female	6	4 years	Married	No	No

Data Analysis.

The constant comparative method (Charmaz, 2006; Glaser & Strauss, 1967) was used to analyse the data. Codes were initially assigned to data line by line, after which focused codes were generated at a more conceptual level. Finally, theoretical codes were developed to explain the connections between categories and to build them into a theory. Detailed memos about themes arising from the data and analytic decisions were also kept throughout the research process. NVivo 8 computer software was used to assist in the analysis of the data.

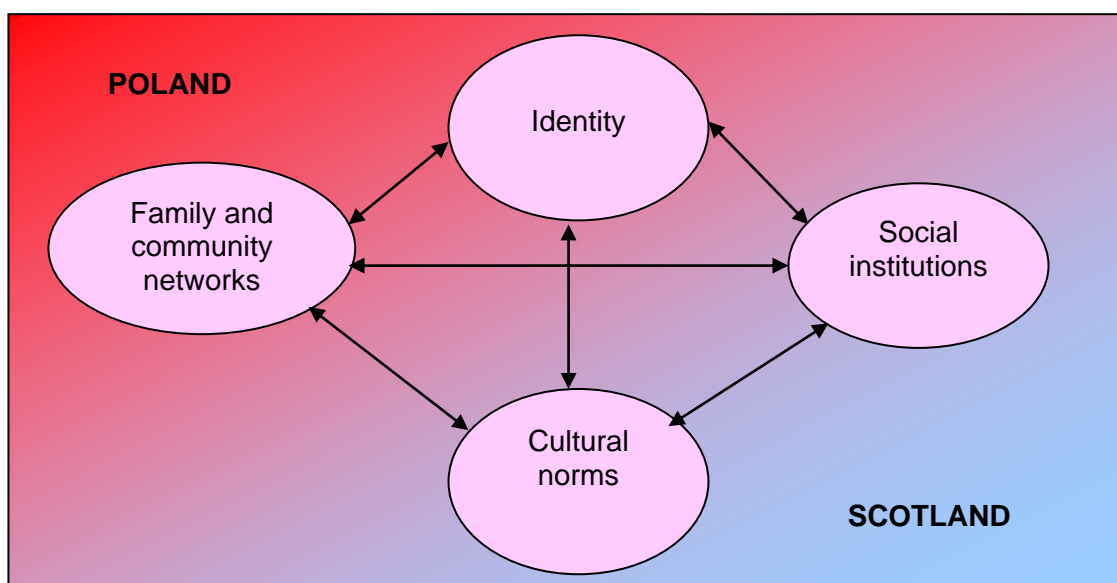
¹⁴ Job classifications follow the Office for National Statistics Socioeconomic Classification (2005).

¹⁵ This interview was conducted predominantly in English, but an interpreter was present for most of the interview to provide assistance if the participant struggled to understand anything.

RESULTS AND DISCUSSION

Participants' responses to distress and decisions about whether or not to seek psychological help were congruent with their sense of identity and the norms of the social groups with which they identified. Identity was constructed on an ongoing basis through complex interactions with significant others, social institutions, and abstract cultural principles. Polish cultural values emphasising family closeness, traditional gender roles and discomfort with difference influenced participants' help-seeking strategies. Core values were illuminated by the experience of being a migrant in a different culture. The theory suggests that the interaction of these factors determines migrants' help-seeking decisions. Figure 1 provides a graphical representation of the theory.

FIGURE 1: INFLUENCES ON POLISH MIGRANTS' HELP-SEEKING DECISIONS



Defining Identity.

Personal identity was constructed on an ongoing basis in interaction with Polish, and to a lesser extent Scottish, cultural values. The process of migration led to a need for identity redefinition in light of living in a new country with different cultural values. Participants differed in the extent to which they identified with Polish culture. Often, they appeared to live their lives in accordance with traditional Polish social norms but without directly reflecting upon them, suggesting that cultural values can operate at an implicit, subconscious level. In a culture which differed from their own, cultural differences appeared to lead them to strive to maintain their identity and sense of self through connecting with Polish communities in Scotland. A degree of awareness of cultural values is necessary to take a position on them and to deliberately define one's identity in relation to them. Moving to a different country appeared to cast Polish culture in a new light, and illuminated aspects which may have previously been invisible to participants. If Polish values were thrown into relief by attributes of Scottish culture which were perceived negatively, people appeared to define their identity more strongly in line with traditional social norms. Participants who were involved in Polish community organisations appeared to identify most strongly with Polish culture.

Polishness was not viewed as a unitary construct: indeed, some participants were keen to distance themselves from other migrant groups, such as seasonal migrant workers who were viewed as irresponsible and bigoted. In contrast, participants defined themselves through their commitments to work, family, and life in Scotland, and through compassion and acceptance of others. A minority of participants

emphasised that not all Polish migrants conformed to traditional values; these participants appeared to bring liberal values with them and developed these further in Scotland. They appreciated the greater freedoms that life in Scotland allowed them, were able to reflect upon troublesome aspects of Polish culture, and were clear about what aspects of Polish culture they wholly or partially rejected. Becoming aware of disadvantages to Polish culture through living in Scotland seemed to lead some participants to construct their identity in a way that minimised their connection to such values. Nonetheless, even when Polish values were rejected, identity was still defined in relation to them, even if contradictory or opposing stances are adopted. Therefore, a sense of Polishness appeared to pervade all aspects of participants' lives. Participants' help-seeking decisions were congruent with their sense of identity: those who identified with traditional values tended to reject psychological services as a potential source of assistance. In contrast, those who identified less strongly with these values were more open to the possibility.

Family and Community Networks.

Identity was primarily defined through relationships with others. A feature of all participants' accounts was the central role which family played in their lives. Social relationships within Polish communities were characterised as being somewhat extreme in nature: close inner circles of family and friends were characterised as being warm and friendly, while people outside this inner circle were approached in a reserved, distant and sometimes hostile manner. This may relate to the important functions which close networks of family and friends served in the communist era, allowing occupational advancement, procurement of black market goods, and

protection from being betrayed to the authorities (Kawalek, 1992; Pawlik, 1992; Stan, 2006).

Gossip was identified as a problem in small Polish communities, and was seen as something which had the potential to damage social identity. The fear of gossip may also lead to cautiousness in disclosing personal information to anyone outside one's inner circle, and there was a sense of wanting to keep problems within close family and friendship networks. Being unable to look after one's relatives was considered shameful, as in the case of caring for elderly relatives, and those with learning disabilities or emotional problems. Family was considered so important that others' difficulties would be tolerated or overlooked. Therefore, problems appeared to be contained within the Polish community. Seeking outside help for such difficulties might reflect a rejection of one's family, or a family's inability to cope, which could be viewed negatively by the rest of the community.

Close family and friendship networks provided the first port of call for the majority of participants, and provided financial, practical and emotional support. This was viewed as being protective of emotional well-being. The majority of participants socialised mainly with other Polish people in Scotland. In some instances, this was attributable to language barriers and did not represent a desire to socialise exclusively with others of the same nationality. Participants reported meeting other Polish people through Polish community organisations and language classes, which allowed for the formation of informal support networks which helped people to navigate life in Scotland, while simultaneously creating cohesion within the

community. Without this support, some participants reported that they would have had to return to Poland.

... for a Polish people the most important, especially in the foreign country, it's their family and their friends. And if good, they've got a good contact with them, believe me I would think be all right. Even if they've got their problems, they can go to family or their best friend and say right, I've got that, this kind of problem. And believe me, their friends can help (C2 382–387).

The more highly educated participants appeared to develop friendships more informally through social contacts or through work, sometimes with Scottish people. They were less connected to the Polish community per se, and friendships reflected joint interests and values rather than Polishness. These participants adhered less closely to traditional Polish values and sometimes rejected them, and appeared to have to search more widely to seek out like-minded others with whom to form social networks.

Polish parents appeared to take an involved approach with their children, and saw their role as being to impart cultural values to their children and to ensure they behaved well. These values in themselves were often geared towards preparing the child for adult life in line with Polish social norms emphasising family relationships. Children's health and well-being was seen as a priority by Polish parents, and they were more likely to approach services to seek help for their children than for themselves. A study of Chinese migrants also found that help-seeking for children was prioritised over personal help-seeking (Wong, 1998). This may be associated with less shame than seeking help for personal issues, as children appeared to be viewed as vulnerable, impressionable, and in need of protection in Polish society.

Cultural Norms.

Catholicism.

It was clear from the field work that Catholicism was an importance force in the Polish community in Forth Valley: indeed, a priest was recruited from Poland to meet the demand. Migrants in attendance at Polish events appeared to respond positively to being identified as regular churchgoers by Scottish speakers. Surprisingly, however, only one participant discussed Catholicism. She felt that Catholic values are so embedded in Polish culture that people simply take them for granted. This may help to explain why no further participants discussed these issues.

Under the communist regime, religious expression was suppressed, a paradoxical consequence of which was that Polish people identified Catholicism strongly with Polishness and fought to preserve it (Wróbel, 2005). Martin (1985) suggests that in societies such as Poland where Catholicism has been associated with threatened nationhood, social institutions and leisure activities develop to defend religious norms, resulting in close-knit communities with explicit social rules. All participants' accounts implicitly reflected these values, particularly in their discussions of family, community, and appropriate behaviour. This contrasts with psychotherapy's egocentric focus, meaning that seeking psychological help may be incompatible with Catholic theology (Worthen, 1974).

Gender Roles.

Gender roles in Poland were described by some participants as being fairly traditional. Bystydziński (2001) links this to the support of the Catholic church in maintaining women's traditional gender roles and the belittling of feminism by the communist regime. The majority of participants were married, and appeared content to conform to traditional gender roles. It appeared that although women often worked and were able to have successful professional careers, they were also expected to maintain a slim and attractive appearance, and to take responsibility for all domestic duties. Additionally, they were held responsible when their relationships failed regardless of the underlying reasons, which was associated with considerable stigma. This social structure placed women in a subordinate position while simultaneously putting them under considerable pressure to meet their multiple obligations. For a few women, migrating to Scotland had been a liberating experience, and allowed them to reflect on the pressures on women in Poland and to develop their identities in directions of their choosing. Men were expected to be strong and to provide for their families, and were still seen as the primary breadwinner even when women worked. Male participants felt that the pressures associated with this could lead to additional stress for men. Therefore, Polish men and women appear to face different gender-related stressors.

... the general way things are, the women have children, and they naturally tend to stay at home and look after, especially if there's more children, you know, stay and look after the house. So obviously men have got to go out and find employment, find work and provide for them ... Of course, there are situations in which the man stays at home and the woman would go, would have a better job offer. And it would be better for her to go and work. But the man can feel belittled by this situation. Because of that, because of the stereotype that man should be the head of the family, the breadwinner and all that (C6 248–263).

Coping strategies in relation to distress also appeared to be highly gendered. Female participants coped through utilising a combination of individual and social coping strategies, such as engaging in enjoyable and soothing activities, and talking to friends and family. Nonetheless, they tended to restrict their discussions of relationship problems to a close inner circle, possibly due to fears of being viewed as inadequate wives or mothers if the broader community were aware of their difficulties. For men, it appeared that there could be considerable stigma attached to discussing one's problems, even with one's wife. The impression gained from the male participants was that when faced with difficulties, they did not engage in any coping strategies per se, but felt that they simply had to push on through their problems. Some female participants talked about men coping through alcohol use in Poland. Addis and Mahalik (2003) suggest that men may be less likely than women to seek psychological help due to internalised gender norms about masculinity which emphasise the need for self-reliance and emotional control. The possibility that Polish men have fewer coping strategies available to them than women may make them more vulnerable to the effects of stress, but also less likely to seek assistance. This could mean that men might not receive any assistance until their problems develop into a crisis.

Rejection of Difference.

Polish history may have led to a perception of difference as being dangerous. Conditions during World War II and the subsequent communist regime meant that standing out often had grave consequences. For instance, during Nazi occupation,

many social groups whose social identity did not conform to Aryan ideals were persecuted and sometimes exterminated, including those with mental health problems and learning disabilities (Mostert, 2002). Although the communist regime did not persecute people to the same extent, oppressive forces continued to operate. Many people were forced to collaborate with the secret police and spy on their neighbours, and any suggestion of political dissidence or practices perceived by the state as socially deviant could lead to interrogation and harsh penalties (Checinski, 1982). Thus, historically there have been considerable social pressures to conform in Poland. This is likely to have been created, somewhat paradoxically, by both a desire to maintain national identity in the face of attempts to suppress it, and the devastating consequences which could result from standing out under the oppressive political regimes.

A likely consequence of this is that intolerance of difference continues to pervade Polish culture today, particularly in rural areas. Institutional and social discrimination towards gay people, people with disabilities, the elderly, teenage mothers, single mothers, childless women over a certain age, and single women was described by participants. There are perhaps two key issues here. Social care services in Poland are underfunded, and the organisation of the welfare system means that the majority of disabled people are cared for by their families (Kerlin, 2005; Siemieńsak & Domaradzka, 2009). Therefore, people from marginalised social groups in Polish society are likely to be less visible due to their inability to access social resources. Secondly, people who deviate from traditional values, including women and gay people, may face prejudicial treatment.

There was some evidence of discrimination towards those with psychiatric problems in Poland, although this relationship was not completely straightforward. It appeared that a distinction was made between everyday distress attributable to life events and severe mental health problems, with the latter being viewed in a far more stigmatising manner. Expression of emotional distress in response to everyday stressors appeared to be part of everyday Polish life, and was considered culturally acceptable.

Reactions to others' expressions of distress related to whether their behaviour was seen as understandable or abnormal. In general, participants attributed distress to life events, such as divorce, and considered it reasonable for people to become distressed and to seek help under these circumstances. Although participants expressed sympathy towards others experiencing difficulties, stigmatising attitudes were implicit in some of their accounts. Further, some participants described negative social consequences associated with being identified as someone with mental health problems.

That's a total catastrophe and you can't even admit that you have any mental problems. If you go to psychologist, it's pretty bad. If you go to psychiatrist, you are straight away the dumbest people in the world ... you're a total idiot, something like that. And there's no respect for you whatsoever. People that go just to talk with the psychologist when they have some, when they would like to talk to someone, they never talk about this. They never tell their friends. They only keep it to themselves. It's the biggest secret and no-one should know about it because you will get criticised straight away. And these two professions, psychologist and psychiatrist, are really bad professions in Poland and the people are very resistant to seek help (C4 276–286).

Gilbert (1992) considers that maintaining one's social position within one's community has a profound impact on emotional well-being; therefore people may avoid contact with mental health services to avoid being stigmatised.

Urban–Rural Class Divide.

Participants' decisions about where to settle were influenced by their migration goals. Fóti (2009) suggests that the majority of migrants from Poland come to the UK for economic reasons, including high rates of unemployment in their home country. This was reflected in many community members' accounts. As Forth Valley contains several factories offering employment to unskilled migrant workers, this may have made it an attractive location for them. Furthermore, it is possible that rural areas in Scotland may appeal due to similarities to the geographical areas in Poland from which migrants originate. Thus, migrating to Scotland represented a rational choice to improve their situations.

Motivations for migrating may be different for migrants from urban areas, which did not suffer from the effects of communism to the same degree (Wróbel, 2005). An impression was gained that people from urban, middle-class social groups in Poland are less likely to have been affected by economic hardship, may be more likely to migrate for reasons such as adventure and independence, and might be more attracted to urban centres than rural areas. Several participants described attitudinal differences between urban and rural Poland, and suggested that migrants from economically deprived areas of rural Poland might hold more traditional values.

Attitudes towards seeking psychological help also appeared to vary between participants from urban and rural areas. Psychological service provision in rural areas in Poland was described as sparse, and seeking help was associated with considerable stigma and fears of gossip. In contrast, engaging in therapy was described as being fashionable in middle-class, urban Poland, and even as necessary for self-actualisation.

... people talk about it openly among my friends. And always the people that live in, I think, like Warsaw, Krakow, Wroclaw, Posnan, wherever ... it's kind of maybe a sort of fashion thing, you know. It was kind of, you know, you're not fully yourself if you don't dig deep. And who can help you? A psychologist can find you the real you and kind of get rid of all the baggage, because everybody's got all that baggage you know, from the families and all that, and I think people now uh, they kind of use it as I kind of, you know, 'You've never, you know, done any therapy. You're all entangled inside and you're not a real person' (C7 827–838).

Social Institutions.

Experiences with General Health Services.

In Poland, the private sector is far more developed than in Scotland. Millard (1995) notes during the communist era, healthcare provision was inadequate and many doctors supplemented their incomes through private practice. The private sector expanded rapidly at the end of the communist era. Due to corruption and bribery in the public sector, people often preferred to access private services where they could access specialists without being referred by a GP (Millard, 1995).

As many participants were accustomed to being able to quickly access specialist care when they wanted to, they felt disappointed when the NHS failed to deliver in a similar manner to the private sector in Poland. Participants perceived a difference in

prescribing practices between Poland and Scotland, with doctors in Poland prescribing more drugs than Scottish doctors, which the majority of participants appeared to equate with good treatment. Many participants were dissatisfied at what they perceived as dismissive treatment on the part of Scottish GPs when they did not receive medication or swift referrals to specialists.

This perception of being dismissed led to a reluctance to access GP services. Participants sometimes questioned Scottish GPs' motives, which were seen to reflect a desire for personal advancement or to adhere to government drivers rather than a commitment to patient care. Participants who were dissatisfied with their contacts with physical health services tended to reject psychological services as a relevant option to them.

... believe me if they've got some mental problem, they didn't go to Scotland. Eh, doctors. Because if they go to the Scotland's doctors with the tooth pain or stomach pain and they giving them with fatty meals, if he's got with the mental problem, aye. You can think well, whatever that person can think what the doctor can say. So believe me, nobody who's got a mental problem eh, and has got eh, experience with the Scottish health service don't go (C2 397–403).

However, several participants felt that Polish GPs over-prescribed medications because that they were poorly paid and could gain extra benefits from the pharmaceutical industry for prescribing particular medications. These participants tended to be more understanding of Scottish GPs' approach, and were more open to the possibility of seeking help for distress through the NHS.

Experiences with Mental Health Services.

Past experience of mental health services appeared to lead more positive views of these services and the notion of seeking help from them. Although only two participants had accessed mental health services directly in Poland, many had indirect experience through friends who had accessed these services. Participants with experience of mental health services appeared to view such services more positively, and generally viewed the help received as effective. Benefits of therapy were construed in terms of being able to function again in line with Polish social norms, in particular being able to fulfil family and work obligations.

Although most participants preferred to confine their help-seeking activities to their inner circle, those who had sought help could identify the benefits of going outside this group: this related to the fear of gossip and social repercussions. Thus, help-seeking attempts which were seen to jeopardise social relationships were avoided, while help-seeking was pursued if this had the potential to preserve one's position within a social group.

... I have this comfort that once I told the specialist what's wrong with me, we will never come back to this conversation. It's like you throw your, I don't know, your issues, your feelings to the well, and no echo will come back up. And if you talk about your problems with your friends, you are still around them, they might come back to it, and you might not want it (C3 471–476).

Participants who had no previous contact with mental health services in Poland appeared to hold more negative views towards them. A key informant suggested that some psychologists and psychiatrists benefited from the communist regime, possibly

due to the social status which it afforded them. There have been reports of psychiatric abuse in communist Poland (Rich, 1982; Subcommittee on Human Rights and International Organizations, 1983), which may have contributed to a distrust of services. Some participants with no experience of mental health services feared that such contact could exacerbate problems.

Participants felt that people who became distressed in Poland were highly motivated to get better in order to re-engage in valued social roles, and might seek help to aid this process. Several participants expressed surprise at their perception that people in Scotland appeared to actively seek psychiatric diagnoses, which they sometimes linked to a desire to escape responsibility. Some participants stated that they would seek psychological help only when attempts to resolve difficulties by themselves or within the family unit had failed, and when they reached a point when they were unable to conceal their difficulties from others. However, it appeared from participants' accounts that seeking help within their social groups is usually effective: reserving formal help-seeking for severe difficulties seems sensible in this context.

Although some participants noted that they would be prepared to seek NHS psychological services if necessary, one participant reported that she would prefer to seek private services from a Polish counselling organisation. Advertisements by Polish therapists in Scotland in the Polish media were also described. A preference for seeking help from Polish services may reflect communication issues, but it is possible that experiences of services in Poland also play a role. Seeking help from private services was valued, and it is possible that these services are viewed as more

acceptable than state services. Furthermore, migrants appeared keen to keep their problems within the Polish community, and seeking services from Polish organisations and individuals may be more congruent with this desire than seeking NHS services.

Communication.

All participants discussed the difficulties created by language barriers in Polish migrants' broader lives. Some non-English speaking participants reported feeling comfortable communicating through interpreters; however, others felt that it would be difficult to disclose personal information with an interpreter present. Even when information is interpreted correctly, there is still the potential for the meaning of participants' discourse to be lost in translation. These issues were not exclusive to non-English speaking participants. Some words and concepts may have no direct equivalent in another language, making it difficult to express certain emotions (Bortfeld, 2003; Watkins, 1989).

... psychology is a funny area really, because although you might speak good English, it might be quite difficult to communicate different, certain emotions, or to communicate certain feelings in English even though you are able to communicate quite proficiently otherwise (K1 31–35).

Communication styles also vary between cultures (Gudykunst & Matsumoto, 1996). Polish communicative styles appeared to be more direct than Scottish styles, while Scottish people were characterised as being polite but distant. It was suggested that this could lead to misunderstandings in consultations with health services.

Therefore, communication appears to impact on how and from whom help is sought. The most obvious manifestation of this is the language barrier, but more subtle processes, such as differences in cultural values and communicative style, may also hinder the process of communication.

Summary and Conclusions.

Polish migrants' decisions about whether to seek psychological help were consonant with their sense of identity, which developed in interaction with cultural norms, community and family relationships, and experiences with social institutions. Approaching services for assistance with emotional problems was incongruent with traditional Polish cultural values, and participants who strongly identified with these values rejected psychological services as a relevant option to them, preferring to deal with their problems on their own or within their social networks. Participants who had more conflictual relationships with traditional Polish cultural values and who identified with social groups where therapy was seen as socially acceptable were more open to this option, although on occasion, a preference for seeking help from Polish therapists in the private sector was expressed. Experiences with health services also impacted on participants' decisions on how to deal with problems; negative experiences were associated with a reluctance to approach services again in future. This highlights the need for services to consider ways of working with migrants which are in line with cultural norms and values, possibly through partnership work with agencies who migrants are more comfortable approaching.

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APPENDICES

**APPENDIX A: VARIABLES MEASURED IN
QUANTITATIVE STUDIES**

APPENDIX A: VARIABLES MEASURED IN QUANTATIVE STUDIES

Study	Independent Variables	Dependent Variable
Barry & Grilo (2002)	Gender: male vs. female Age: continuous variable Length of residence: continuous variable English fluency: unclear how measured Acculturation: East Asian Acculturation Measure (EAAM; Barry, 2001) Self-Constraint: Self-Constraint Scale (SCS; Singelis, 1994) Ethnic identity: East Asian Ethnic Identity Scale (EAEIS; Barry, 2002) Distress: Hopkins Symptom Checklist (HSCL; Derogatis et al, 1971)	Willingness to seek psychological help: single item
Barry & Mizrahi (2005)	Self-disclosure: Guarded Self Disclosure Inventory (GSDI; Barry, 2003)	Willingness to seek psychological help: single item
Bassaly & Macallan (2006)	Acculturation: Polish Cultural Attitudes questionnaire (PCA; adapted from Cuban ethnic attitudes questionnaire; Fernandez, 1988) Resilience: Ego Resiliency questionnaire (Block & Kremen, 1996)	Attitudes towards seeking psychological help: adapted version of Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPHS; Fischer & Turner, 1970)
Beckwith (2005) <i>Unpublished doctoral dissertation</i>	Gender: male vs. female Age: continuous variable Length of residence: continuous variable Marital status: married vs. single/divorced/widowed Language spoken at home: English vs. Russian Socioeconomic status: Four-Factor Index of Social Status (SES; Hollingshead, 1975) Acculturation: Soviet-Jewish Acculturation Measure-II (SAM-II; Ben-Rafael <i>et al.</i> , 2005. Social networks: Network Orientation Scale (Vaux <i>et al.</i> , 1986)	Attitudes towards seeking psychological help: ATSPPHS

Study	Independent Variables	Dependent Variable
Cabassa (2005) <i>Unpublished doctoral dissertation</i>	General health status: single item (Fayers & Sprangers, 2002) Life time use of general medical providers for mental health problems: yes vs. no. Perceptions of depression: Illness Perceptions Questionnaire (IPQ-R, Moss-Morris <i>et al.</i> , 2002) Attitudes towards depression treatments: Patient Attitudes Toward and Ratings of Care for Depression short version (PARC-D; Cooper <i>et al.</i> , 2000) Family and friends' attitudes towards help-seeking: measure developed from Theory of Planned Behaviour (Fishbein & Ajzen, 1975)	Intentions to seek professional help: measure developed from Theory of Planned Behaviour (Fishbein & Ajzen, 1975)
Cabassa and Zayas (2007)	Gender: male vs. female Age: continuous variable Years of education: continuous variable Acculturation: Bidimensional Acculturation Scale for Hispanics (BAS; Marín & Gamba, 1996) Depression: Center for Epidemiological Studies Depression Scale (CES-D; Radloff, 1977) General health status: single item (Fayers & Sprangers, 2002) Past use of a mental health professional: yes vs. no Life time use of general medical providers for mental health problems: yes vs. no. Total access barriers endorsed: measure based on Manos <i>et al.</i> (2001) Perceptions of depression: Illness Perceptions Questionnaire (IPQ-R, Moss-Morris <i>et al.</i> , 2002) Attitudes towards depression treatments: Patient Attitudes Toward and Ratings of Care for Depression short version (PARC-D; Cooper <i>et al.</i> , 2000) Family and friends' attitudes towards help-seeking: measure developed from Theory of Planned Behaviour (Fishbein & Ajzen, 1975)	Intentions to seek professional help: measure developed from Theory of Planned Behaviour (Fishbein & Azhen, 1975)

Study	Independent Variables	Dependent Variable
Derry (1996) <i>Unpublished doctoral dissertation</i>	Gender: male vs. female Age: continuous variable Length of residence: continuous variable Location of education: South Asia vs. elsewhere Cultural assimilation: measured designed for purposes of study	Amenability to psychotherapy: measure designed for purposes of study
Fruchtbaum (1995) <i>Unpublished doctoral dissertation</i>	Gender: male vs. female Vignette sex: male vs. female Disorder depicted in vignette: panic vs. depression Scores on physical, psychological, social, and spiritual causes from modified version of Narikiyo's (1991) Causal Attributions and Help-Seeking Questionnaire (NCAHSA)	Modified version of NCAHSA (help-seeking attitudes section)
Fung & Wong (2007)	Age: continuous variable Years of education: continuous variable Acculturation: Vancouver Index of Acculturation (VIA; Ryder <i>et al.</i> , 2000) Causal attributions: Mental Distress/Illness Explanatory Model Questionnaire (MDEMQ; Eisenbruch, 1990) Access: measure designed for purposes of study	ATSPPHS
Knipscheer & Kleber (2001) – Study 1	Gender: male vs. female Age: continuous variable Length of residence: continuous variable Educational level: low, middle, or high (no further details provided) Source of income: job, benefit or no income Ethnicity: Hindustani vs. Creole	Attitudes towards help-seeking: single item
Knipscheer & Kleber (2005)	Gender: male vs. female Age: continuous variable Length of residence: continuous variable Childhood surroundings: urban vs. rural Educational level: low, middle or high (no further details provided) Source of income: paid job vs. benefit	Attitudes towards help-seeking: single item

Study	Independent Variables	Dependent Variable
Mo <i>et al.</i> (2007)	Age: continuous variable Length of residence: continuous variable Education level: less than grade school, some high school, high school graduate, or some college Household income: less than Hong Kong \$5,000; HK\$5,001–10,000; HK\$15,001–HK\$20,000; or more than or equal to HK\$20,001 Acculturation: measure designed for purposes of study Enculturation: measure designed for purposes of study Acculturative stress: measure designed for purposes of study General stress: measure comprising Daily Hassles Scale (Kanner <i>et al.</i> , 1981) and Social readjustment ration Questionnaire (Holmes & Rahe, 1967)	Help-seeking attitudes: measure adapted from Kung (2003)
Sheikh (2000)	Gender: male vs. female Suinn–Lew Asian Self-Identity Acculturation Scale (SL-ASIA; Suinn <i>et al.</i> , 1987) Attitudes Toward Women Scale – Short Form (AWS; Spence <i>et al.</i> , 1973)	ATSPPHS

**APPENDIX B: CHARACTERISTICS AND
PSYCHOMETRIC PROPERTIES OF
MEASURES USED IN QUANTATIVE
STUDIES**

APPENDIX B: CHARACTERISTICS AND PSYCHOMETRIC PROPERTIES OF MEASURES USED IN QUANTITATIVE STUDIES

MEASURES OF ATTITUDES TOWARDS HELP-SEEKING

Attitudes Towards Seeking Professional Psychological Help Scale (ATSPPHS, Fischer & Turner, 1970).

Fischer and Turner (1970) developed items for the ATSPPHS from a pool of 47 potentially relevant items suggested by clinical psychologists; the 31 thought to be most relevant by a panel of 14 clinicians were initially included. Items were scored on a four-point Likert scale. After pilot testing with two groups of students, comprising 97 and 115 participants respectively, two items were dropped as they correlated poorly with the overall attitude score. Four subscales were derived from factor analysis of the responses of 424 college students: recognition of need for psychological help (eight items); stigma tolerance (five items); interpersonal openness (seven items); and confidence in mental health practitioner (nine items). Internal reliability using Tyron's (1957) method for the overall scale was found to be 0.86 on the initial standardisation sample, and 0.83 on a later sample of 406 participants, indicating good internal consistency. Reliability estimates for each factor using Tyron's (1957) method ranged from 0.62 for interpersonal openness to 0.74 for confidence, suggesting that some subscales may not be optimally reliable. Inter-correlations ranged from 0.25 (openness–confidence) to 0.35 (stigma–confidence), suggesting that the factors were reasonably independent. Test-retest reliability was established by administering the measure to five groups of students at various intervals from five days to two months: reliability was good and ranged from

0.73 in a group of 19 students at six weeks, to 0.89 in a group of 47 students at two weeks.

The ATSPPH was used in four studies included in the systematic review (Bassaly & Macallan, 2006; Beckwith; Fung & Wong, 2007; Sheikh, 2000). Both Beckwith (2005) and Fung and Wong (2007) made minor amendments to the scale in order to make it more applicable to these participants, but these changes did not appear to substantially alter the items conceptually. Beckwith (2005) and Sheikh (2000) did not provide details of the internal consistency of the scale in their samples. Fung and Wong (2007) reported internal consistencies ranging from 0.71 to 0.83 (Cronbach's alpha) across the groups included in their study, which seems acceptable. On the other hand, Bassaly and Macallan (2006) made substantial modifications to the scale, dropping some items and including additional items from their pilot study. As they did not provide any psychometric data on the modified version which they used, it is not possible to establish its reliability or validity in this sample. Overall, this seems like a reasonably reliable and valid scale, and as it has been used in several different ethnic groups, appears to have reasonable cross-cultural validity.

Measure Adapted from Chinese American Psychiatric Epidemiology Study (CAPES; Kung, 2003).

Mo *et al.* (2007) used a measure adapted from the CAPES, which included a list of sources from which participants might seek help for psychological problems. The original study appeared to select the items included in the measure in a rather arbitrary fashion, and did not provide psychometric data on the scale. Participants were asked to rate the possibility of seeking help from several sources on a four-

point Likert scale, and to indicate whether they had every sought help from these sources. Mo *et al.* (2007) report that internal consistency for the mental health professionals subscale, which included psychologists and psychiatrists, was 0.83. However, they provide no further psychometric data.

Amenability to Psychotherapy Scale (Derry, 1996).

Derry (1996) designed a 62 item Attitudinal Questionnaire for the purposes of her study to elicit attitudes towards various cultural values, customs, and help-seeking behaviours. It incorporated two subscales, one of which measured Amenability to Psychotherapy. She reports that the questionnaire was designed after reviewing the results of the pilot study and other scales measure similar constructs, but provides no details on the pilot study itself. Although she states that split-half correlations were conducted to assess reliability, no data is provided on this. She reports that the scale has as high degree of face and content validity; however, the construct validity of the scale is not clear. Further, assessing test-retest reliability may have been helpful. Overall, she does not provide sufficient data to assess how reliable and valid the scale actually is.

Single Item Measures.

Barry and Grilo (2002) and Barry and Mizrahi (2005), using the same participants, included a single self-report item, scored on a 7-point Likert scale, to assess willingness to seek psychological services: 'If I felt depressed for a long period of time, I would go see a psychologist' (p.35, p.53). This question is problematic, as it does not assess participants' views on seeing a psychologist for other problems, or

problems that had existed for a shorter amount of time. Clearly, as a single item, it is not able to assess other aspects of willingness to seek psychological services, and is a very crude attitudinal measure.

In a structured interview, Knipscheer and Kleber (2001, 2005) asked participants, 'Would you ever consider visiting a doctor, psychiatrist or psychologist in connection with a nervous or emotional problem?' The answer format in Knipscheer and Kleber's (2001) study was 0 = 'no', 1 = 'Would consider but probably yes', and 2 = 'yes, definitely'. Knipscheer and Kleber (2005) initially recorded responses to the question in an open format, and later categorised them into '0 = no, definitely not, 1 = would have to consider but likely yes, 2 = yes, certainly' (p. 375). However, they do not report any inter-rater reliability data on this. This also appears a rather crude measure of attitudes towards help-seeking.

MEASURE OF ACCULTURATION AND ETHNIC IDENTITY

East Asian Acculturation Measure (EAAM; Barry, 2001).

Barry (2001) developed the items from this measure from a qualitative study of 18 East Asian students' social interaction and communication styles with both American peers and those from their own ethnic group in a range of different settings (Barry, 1999), and from Berry's (1980) model of acculturation. Thus, subscales measuring assimilation (eight items), separation (seven items), integration (five items), and marginalisation (nine items) were developed, although this appears to have been done in a deductive manner rather than by using statistical procedures such as factor analysis. Items are scored on a 7-point Likert scale. Focus groups were conducted

with pilot participants to check the draft EAAM for meaning and clarity and the measure was revised accordingly: this is likely to have enhanced content validity. The measure was then standardised on 150 East Asian immigrant students. Cronbach's alphas ranged from 0.74 for the integration subscale to 0.85 for the marginalisation subscale, indicating good internal consistency. Cronbach's alpha coefficients for item–total correlations appeared adequate. Limitations of this measure include the limited number of items per subscale, and the fact that the subscales were derived pragmatically rather than statistically. Barry and Grilo (2002) used the EAAM to predict attitudes toward help-seeking in their analysis.

East Asian Ethnic Identity Scale (EAEIS; Barry, 2002).

Barry (2002) constructed this measure from the same qualitative study as that used in the development of the EAAM (Barry, 1999). Items were developed to address the main themes identified in the qualitative study, and items selected by these participants from existing measures of similar constructs were also included (Multigroup Ethnic Identity Measure, Phinney, 1992; Ethnic Identity Scale, Meredith, 1967; the Ethnic Identity Questionnaire, Connor, 1997). To enhance content validity, the resulting measure was reviewed by focus groups of pilot participants, and revised accordingly. The measure was then administered to the same 150 participants who comprised the standardisation sample for the EAAM. Factor analysis resulted in three subscales: family values (14 items); ethnic pride (13 items); and interpersonal distance (13 items). Items with a factor loading of less than 0.40, those which loaded significantly onto more than one factor, those which reduced the Cronbach's alpha for the subscale, and those which did not fit

conceptually with other factor items were dropped. A further item was dropped because it was highly correlated with another item which made a greater contribution to the factor's internal consistency. This resulted in 40 items being included in the final measure. Items are scored on a seven point Likert scale. Cronbach's alphas were 0.81 for family values, 0.85 for ethnic pride, and 0.80 for interpersonal distance, and 0.80 for the overall scale, indicating good internal consistency. Therefore, overall the measure appears to have good internal consistency and face and content validity. However, it may have been useful to assess test–retest reliability. The EAEIS was used in Barry and Grilo's (2002) study.

Polish Cultural Attitudes Questionnaire (PCA; Bassaly & Macallan, 2006).

Bassaly and Macallan (2006) adapted this measure from the Cuban Ethnic Attitudes Questionnaire (Fernandez, 1988). It is unclear why they chose a measure developed for Cubans and applied it to Polish migrants: it is possible that there may be similarities between the cultures, but they did not offer any explanation of this. The 48 items of the measure map onto four subscales with 12 items each derived from Sue and Sue's (1990) Minority Identity Development model: conformity, resistance, transition, and awareness. As the unpublished study in which the development of this scale is described could not be obtained, it was not possible to establish its psychometric properties. Furthermore, Bassaly and Macallan (2006) provide no psychometric data on their adapted version.

Soviet-Jewish Acculturation Measure – II (SAM-II; Ben-Rafael et al., 2005).

Beckwith (2005) used this 40 item self-report measure, which includes items on cultural interests, values, and identity. Acculturation is measured by level of agreement on a four-point Likert scale. He reports that a Russian language version has previously been tested, and states that internal reliability has previously been reported as 0.83 for the involvement in US culture subscale, and 0.85 for the level of involvement in Soviet-Jewish culture subscale. However, it was not possible to access the book in which the development of this measure was described.

Bidimensional Acculturation Scale for Hispanics (BAS; Marín & Gamba, 1996).

Marín and Gamba (1996) developed this measure by identifying measurable behaviours from the literature in relation to individual acculturation along two cultural orientations: Hispanic culture and non-Hispanic culture. Initially, 60 items relating to 30 types of acculturative changes were included. This measure was administered to a random sample of 254 Hispanic residences of San Francisco. A factor analysis was conducted. Items were retained if their loading onto a particular factor was greater than 0.45, and they had low loadings on all other factors, and if they loaded onto the same factor regardless of their cultural domain. Subscales with at least three items per cultural domain were retained for further analyses. This resulted in three language-related factors and a celebrations factor being identified. However, the celebrations factor was dropped due to poor internal consistency. The resulting questionnaire included 24 items measured on a four-point Likert scale. The three subscales were: language use (6 items), linguistic proficiency (12 items), and

electronic media (six items). Internal consistencies were good, and ranged from 0.81 for the Hispanic domain electronic media subscale to 0.97 for non-Hispanic domain Linguistic proficiency. Internal consistency for the overall measure was 0.90 for the Hispanic domain and 0.96 for the non-Hispanic domain.

Concurrent validity was established by comparing scores to those obtained on the Short Acculturation Scale for Hispanics (SASH; Marín *et al.*, 1987). Subscale correlations ranged from -0.56 for the Hispanic domain of the linguistic proficiency subscale to -0.88 for the Hispanic domain of the language use subscale. The overall correlation for the non-Hispanic domain was 0.88, and was -0.84 for the non-Hispanic domain. No further tests of reliability were conducted. A limitation of this measure is that it focuses on language use, and does not incorporate other cultural markers.

This measure was used by Cabassa (2005; Cabassa & Zayas, 2007), who categorised participants as being high or low on both domains using a cut-off score of 2.5. Those with high scores on the Hispanic domain and low scores on the non-Hispanic domain were categorised as being unassimilated, while those with high scores on both domains were categorised as being bicultural. This could be interpreted as something of an over-simplification of acculturative processes.

Cultural Assimilation (Derry, 1996).

Derry (1996) designed this measure for the purposes of her study, as she could not identify any existing measures which assessed acculturation in Indian populations. The psychometric properties of this scale are not clear: see the discussion of her Amenability to Psychotherapy scale above.

Vancouver Index of Acculturation (VIA; Ryder *et al.*, 2000).

Ryder *et al.* (2000) developed this instrument to measure identification with several aspects of host and heritage culture, including values, social relationships, and adherence to traditions. Items are measured on a nine-point Likert scale. The measure was an adaptation of an earlier version of the VIA (Ryder *et al.*, 1999). Initially, two items were included for each of 15 domains thought to be relevant. This measure was administered to a population of 414 students of Chinese descent, non-Chinese East Asian descent, and non-English-speaking (excluding Chinese and East Asian descent). The participants were randomly split into two subsamples. Reliability analysis and principal components factor analysis were performed on one half of the sample, resulting in five items pairs being dropped: these items either lowered scale reliability or did not clearly load onto a single principal component. The resultant measure was validated on the second half of the sample: close convergence between samples was observed.

High internal consistencies were found for both dimensions across cultural groups, ranging from 0.85 for mainstream culture in the East Asian group to 0.92 for the heritage dimension in the East Asian group. Low negative correlations were found

between the dimensions across groups. Both subscales were significantly related to the Suinn–Lew Asian Self-Identity Acculturation Scale (SL–ASIA; Suinn *et al.*, 1987) in Chinese and East Asian groups (this measure was not administered to the other group), indicating good concurrent validity. Therefore, this measure appears to have good reliability and validity. In Fung & Wong's (2007) study, Cronbach's alpha for the subscales ranged from 0.82 to 0.90 across the ethnic groups.

Acculturation and Enculturation Scales (Mo *et al.*, 2007).

Mo *et al.* (2007) designed two scales measuring acculturation and enculturation respectively. They state that the format of the items was modelled after the general Ethnicity Questionnaire (GEQ; Tsai *et al.*, 2000), on which participants rate the extent to which they identify with items relating to Mainland China and Hong Kong. The scales incorporated six items on language proficiency, five items on personal preferences, five items on social affiliation, four items and lifestyle, and four items on attachment to values and traditions. Items were measured on a six-point Likert scale. Cronbach's alpha was 0.78 for the acculturation scale and 0.71 for the enculturation scale. However, they provide no further details on how these measures were developed, or whether any further tests of reliability and validity were conducted.

Acculturative Stress (Mo *et al.*, 2007).

Mo *et al.* (2007) also designed a nine item measure of acculturative stress for their study. They report that items were selected based on the acculturative stressors most commonly reported by Chinese female immigrants in Hong Kong in studies by Chan

(1999) and the Hong Kong Federation of Trade Union Social Policy Committee (2004). Items were measure on a six point Likert scale. Cronbach's alpha for the measure was 0.86. Again, no further psychometric data on this measure was provided.

Suinn–Lew Asian Self-Identity Acculturation Scale (SL–ASIA; Suinn *et al.*, 1987, 1995).

The SL–ASIA (Suinn *et al.*, 1987, 1995) is a unidimensional measure of acculturation. Items are measured on a five point multiple choice scale with high scores indicating identification with Western culture, low scores indicating identification with Asian culture, and intermediate scores indicating bicultural identity. The original measure was based on the Acculturation Rating Scale for Mexican Americans (Cuellar *et al.*, 1980), and contains 21 questions covering six domains: language; identity; friendship choice; behaviours; generation/geographic history; and attitudes. A subsequent factor analysis by Suinn *et al.* (1995) suggested five factors: reading/writing/cultural preferences; ethnic interaction; generational identity; affinity for ethnic identity and pride; and food preferences. These factors differ from those originally proposed by Suinn *et al.* (1987).

Reliability was assessed by Suinn *et al.* (1987) in a group of 82 first to fifth generation Asian university students in the USA, and by Suinn *et al.* (1995) in a group of 324 US university students, resulting in alpha coefficients of 0.88 and 0.91 respectively.

Suinn *et al.* (1987) validated the measure by comparing scores with variables thought to be associated with acculturation; scores increased with generation level and length of residence. However, as only descriptive data are provided, it is not possible to assess whether or not these associations were statistically significant. Furthermore, Suinn *et al.* (1995) compared the scores of 324 Asian–American students with those of 118 Singaporean students, and found that acculturation scores were higher for the Asian–American group

Sheikh (2000) used 14 items from the version developed by Suinn *et al.* (1995), although it is not clear how these were selected. However, she provides no psychometric data on her modified version, making it difficult to assess its reliability and validity.

MEASURES OF SELF-CONSTRUAL AND SELF-DISCLOSURE

Self-Construal Scale (Singelis, 1994).

In order to develop this scale, Singelis (1994) rewrote items from existing measures of similar concepts to focus on individual self-construal, resulting in an initial pool of 45 items. Items are measured on a seven-point Likert scale. This measure was administered to 364 students of a range of ethnic backgrounds in Hawaii. Factor analysis revealed two factors. Items which did not load strongly onto either factor or which loaded equally onto both factors were deleted, resulting in a 24 item measure. Cronbach's alpha was 0.69 for the independent self-construal subscale and 0.73 for the interdependent self-construal subscale. Confirmatory factor analysis indicated that the two-factor model provided a better fit than a one-factor model for the data.

In a confirmatory factor analysis with a second set of 165 students, Cronbach's alphas was 0.70 for the independent self-construal subscale and 0.74 for the interdependent self-construal subscale, indicating reasonable internal consistency. Again, the two-factor model provided a better fit than a one-factor model.

Construct validity was established by comparing Asian Americans to Caucasian Americans: Asian Americans scored significantly higher on interdependent self-construal, and Caucasian Americans scored significantly higher on independent self-construal. Predictive validity was assessed by presenting participants with vignettes of conversational interactions and asking them to rate the degree to which the situation had influenced the conversant's reply to a request: they state that members of collectivist cultures attribute greater influence to the situation than the individual. The interdependent subscale (but not the independent subscale) was a better predictor of situational attributions than ethnicity, suggesting that the scales have a degree of predictive validity. Therefore, this scale appears to have reasonable psychometric properties. In Barry and Grilo's (2002) study, internal consistencies (Cronbach's alpha) were 0.67 for independent self-construal and 0.70 for interdependent self-construal; therefore, the independent self-construal scale may not be entirely reliable.

Guarded Self-Disclosure Inventory (GSDI; Barry, 2003).

Barry (2003) developed this eight-item measure from a qualitative study of 18 East Asian students. Items comprising the measure were then reviewed by focus groups of these participants, enhancing content validity. Factor analysis suggested a three factor solution explaining 59 per cent of the variance. Subscales included privacy,

self-concealment, and conflict avoidance. Item–total correlations were reasonable. Cronbach's alphas were 0.64 for privacy, 0.50 for self-concealment, and 0.71 for the overall scale. This suggests that the subscales lack internal consistency, probably due to the small number of items in each. No further tests of reliability were reported. Barry and Mizrahi (2005) report on data from the same study.

MEASURES OF DISTRESS AND RESILIENCE

Ego Resiliency Scale (Block & Kremen, 1996).

Block and Kremen (1996) evaluated a 14 item version of a previous ego resiliency scale designed by the authors. Internal consistency was 0.76. Test–retest reliability over a period at five years was 0.67 for a female sample and 0.51 for a male sample after attenuation effects had been corrected for, indicating moderate test–retest reliability. Bassaly and Macallan (2006) used this measure to predict attitudes towards help-seeking.

Hopkins Symptom Checklist (HSCL; Derogatis et al., 1974).

Derogatis *et al.* (1974) describe the development of this 58 item measure, which is administered by clinical interview. In order to establish construct validity, experienced clinicians were asked to assign the symptoms described in the HSCL to homogeneous clinical clusters based on their clinical experience. Symptoms assigned with a high level of consistency were retained. A five factor solution was suggested by factor analysis. In the standardisation sample, Cronbach's alphas ranged from 0.84 for anxiety to 0.87 for somatisation and obsessive–compulsive, indicating good internal consistency. Test–retest correlations ranged from 0.75 for

anxiety to 0.84 for obsessive–compulsive. Inter-rater reliability correlations ranged from 0.64 for depression to 0.80 for interpersonal sensitivity. Therefore, while the scale appears to have reasonable reliability and validity from a statistical point of view, the fact that inter-rater reliability was not as strong raises the question of how meaningful and valid these diagnostic categories are.

Barry and Grilo (2002) and Barry and Mizrahi (2005) report Cronbach's alphas of 0.82 for somatisation; 0.83 for obsessive-compulsiveness; 0.80 for interpersonal sensitivity; 0.86 for depression; and 0.74 for anxiety; and 0.95 for the total score in their study, indicating good internal consistency.

Center for Epidemiological Studies Depression Scale (CES–D; Radloff, 1977).

Radloff (1977) initially selected CES–D items from previously validated depression scales. Items are measured on a four-point Likert scale. She reports that:

Pretests on small 'samples of convenience' indicated appropriate performance of the scale and guided minor revisions for clarity and acceptability (p.386).

However, she presents no further data to support this claim. Twenty items were included in the scale. The CES–D was incorporated into two versions of another questionnaire which was administered by interview to a probability sample of households in Kansas City and Washington County: response rates were 75 per cent for both versions. Alpha coefficients for the scale ranged from 0.84 in white

community members who were re-interviewed to 0.90 in a clinical sample, indicating good internal consistency.

Participants who completed the second version were sent a questionnaire by mail at intervals of two, four, six or eight weeks after the original interview: the response rate was 56 per cent. Second interviews were also attempted with participants at various intervals from three to 12 months; this was achieved with 78 per cent of participants in Kansas City and 79 per cent of participants in Washington County. Test-retest correlations ranged from 0.51 at two weeks to 0.67 per cent at four weeks for participants who posted back questionnaires, and from 0.32 in the Kansas City group re-interviewed at 12 months to 0.54 in the Washington County group re-interviewed at 6 months, indicating moderate test-retest reliability. However, depressive symptoms cannot necessarily be expected to remain stable over time.

Additionally, a sample of 35 psychiatric in-patients diagnosed with depression were administered the CES-D, the Rockliff Depression Rating Scale (RDRS; Rockliff, 1971), and the Hamilton Rating Scale (HRS; Hamilton, 1960). Initial correlations were 0.44 for the RDRS and 0.54 for the HRS at admission, indicating moderate concurrent validity. After four weeks of treatment, this had risen to 0.69 on the RDRS and 0.75 on the HRS. Seventy per cent of the clinical sample and 21 per cent of the general population sample scored above an arbitrary cut-off score of 16, suggesting reasonable discriminant validity. Coefficient alpha was above 0.80 in a subsequent analysis with black participants, suggesting that the scale may have

cross-cultural validity. Cabassa (2005; Cabassa and Zayas (2007) report an internal consistency of 0.90 in their Hispanic sample.

General Stress Scale (Mo *et al.*, 2007).

Mo *et al.* (2007) used six items measuring financial strain from the Social Readjustment Rating Questionnaire (SRRQ; Holmes & Rahe, 1967) and asked participants to indicate on a four-point Likert scale how frequently they had experienced these difficulties in the past month. However, they provide no further details of the items which they selected. They also appear to have selected 16 items to assess 'interpersonal conflicts, social constraints, and unpleasant environmental disturbances' (p.136) from the Daily Hassles Scale (Kanner *et al.*, 1981) – this measure has 117 items – but again provide no further details of which items were chosen. They combined these scales to form a general stress scale: they state that the high correlation between the scales ($r=0.55$, $p<0.01$) justifies conceptually merging them. They report internal consistencies (Cronbach's alpha) of 0.76 for the Daily Hassles Scale, 0.68 for the Social Readjustment Ratings Scale, and 0.83 for the combined stress scale, but provide no further psychometric data on this new measure.

MEASURES OF SOCIAL NETWORKS

Network Orientation Scale (Vaux *et al.*, 1986).

Vaux *et al.* (1986) selected 20 items for this measure to reflect Tolsdorf's (1976) concept of network orientation. Items are measured on a four-point Likert scale. The measure was standardised on a sample of 334 participants, comprising four groups of students and one of adult community members. Item–total correlations

were generally reasonable, although some correlations were weak and insignificant, at least in some groups. However, the authors state that removal of these items did not have a consistent effect on other item–total correlations, and as they were felt to measure important aspects of network orientation, they were retained. Thus, they report that they traded off a small degree of internal consistency for greater construct validity. Cronbach's alpha ranged from 0.60 in the community sample ($n = 37$) to 0.88 in the second group of students. The latter value indicates good internal consistency, but the former does not; however, the small sample size may have prevented a strong correlation from being detected. Test–retest reliability was assessed by re-administering the measure to the first student group and the community group after three weeks, and resulted in coefficients of 0.18 and 0.85 respectively. Test–retest reliability with another student group after two weeks was 0.87. A degree of concurrent validity was demonstrated: the measure was associated with size of network; specific supportive behaviours; less emotional support and guidance from friends; less tangible assistance from friends and family; less perceived support from others; and mobilising the social network. Therefore, this measure appears to have reasonable validity. However, its reliability is more questionable, given its inadequate internal consistency and test–retest reliability in some groups. This measure was used in Beckwith's (2005) study to predict attitudes towards help-seeking.

Subjective Norms (Cabassa, 2005; Cabassa & Zayas, 2007).

Cabassa (2005; Cabassa & Zayas, 2007) reports that he constructed a measure of subjective norms following Fishbein and Ajzen's (1975) recommendations. The

measure included two components. The first assessed participants' perceptions of the likelihood that their friends and family members respectively would think that they should seek psychological help if they were experiencing a situation portrayed in a vignette, and asked two questions with the format:

How likely is it that your friends would think that you should seek professional help if you were experiencing Laura's situation? (Cabassa & Zayas, 2007, p. 234).

The second component assessed whether participants generally did what their friends and family members thought they should, and incorporated two items with the format, 'Generally, you do what your family members think you should do' (Cabassa & Zayas, 2007, p. 234). All items were measured on a seven-point Likert scale. Subjective norm scores for each reference group were derived by multiplying normative belief items with their respective motivation to comply items. Cronbach's alpha was 0.80 for the formal sources scale, indicating good internal consistency. The authors do not provide any further psychometric data on this measure.

MEASURES OF SOCIOECONOMIC STATUS

Four-Factor Index of Social Status (SES; Hollingshead, 1975).

Beckwith (2005) used this measure to assess socioeconomic status. He reports that the measure assigns a numeric ranking of zero to nine for occupation, and a numeric ranking of one to seven for years of completed education. The socioeconomic score is obtained by multiplying the occupation ranking by five, multiplying the education

ranking by three, and adding these figures together, with higher scores representing higher socioeconomic status. However, the study describing the development of this measure is unpublished and it was not possible to obtain it.

MEASURES OF VIEWS ABOUT DISTRESS.

Illness Perceptions Questionnaire (IPQ-R; Moss–Morris *et al.*, 2002).

This measure was standardised on eight groups of 711 patients with different physical health conditions attending hospital. Response rates were above 80 per cent for all groups except chronic pain patients (50 per cent) and multiple sclerosis (44 per cent); response rates for the HIV group were not recorded. Moss–Morris *et al.* (2002) added several items to the original scale developed by Weinman *et al.* (1996), resulting in an initial pool of 50 items. An initial factor analysis indicated 11 factors accounting for 68 per cent of the variance. Twelve items which loaded onto more than one factor or which did not load strongly onto any factors were then deleted. A subsequent factors analysis resulted in seven factors accounting for 64 per cent of the variance: timeline (acute/chronic; 6 items); timeline cyclical (4 items); consequences (6 items); personal control (6 items); treatment control (5 items); illness coherence (5 items); and emotional representations (6 items). Cronbach's alpha ranged from 0.79 for timeline cyclical to 0.89 for timeline acute/chronic, indicating good internal consistency.

An additional causal dimension was assessed separately, and comprised 18 items. A factor analysis revealed four factors accounting for 57 per cent of the variance: psychological attributions (6 items); risk factors (7 items); immunity (3 items); and

accidence or chance (2 items). The correlation between the latter two items was low. Cronbach's alphas for the other factors ranged from 0.67 for immunity to 0.86 for psychological attributions.

The measure was re-administered to a subgroup of 76 renal dialysis patients after three weeks and a group of rheumatoid arthritis patients after six months. Correlations were moderate to strong, and ranged from 0.35 for consequences in the rheumatoid arthritis group to 0.88 for risk factor attributions in the renal dialysis group. Discriminant validity was assessed by comparing participants with acute and chronic pain: significant differences were found on all subscales.

Cabassa (2005; Cabassa & Zayas, 2007) reports that he modified the original wording of this measure in order to make the items more relevant to his research. He conducted a factor analysis of this measure, and discovered four meaningful factors accounting for 71 per cent of the variance. Nine items loaded onto a fifth factor, which was unreliable (Cronbach's alpha = 0.57), and which he did not feel made any conceptual sense. Therefore, these items were excluded from further analysis. Four of these items were originally in the cyclical timescale subscale, and the remainder were from the original personal control subscale. A second factor analysis using the 18 items retained was found to account for 95 per cent of the variance. The consequences and treatment control subscale of the original measure were replicated. However, two new subscales were discovered, representing fatalistic and optimistic views about the course of depression respectively. Cronbach's alphas were 0.68 for the fatalistic and optimistic subscales, 0.75 for the treatment control subscale, and

0.78 for the consequences subscale, suggesting that some subscales may not be optimally reliable.

Although they used the same sample, Cabassa and Zayas (2007) appear to have used this measure in a different way. They report on five subscales of this measure: label/identity, causes, timeline, consequences, and controllability. Responses were measured on a five-point Likert scale. Single items were used to measure the label/identity and causes dimensions. Cabassa and Zayas (2007) report internal consistencies (Cronbach's alpha) of 0.65 for the timeline subscale, 0.78 for the consequences subscale, and 0.62 for the controllability subscale. They suggest that the translation and modifications made to the measure may have lowered the reliability of the timeline and controllability subscales. An alternative interpretation could be that as this measure was developed in medical settings in relation to physical health, it may not be applicable to depression, as perceptions of depression may be conceptually and qualitatively different from conceptions of physical disorders. This may be particularly true in non-Western cultures, therefore it is not clear how cross-culturally valid this measure is. Furthermore, from Cabassa's (2005) factor analysis of the measure, it appears that different factors are relevant to this population than in the original standardisation sample.

Mental Distress/Illness Explanatory Model Questionnaire (MDEMQ; Eisenbruch, 1990).

Eisenbruch (1990) developed several items to reflect each category suggested by Murdock *et al.*'s (1978) profile of illness theories. Items were measured on a five point Likert scale. A pilot study was conducted 'to look for floor and ceiling effects

in discriminating items' (p.714), although no further details of the sample or statistical procedures used are provided. Forty-five items were retained, reflecting natural causes, stress, and mystical causes. The measure was validated on a sample of 261 students of mixed ethnicities. A multidimensional scaling analysis was conducted, and resulted in four subscales being identified: Western physiology; non-Western physiology; stress; and supernatural. No further psychometric data are provided.

Fung and Wong (2007) used this scale to assess participants' conceptualisations of distress and predict attitudes toward help-seeking. Cronbach's alphas were high for all groups on each of the subscales in this study, ranging from 0.85 for non-Western physiological causes in the Korean group, to 0.95 for supernatural causes in the Taiwanese group.

MEASURES OF PHYSICAL HEALTH

Cabassa (2005; Cabassa & Zayas, 2007) used a single item measure developed by Fayers and Sprangers (2002) asking participants to rate their health status on a five point Likert scale ranging from 'excellent' to 'poor' to predict attitudes toward help-seeking. They state that this measure has been found to be a powerful predictor of clinical outcomes and mortality across multiple diseases and populations.

MEASURES OF ACCESS TO SERVICES

Cabassa and Zayas (2007) developed an 11 item measure of perceived barriers to accessing services. They chose items based on pilot work, although they provide no further details of this, and from a measure developed by Manos *et al.* (2001). They used the total number of barriers to predict attitudes towards help-seeking.

MEASURES OF ATTITUDES TOWARDS TREATMENT

Patient Attitudes Towards and Ratings of Care for Depression (PARC-D; Cooper *et al.*, 2000).

Cooper *et al.* (2000) drew on the results of a qualitative study by Cooper–Patrick *et al.* (1997) to develop this measure. The latter study asked three focus groups about attitudes towards seeking treatment for depression. Two groups of African-American and white patients respectively who had experienced depression were recruited through primary care physicians, mental health specialists, and community leaders. A third focus group was conducted with biracial health professionals. Sixteen categories relating to depression care were derived from content analysis (Cooper–Patrick *et al.*, 1997). Cooper *et al.* (2000) developed a 126 item questionnaire from these results, and included between five and 13 items for each theme. Three of the sixteen themes from the original study were not included, as they were derived purely from the health professionals focus group or were general in nature. The questionnaire was completed by 76 patients at an urban university-based primary care clinic, who were asked to rate each item on a five point Likert scale in terms of importance.

A 30 item and a 16 item version of the scale were then developed using the items considered most important in terms of mean scores and percentage of participants ranking them as extremely important. Both versions were reviewed by the research team, and items were deleted by consensus if they were endorsed infrequently or rated as unimportant by patients, were felt to be redundant or unclear by the researchers, and if they did not correlate well with any scale. Factor analysis revealed seven factors: health professionals' interpersonal skills (12 items); treatment effectiveness (10 items); treatment problems (five items); patient education (two items); intrinsic spirituality (six items); access to care (five items); and recognition of depression (two items). However, many of these subscales were highly correlated, the intrinsic spirituality subscale being the only one with a high degree of independence. Correlations of items constituting the subscales were examined to determine whether they correlated more strongly with items within the same subscale or other items in the measure. This method indicated that 64 per cent of items were scaled appropriately, but that 33 per cent were possibly scaled incorrectly (i.e. item-scale correlations were greater than the correlation of the item to other scales, but by less than two standard errors), and 3 per cent definite scaling failures. The authors report that Cronbach's alpha for all subscales was greater than 0.70 for both the 30 and 16 item versions, indicating reasonable internal consistency. A potential difficulty with this scale is that it includes a relatively large number of factors, with some comprising very few items, and that its subscales may not be sufficiently independent of each other.

Cabassa (2005; Cabassa & Zayas, 2007) used the 16 item version of the PARC–D. As three subscales (Treatment Problems, Patient's Education and Understanding of Depression Care, and Recognition of Depression) had Cronbach's alpha values lower than 0.55, they were excluded from further analysis. Cronbach's alphas for the included subscales ranged from 0.67 (access to depression treatments) to 0.83 (intrinsic spirituality). Therefore, the PARC–D's validity appeared somewhat lower in the Cabassa group's study than in the standardisation sample. This could reflect the fact that the scale was developed with black and white Americans, and may have less validity in Hispanic immigrant populations.

MEASURES OF SOCIAL ATTITUDES

Attitudes Toward Women Scale – Short Version (AWS; Spence *et al.*, 1973).

Spence *et al.* (1973) developed a short version of the 55 item Attitudes Toward Women Scale (Spence & Helmreich, 1972), which measures attitudes about the rights and roles of women in society. Items are measured on a four point Likert scale. They administered the measure to 527 students and 524 parents, and selected the 25 items which had distributions which maximally discriminated among quartiles for both sexes and which had the highest biserial correlations. Correlations between the long and short version were 0.968 for males and 0.969 for females. Item–total correlations ranged from 0.31 to 0.73 for students, and 0.14 to 0.70 for parents. Item–total correlations were higher for the short version than the long version. Factor analysis indicated that the scale was unifactorial, and accounted for 67.7 per cent of the variance in females and 69.2 per cent in males. Therefore, shortening the

measure did not appear to weaken its psychometric properties. This measure was used in Sheikh's (2000) study to predict attitudes toward help-seeking.

**APPENDIX C: SEMI-STRUCTURED
INTERVIEW SCHEDULE**

SEMI-STRUCTURED INTERVIEW SCHEDULE

CULTURE

What was it like coming to Scotland?

Prompts:

- What sort of issues were you faced with?
- What support was available to you? (formal, informal)
- How much awareness do you think Scottish health professionals have about these issues?

VIEWS OF HEALTH SERVICES

What contact have you had with health services since coming to Scotland?

Prompts:

- What services have you used? (GP, specialist)
- How did you find out about them?
- What did you think of them? (compared to Polish/Lithuanian services, staff, convenience)

MODELS OF DISTRESS

If you were feeling distressed, what would you do? (very sad, worried or confused)

Prompts:

- What sorts of things have caused you to feel distressed?
- What do you think might happen as a result of these feelings?
- How might other people react? (friends, family, colleagues, health professionals)

PSYCHOLOGICAL SERVICES

If you were feeling distressed, what things might influence your decision on whether or not to see a psychologist?

Prompts:

- Do you know anyone who has had contact with mental health services?
- What effects might seeing a psychologist have on your life?
- What help would you like to be available?

**APPENDIX D: PARTICIPANT
INFORMATION SHEET**

**INSERT PARTICIPANT INFORMATION
SHEET**

APPENDIX E: CONSENT FORM

INSERT CONSENT FORM

**APPENDIX F: LETTERS OF ETHICAL
APPROVAL**

**INSERT LETTERS OF ETHICAL
APPROVAL**

APPENDIX G: CODING STRUCTURE

CODING STRUCTURE

Defining Identity

- Identifying with Polish Culture
- Rejecting Scottish culture
- Rejecting Polish Culture
- Appreciating Benefits of Life in Scotland
- Making Help-Seeking Decisions in Line with Identity.

Family and Community Networks

- Migrating With or to Join Significant Others
- Socialising Mainly with Other Polish Migrants
- Depending on Others to Navigate Life in Scotland
- Prioritising Children's Well-Being
- Viewing Relationships as Protective of Emotional Well-Being
- Containing Problems within Small Social Units
- Describing Negative Effects of Close Relationships
- Attributing Closeness of Relationships to Sociohistorical Factors.

Cultural Norms

- Catholicism
 - Enacting Catholic Practices
 - Holding Implicit Catholic Values
- Gender Roles
 - Being Expected to Enact Polish Gender Norms
 - Having Access to Professional Careers for Women
 - Describing Domestic Abuse in Poland
 - Experiencing Stress, Disadvantage and Stigma as a Result of Gender Norms
 - Coping Through Gendered Practices
 - Feeling Liberated from Social Pressures in Scotland.
- Rejection of Difference
 - Highlighting Discrimination Towards Particular Social Groups
 - Being Assigned a Stigmatised Identity as a Result of Contact with Services
 - Discussing Historical Antecedents of Discriminatory Practices
 - Viewing Emotional Expression as Culturally Acceptable
 - Judging Reasonableness of Behavioural and Emotional Reactions.

- Urban–Rural Class Divide
 - Describing Urban–Rural Divide in Poland
 - Describing Life in Poland as Stressful and Difficult
 - Migrating for a Better Life
 - Migrating to Gain Freedom
 - Thinking Different Demographic Groups Settle in Different Areas
 - Employing Help-Seeking Strategies in Line with Social Class and Urbanicity.

Experiences with Social Institutions

- Experiences with General Health Services
 - Feeling Disappointed with Scottish Health Services
 - Questioning Health Services' Motives
 - Avoiding Contact with Health Services Unless Absolutely Necessary
 - Preferring to use the Private Sector in Poland
 - Having Access to Services Determined by Social Class in Poland
 - Describing Corruption in Polish Healthcare System
 - Appreciating Benefits of Scottish Health Services.

- Perspectives on Mental Health Services
 - Having Little Contact with Mental Health Services
 - Distrusting Mental Health Professionals due to Associations with Communism
 - Accessing Mental Health Services in Poland
 - Viewing Assistance from Mental Health Services as Effective
 - Discussing Benefits of Therapy
 - Thinking that Motivation for Recovery is Greater in Poland due to Fewer Secondary Gains
 - Thinking that Polish Psychiatrists are Less Likely to Prescribe Medication and Hospitalise People
 - Discussing Benefits of Scottish System
 - Viewing Formal Intervention as Necessary in Some Circumstances
 - Preferring to Seek Private Therapeutic Assistance.

- Communication
 - Experiencing Difficulties as a Result of Language Barriers
 - Communicating through Interpreters
 - Having Friends Act as Interpreters
 - Contrasting Scottish and Polish Communicative Styles
 - Losing Meaning in Translation.

APPENDIX H: SUPPLEMENTARY QUOTES

SUPPLEMENTARY QUOTES

DEFINING IDENTITY

Identifying with Polish Culture.

... I'm in a manager in my factory, and I'm working with a lots of Polish and we not working as the manager and the workers. Not higher level, lower level. Working on the same level (C2 373–376).

In Poland the children are a different mettles, mettles of parent thing. You see, in the Eastern Europe, the children are got a different of learning. You see, the parents try to learn him things like culture, like saving money, like be good for other people, like other good things. Who can be very useful in the future. When they start working or when they start by the family (C2 486–491).

... to live here, we as Polish people, we don't feel fully at home because it's not our country (C3 105–106)

... I think because children are generally I think more unruly here. They're not as wild in Poland, they're not. There, there you get schools that are kind of rougher than others. But basically, I think there's more discipline. Maybe even old-fashioned discipline sometimes. You know, kind of, I don't approve of that but there's lots of parents that kind of really, yeah, hold their children with a firm hand and they don't want them to run about. And most of my friends are really, their children are all well-behaved (C7 277–284),

... They are nice people most of them. They're really nice people. They're kind of helpful and. Well I help them with a few things, translating some documents, and filling forms sometimes. And they always want to pay me, but I always say, 'You can pay me a different way.' And she for example mended my son's top on her sewing machine and kind of you know this is, you know I think that's a better way of dealing with things. Unless it's something major. But if it's something minor, something kind of small, it's a better way. Because you kind of network with people, and I'm not saying you've got to kind of make people feel they're obliged to do something. But it's, they know they can ask you, and it's not going to be a big problem, and then you can ask them something in exchange if here is something. So that, I think that's the best way to kind of, you know, be with people (C7 1358–1359).

Rejecting Scottish Culture.

... with the immigrants workers in Scotland, it's much better. You see it's the locals like you who get trouble (C2 273–274).

... in the Polish people, she like two things. For a Polish people, the most important it's their family and their friends. Not for like Scottish people: money and good parties. Aye. That was he say it, but that's a true. Because it seems to be similar relationships with the Polish people. See, for example, I'm in a manager in my, factory, and I'm working with a lots of Polish and we not working as the manager and the workers. Not higher level, lower level. Working on the same level. And that's the things, why you, why the Scottish people can't understand that (C2 370–377).

... they think if I'm a manager, the other people should feel respect, respect. I shouldn't be a friends for them. I shouldn't be, I should be for them a boss. You see, they should scare me. Aye, that's the thing how they, how my bosses thinking (C2 379–382).

The shops are different. The displays in shops are very different, and everything is being displayed much earlier. For example, for Christmas now, we have now all everything ready to go. It's not the case in Poland really (C4 37–40).

... last year when we arrived, well two years ago actually almost, they were like 13, 14. They were all drinking and smoking. And for me it's really yeah, I don't have that kind of experience from where I come from. So not, Poland's not, because there probably there are areas where people, children starts quite early. But my personal experience, it's not like that (C7 284–290).

... if I did what most parents here do, 'Just do what you want. Would you like a fag, and go away.' You know. Because they do that. They would give cigarettes or alcohol to their children. And for me, like for me it's shocking (C7 293–296).

... people at the weekend, binge drinkers. You know like, I mean, the whole city is drunk on Saturday. And that seems to be like every week the same. So it seems like that here people manage during the week and then they just release everything, energy, you know (K2 217–218).

... I'm not sure how it is with the Scottish family obviously, but I've got a feeling that there is like some sort of father, the whole family is like, I don't know, the father was, is an alcoholic, mother is maybe not, but like all the children are, and they are all just kind of small, they're a small community of people who drink in here (K2 606–610).

Rejecting Polish Culture.

... there is another group of people I work with which are contract workers. They come here just to work and make money and they drink and they don't, they're not very nice people (C6 163–165).

... going back to, to people being hypochondriacs, I think they are, they are kind of conditioned towards that. But because the society is like, oh that's one thing

I'm going to tell you. Is I always find it with people about the clothes. Proper clothes. And the perception of warm or cold weather and how. Homes in Poland are overheated. They are just like you know like ovens, roasting. And people go in there and they put huge big clothes on and layers and layers and if you, all year round, even though maybe if it's a summer and it's like plus 30 or something they will take some things off. But like just, especially older people, but even just some younger as well. Or you can see the mother. You know, it's really warm. Or in a shop. The mother is kind off to t-shirt and you know jeans and just looking normal. And the child's sitting there red in the face and kind of layers of clothes, it's like, woman you've stripped yourself. You're hot, yeah. That's why you took your jacket off. And you took and your jumper off and your hat and scarf. And the child's still sitting. Oh no, no, no, no, you know. They've got to keep that warm. Really warm! And here, exactly opposite. The fact that coming to Britain, even Scotland's even sometimes colder. It's kind of you know, maybe not the temperature itself, but because of the wind and kind of moisture in the air, it can be quite, quite nippy. And I saw children sitting with their bare feet. It was like, it was the beginning of June. It was a really cold day. I was kind of, you know, jumper, coat, and kind of ohhh, cold. And it was purple, little purple legs sticking out. And nobody was, the mother was also purple. Nobody was. And I think those children are much healthier than the red puffy ones in Poland. So I think purple colour is better than red (C7 580–603).

... people in Poland, it's just kind of, ohhh. And I remember when I was when I was living there and my son was young. If I ever ventured out without a hat or his hat, people would scream in the street, 'Where is the child's hat? He'll die of exposure!' You know, it's like, it's warm. It's like May. He don't need a hat. But people, that's the whole thing. So I think a lot of problems, people are just conditioned by their families, and by their doctors, to always feel, you know, kind of never feel secure from disease cause it's just lurking. So they've got to be, you know, kind of look around and check (C7 608–616).

... most people would kind of you know really, in Poland, they would kind of, if they saw someone in winter walking with just a jumper they would kind of, huh! Really panicky faces, 'Oh!' You know. 'Mad person!' or something they would do. Yeah. They would react. Cause here. You just, you know, people are just huddling on the bus stop with just you know, really cold and they're just, they're in their shirtsleeves. You know, standing there. You know, as I say, women in skirts, no tights or anything, purple legs. And it's normal. They're cold. So what? You know, they'll get, they get warm. And as long as I say, it's just the, I think, that's my personal opinion, I always tell that to people that you're more likely to get disease from overheating yourself permanently than from getting a bit cold now and then. That's my opinion. I just think it because the body is completely unable to regulate the temperature in a really hot and they go too cold. But if you can keep the temperature, and immediately in the middle somewhere, it's kind of makes it easier for the body to adjust. So that's my opinion anyway on that. I tell the, I always tell my friends in Poland so, 'I've seen perfectly healthy purple babies in Scotland.' (laughs) So uh, and you see with children like swimming, when they go swimming and the water's cold, they don't

mind, they go, they go cold, they go sshh, shaking and you know, they get warm, and then they go back in again, and they're fine. So yeah, I think Polish people and I think most of them take it with them here. Would have that kind of approach. And their house was quite warm, I don't know if you've noticed. And I think most of the houses I go to, they're quite warm. They turn the heating up, well up. Whereas local homes where I go to, Scottish people ... just have it like cooler inside their houses, they're not too, too bothered about that ... (C7 650–676).

... there's going to be a carnival kind of party. I'm going to it because I'm going to be away that week but eh, anyway it's just not my (laughs), not my fun. We went to one before Christmas, and it was just, oh. I was just sitting there going, oh God. What am I doing here? Trying to smile. But yeah, they've got families, and as I say, they need kind of simple, they don't go to theatre or concerts or cinema or anything like that, but language probably one thing, but also in Poland, they wouldn't go either. Television, Polish television they can get it through satellite. Friends chatting. Yeah, going to a party, you know. Have a drink, have a dance, and kind of, you know, kind of simple stuff. And I'm not saying I don't like that kind of thing, it's just not the kind of music, not the kind of dancing, and not the kind of drinking (laughs) (C7 1347–1358).

... [C6] said he's got a few guys at work who are not that nice. But yet they're not within the circles I am in. So kind of you know just, I manage to avoid. I know there are some people, because I used to live in [street] and there, I don't know, somehow people used to walk that way, maybe they lived somewhere, there were Polish people on Fridays and Saturdays who walk singing Polish drinking song really loudly in the middle of the night. So I wouldn't want to probably live with them or next to them (C7 1375–1381).

I love driving in this country. Cause in Poland, especially [major city], it's like you know, one for all basically. And it's like, it's a jungle basically. It's getting slowly better. But still you get the percentage of mad drivers is quite high. So you really have to have eyes all around your head when you're driving. And here you can relax. Because people are predictable. That's the important thing that makes you ooh, get rid of the stress. Because you know what to expect. And of course, if you were going on a survival course, you don't want that. But if you were living normally, you want to go to the shop and buy something, you don't want to fight for your life. So in Poland, it was like that. It was like every day I came from driving somewhere, coming back, I think I'm quite a kind of calm and you know, I'm not a, but I did get road rage sometimes. Because of what people were doing. Stupid things. And, and nobody takes any notice of regulations. They're there. But it's, pfff. 'I'm not driving at 30 miles an hour. Like, how long will it take me to get home?' It's like, well, as long as it gets to be. But here, you seldom, sometimes you see someone who is going a bit faster or doing something silly, but basically people just, you know, they stop, and they let you in, and they give, you know, they smile, they wave, 'Thank you,' 'Oh thank you.' Ooh, it's so nice. In Poland, you'd be nnyy nnyy (both laugh) (C7 1394–1411).

In Poland it is (pulls glum face), they just sit there. Stares. So its a kind of, you know, that shows you what the society's like. But they do have that need for information. Even reading, you know, a leaflet. You know, they take people leaflet and read it so you can have you know, you feel the need to get busy and not just kind of (robotic voice) vacant. You know, just sitting there, you know. So, yeah, it's just kind of, yeah, that might be just I guess completely wrong observation. But there's something with that. And it's, yeah, there's some grain of truth that Poland, Polish people are still not kind of, lots of people there are kind of yeah, they're all vacant. And they, they're not, they don't mean anything wrong by it. But they're not taught to kind of react to the people. And they think it's kind of weird if someone smiles at you and says hello or something. They're kind of, uh? 'What did you say, I don't know you.' You say, 'Hello,' just you know when you're passing in the door or something or you know we're going same way or in, but of course, tourists, yes. When you, you're walking, tourists are more likely to say hello, then it's, but we're tell the tourists to say hello. But generally if you just you know, people are kind of, yeah, if you smile at someone on the bus or something. 'Weirdo.' You know. (laughs) But maybe you know, this, if you smile too much. (laughs) You know, I just cause, you know, when someone said, if you don't want someone to sit next to you don't put the bag there, you pat the seat and smile at them and say, 'Hello!' 'Aargh!' (both laugh) So I guess that works for men but not then women. But em, yeah, but kind of yeah, people in Poland are still not used to that kind of level of social reaction (C7 1417–1439).

... people are a little bit less likely to work together to come with their own initiative. And probably with, it's probably also a little bit to do with initiative and taking initiative and coming up with your own ideas and suggesting something, and then getting other people to follow that or agreeing with something. So I think, well that might be a result of the previous system as well (K1 514–519).

There are alcohol treatments obviously, but people don't do that, because the nation is a bit of a drinking nation (K2 207–208).

I think that like if the Polish guys, but usually guys would be having drinking problem, they'd drink at home or with their friends in their homes. They would drink probably vodka or beer but like all of that like in this home setting sort of thing. And there are quite a lot of people who drink but still cope to go to work and stuff. Or they would be such an alcoholics that you cannot really help them much because they've crossed the line and that's it (K2 211–216).

... in Poland, nobody believes in their own achievements and abilities. You, even if you actually do things properly or successfully, they don't acknowledge in this way. And lots of people would be commenting only if like all right, she had these connections you know if her father was like that, so always I've seen as somebody's daughter, somebody's father, somebody's sister, you know. That would be the first thing. Second, that in Poland you cannot really talk about your achievements. Cause that would be like showing off, it is quite criticised really, the people, they cannot really express yourself in this way ... In Poland it

wouldn't, you would be, your whole life would be sort of driven by, by these other conditions and other the connections or like once you've chosen something ... you would be stuck with this. You wouldn't be doing anything else because you wouldn't find a job or, I don't know, people would think you are crazy you know like probably you would, yeah, there is not so much freedom, not so much tolerance to a lot of things (K2 344–361).

... the lifestyle is very structured. You do that, you do that, you do that, you do that, so you finish studies, find a job, get married, have children, have a car, have a house, you know, all of that and all your life is defined like that. Plus even like in the small unit of the family, also there are certain sets of behaviour that you don't fit in (K2 368–372).

The communists, well because one thing is what I mentioned, that people were asked, they were interrogated, everybody had to sign some papers, everybody had to do that, so that was one thing. Second is that everybody had work, everybody had a job and there was nothing extraordinary about it, but I don't know, to get something you had to pay. There was no, the rules, there was like, there wasn't any policies and procedures and things, you know like so people were doing what they wanted. So even they were all to be equal because that was what was coming down from socialism, it wasn't true, you know like people were taking advantage of each other in a lot of ways (K2 884–891).

... I was just thinking about my particular group of friends and that's people they are all my friends are single at the moment. Apart from myself. And they don't have children and they are not married with children, and the reason why they are here is like because of that, that they can do that (K2 1159–1162).

... I'm thinking about like my friends again. They are just completely different, you know. Completely. Like more similar to Scottish in a lot of ways or maybe not similar, but just, I don't know, more independent, more like rebellious towards the Polish tradition. You know, they wouldn't, for example they, a lot of them don't celebrate Christmas or celebrate Easter or don't like anything Polish, they don't like Polish people like have like some kind of negative approach towards Poland ... (K2 1189–1196).

Appreciating Benefits of Life in Scotland.

... I feel that from what I've observed from my own observations, people are not that much interested in each other here as they would be you know, especially that kind of mental health problems and that would be at home in Poland (C6 138–141).

... I think coming back to what you asked about the differences between the societies or between the cultures, I found in terms of working at the, well at the community level, they are more likely to join community associations or to work together towards achieving something. I think that uh, I think this, it's like almost

like a social trust. I think people are more likely to trust each other and to share it with each other to be able to achieve something they want to work towards together. It might be a little bit more difficult in Poland (K1 507–513).

... it's all like sort of interconnected with this independence thing but basically, I've got a feeling that whatever I achieve here, it is only because of my own work and my own ability (K2 342–344).

I would say that, I don't know, yeah, I've come to realise in here that the structures, the procedures and all of that is really good and helpful (K2 915–916).

Making Help-Seeking Decisions in Line with Identity.

... I would say it's simple, you know. If you want to go and see someone who you think might help and you're thinking that way, you just go. And if you don't feel this way, you just don't go, and you know, try to help yourself, you know (C1 226–228).

... they are people who they are very, very brave, very stable, who they are very understand, who know what they've got position in them's life, what they've got a right, but they are people with, it is a lot of people, there are a lot of people who they are not really as strong as, you understand. They don't know what they, what kind of right they've got anyway. Even what, how can they use everything, you understand. How can they manage in their lives (C5 507–513).

I believe in my life that if you've got a problem, don't, I don't know how to explain, I know that really, nobody is able to help me. If I don't help myself, you understand. I might be very strong, if I've got a problem I need to get over it, either it is very, very present in this moment but heavy, something like that. I know because it at this time, and I've got a like a hope in the future that really it could be better and better. And I try to keep very, very strong all this. Because I know that it isn't for, it isn't easy for everybody. Everybody got some kind of problem. Some kind of difficult life. And usually I try to keep a very like a strong. Because I compare a life how people when they've got sometimes I upset, for example, of course, I've got a husband, I've got a normal family. They are a kind of people, some of people, they don't have something. And in different situation, I observe that people who they are for example are very well educated, or who can speak a few languages, something like that, they are ambitious, I try be nothing like them. Because I always looking to be a better in my life. Better and better. I'm looking a very put, I'm looking always a very positive sides of my life. Something like that. Always (C5 534–549).

I try make my life very, very busy. Very busy. Every day busy. You understand, when I waiting, when people they've got a too many free time. They've got really too many, and they start, oh my God, why I am poor, something like that. They always busy, busy, they are, they've got a lot of ambition in their view today and

very good motivated, they can do everything they need. Oh, world is open for everybody (C5 560–565).

I think that people, they're most often, or they're often people who have a psychologist, they are people who, they are people in very low income. Very low education. Without any like ambition in the future. Without any family. Or with a family who have a broken connection or lack emotion between each other. And getting there, there are people who that things is with. I think that the most of them. And people who it's sometimes is, just now I'm thinking about it, is it's a touch of people who they sometimes even are good educated, they've got a good really, they can earn a lot of money. But I think that just now, it is a very stressful life, you understand. When somebody for example, people who they've got a good position, good earnings, but they've got a so pressure from their in his job from his manager, that they couldn't manage, you understand. Because they always every day they like the big stress, do you understand. The people should find a really, really a, I don't know, a balance (C5 573–585).

... that's quite normal. And people talk about it openly among my friends (C7 827–828).

FAMILY AND COMMUNITY NETWORKS

Migrating with, or to join, significant others.

Well I arrived here to see my friend and she kept me here. She convinced me to stay. So she was helping me quite a lot at the very beginning (C1 91–92).

... usually migrant workers when they come here, they usually living own self or with their wife and with their kids (C2 346–347).

I had one friend from Poland who actually encouraged me to come over here ... (C3 219).

Even before I came here, my husband and my two older daughters already lived here (C4 45–46).

First, it appears, my husband came here, four years ago, and he can do still his job here (C5 39–40).

I'm here for six years. And it's a year and a half since my wife and kids arrived. For the first few years, I spent this time to do research and find out if I can bring my family here (C6 39–41).

Young people coming here. Some of them their own, others with the families ... (C7 1385–1386).

I know people that moved with, with their families. And they feel quite settled after a couple of years of being here (K1 322–323).

It sounds basically that somebody found a job. With 11 years ago whenever it was, you know. Got another, like they found out that there is another like let's say three vacancies next year. So he goes like his uncles or his cousins or his friends, and they came over. And then they brought families. And then, and other people came over hearing about it and they were all from some sort of one region or something like that, because there is quite a lot of these kind of small environments of Polish people that hear that they, I don't know, let's say [local bus company] have cleaning, you know, like that's a big, or there was a cookie factory and there was like everyone, lots of Polish people and they would be like coming, friends of the friends of the friends, you know. And staying there. Like for example, from my early job, lots of people went to Ireland. And there is maybe 70 people in Galloway from my town, like they leave my town. And they live there, and they are happy and like half of my village emigrated as well (K2 1207–1220).

Socialising mainly with other Polish migrants.

I know some people in the area, and I wouldn't say that I know very few of them, but some of them have been here for longer and I haven't lived here for so long, and I realise that everyone has their own life. So even if I know quite a few people who are really friendly and helpful, they do take care of their own lives and it's normal (C3 212–216).

I had one friend from Poland who actually encouraged me to come over here, and we have lived together for the first six months in [local town], but now she has left, so she was the only person who I knew from before, and everyone else is my new friends from once I moved here ... Most of the very good friends I have met in language schools (C3 219–224).

... I am in the organisation, like our organisation, for these organisation I meet people, I would like go for example always, for example, when I, when somebody even hear from especially when I start to live here, I didn't speak English well. And just for me, I meet with Scottish people, it was very, very stressful (C5 553–557).

Well the thing is that I mostly contact Polish people here (C6 150).

... they are a bit isolated. Because of the language. As he said, he could probably socialise with Scots and kind of do things if not for the language. So because of that, they keep, they stay in, within the Polish community mostly (C7 1341–1343).

... the Polish community does come out to them and it does more and more things happening. There's ones association in [local town]. Polish association. There is now a [Polish organisation in another local town] that's been created in this

area. *There are people starting to do some things, there's going to be a carnival kind of party (C7 1344–1348).*

... I think there might be a trend for especially if people have difficulty communicating in English for people from one nationality to stick together, and if that happens, I think it's quite difficult to, for these people to integrate into Scottish society as a, I think that's one of the difficulties that might happen (K1 339–343).

... in terms of social thing, because I did the job at first in hospitality, you don't have much contact with Scottish people. There was all the people who were working with were from one or the other country. There wasn't Scottish people at all. There were some Scottish guys in the kitchen, but they weren't interested in foreigners in general (K2 989–993).

Depending on others to navigate life in Scotland.

... she's quite a close friend of mine and I've been quite a lot through her, through this with her, translating and also you know just being with her and doing the research, finding the right places to go to and seek help obviously (C1 247–249).

R: ... what do you think would have happened with your friend if she hadn't had you there to support her and help her with all that sort of stuff?

P: If she would have the support?

R: Sorry?

P: If she wouldn't have my support?

R: Yeah, uh huh.

P: I don't know. I think she, you know, she would be going to Poland basically. If she would get my support, she would obviously get someone else I think (C1 304–312).

... I know from my own experience how you, how it's work and I try explain to the people (C2 61–62).

... I was forced to find out about services when I fell pregnant, and it was first other friends, other people who were Polish that let me know where to go ... (C3 39–40).

It wasn't difficult really because there's so many Polish people here and they have helped me a lot because they have been staying here for a few years now so they knew exactly what to do and how and they helped a lot (C3 46–48).

... I remember even the day, I came [date]. It was a Saturday. But very immediately, on Monday, I start a English class. Immediately, after two days be here, I start English. It was quite, quite lucky for me. Because I could meet a Polish people through the, you can, they organise themselves in any Polish

association in [local town] and it was very, very helpful indeed in that time for me (C5 59–60).

... I went as interpreter with one girl. She had to have an operation on the breast. She doesn't speak any English. And she was really, well she knew she had to do it. She was kind of, I could feel that she was scared. Because she didn't, you know, she was on her own. Nobody, her sister and mother and didn't go with her and nobody else would do that. So I said, 'I'll come with you. And I'll interpret.' And then she said, you know 'Do you want me to stay when you wake up after the operation?' and all that (C7 1157–1163).

... I help them with a few things, translating some documents, and filling forms sometimes (C7 1360–1361).

Prioritising children's well-being.

I know in Poland, usually every school's got one person who serves psychology. So that's the, I think good point for children (C2 285–287).

I've got some ideas to go back to Poland, because I can still do my job and everything, but after that, I start thinking about my children. And I'm thinking they start to speak English and I know now that they've got here in the UK a more chance to develop them skills than in Poland (C5 45–48).

We did not have many opportunities to really use the services because the children are quite healthy (C6 10–11).

... we think that services, sort of health services here are much, much better. Especially for children. We've noticed that children get much better care (C6 55–56).

They're more hypochondriac about their children (C7 539–540).

... with children, the first kind of sneeze achoo, you know, go to the doctor (C7 552).

Viewing relationships as protective of emotional well-being.

... I've got to kids to cheer me so I don't have time to feel distressed to be honest (C1 177–178).

... for a Polish people the most important, especially in the foreign country, it's their family and their friends. And if good, they've got a good contact with them, believe me I would think be all right. Even if they've got their problems, they can go to family or their best friend and say right, I've got that, this kind of problem. And believe me, their friends can help (C2 382–387).

R: ... the sort of feelings that you've been having, the feeling stressed and feeling down, is there anyone that you're able to talk to about that sort of thing?

P: My little son (C5 225–228).

... she's still got problems. But she's kind of managing. I think she's kind of, she's better because she's with someone who cares (C7 898–899).

... they've got quite good social network to help them out. And this is a very good quality network, you know what I mean (K2 91–92).

Containing problems within small social units.

... I think if they've got a good friends and family or something like that they try explain him or her, try one more time. Do that any other way. Or in other ways, they just go back to the Poland. That they can find other ways to help own self. Because if they go to the Poland, they can find help with the family (C2 364–368).

She probably doesn't talk to many people about this, probably only me that knows about it and her sister. Her mother has died already, so she doesn't have many close people to talk to, so it would be me and her sister (C4 300–304).

From my own experience, one of the first things, first forms of help that would be offered would be advice by a more experienced person, older or more experienced from life giving advice to people who are less experienced in that kind of area (C6 229–232).

She was really, she was surviving on £10 for a month sometimes or something like that, you know. It was just like, I helped her out sometimes, and other people helped her, but she was kind of, she was really destitute (C7 895–897).

... maybe it is because of economical situation, maybe it is because of the value of family that I know if the teenager's ill, escapes from home or something like that, the family is always very, very involved. In making the person, trying to find ways to make that person be OK (K2 184–188).

... I remember, for example, my small society in the village, there were people with some learning disabilities, there were people with, like emotionally distressed and they've got their problems, and they were still a part of the community. They still have work. They still were doing useful things. So in this way, there's no as such the segregation of people, you know (K2 558–563).

People don't segregate. They, the family is so important that even if your uncle is, I don't know, depressed or your auntie is even like schizophrenia but never diagnosed, you know. And I don't know, and your best friend's mother is something as well you know like, they are still, these particular people, they don't go away, they are there and you just try to accept the way they're (K2 610–615).

... there is a social structure, there is like lots of helpfulness, you know, that people help each other. And that comes from probably all that oppression again, you know, like you had to rely on others (K2 874–876).

... there is some kind of I don't know, feeling that they can be very good like get into the group you know and do something together and be helpful and be very open and be very welcoming towards others, that's all quite apparent (K2 895–898).

... older people are looked after by their family (K2 1288).

It is quite obvious for us that if something goes wrong with my mum, one of us is gonna take responsibility and look after so (K2 1299–1301).

... people look after their, you know, we have like, I don't, mother with dementia, you would be looking after her or your grandmother quite often like lots of people like in my age would have experienced their grandparents illnesses and they would have stayed with them at home. They would look after them and they would look after them until the end you know. So with all their personal care and everything, they wouldn't have help from the state (K2 1321–1327).

Describing negative effects of close relationships.

... they live in a small village. Everybody knows about everybody. And that's one of the, apart from watching soaps on the television, the other thing is to gossip probably (C7 745–747).

... if you're a stranger in a small village, you can walk up to people and talk to them and they will happily talk to you because it gives them material for more gossip. So in a village shop, usually it's the one shop, and everybody would congregate there, you know, and kind of have a chat (C7 1463–1466).

People know each other, and know about each other, and they're interested about people they don't know (C7 1472–1474).

... the whole structure was so different and was all about who you know and who you don't know, who you report about, who you report to things like just going on. And like, I think that lots of gossiping or lots of things which I'd rather spell about that or I think is coming out of that because you had to report things. In the past (K2 25–29).

... I think that in terms of coping strategies, because you have such a big support from people, you become as well quite dependent on them (K2 247–249).

... I know that if I ever would go back to Poland, I would need to rely on family (K2 330–331).

Attributing closeness of relationships to sociohistorical factors.

... Poland's still a very fresh country. It's still dealing with things. It's still, people have come out from communism with a lot of baggage ... things like you couldn't get things in the market. So you had to organise things. Sometimes would, things would fall off the back of the lorry and people just do things. So things that normally, you know, normal society when people are used to living in a lawful society, law abiding society, would never think of. And they would easily think, 'Oh no, no'. But in Poland it's a bit, the more important thing was, was trying to live normally and get things. So you would start, you know, kind of, the moral boundaries would start getting really fuzzy. You'd push them and say, 'Eh, you know, it's nobody's, I can take it, you know. Because it's belongs to the state. Because everything look.' People work mostly in public institutions. And they would just take home like bags of toilet paper and pencils and pens, and they would take everything, they would clean the place out now and then and it would have to be replaced. And they thought, 'It's nobody's. And if it's nobody's, I can take it. You know. And I can share it with friends as well'... (C7 430–446).

CULTURAL NORMS

Catholicism.

This category was mainly developed from the field work, therefore there may be less quotes to support it than in other sections.

Enacting Catholic Practices.

See Family and Community Networks and Gender Roles Sections for further examples of how people lived their lives in accordance with Catholic values.

Holding Implicit Catholic Beliefs.

There is like one thing which I forgot to talk about, I think this big impact it has is the Catholicism and the fact that 98 per cent of population are Catholics and I think that all these attitudes come out of there actually ... All their family thing, all the negativity towards different figures you know but at the same time this helpfulness and maybe everything comes from there as well. That you help weaker people and you help, you know (K2 925–932).

I think that like now I would think, because I didn't mention it at the beginning as well, but I think because it is so deep in your mind ... I don't regard myself as Catholic, but I am Catholic, like I'm baptised and I've been going to church until I was 18 every week. And I was forced to do that, you know so it was, but there is so many things that influence your way of thinking, your values, your approach to your life from coming up from there. You know, that would have a lot to do with that for those attitudes (K2 940–949).

I was forced to go to church and there was no way you couldn't go. And it was, you would be quite laboured for it as well in the small village. Because everybody would know that you didn't have been in church, you know. So yeah, that's quite a difficult subject I suppose. So a lot of people who maybe don't feel or regard themselves as Catholics, they would still go and celebrate a lot of things in the churches in Poland. But they don't do that here. Because they feel a choice (K2 964-970).

Gender Roles.

Being Expected to Enact Polish Gender Norms.

This code was partly developed from field work and observations about how Polish men and women lived their lives.

... people wanted to finally have children in a kind of calm, nice atmosphere and with your family next to you because previously people were not allowed like father, 'Get out, wait outside.' They shouted to him through the window, 'You've got a son!' Say, 'Woo, I can go and drink with my friends now' (C7 1198–1202).

In the family, there is a very big, and I've realised of that once I've, I'm here actually, it's a very kind of chauvinistic approach to the roles. So the female role or the wife's role is very, you need to do a lot of things. And you need to clean a lot of ways. The guy's role, more or less just to work. And provide. So it's very traditional. The woman's role because obviously she cannot stay home, so she needs to work as well. But also she has all the mother and housework role to incorporate, but the father, the guy doesn't do much. Apart from work. Because in his own free time, he doesn't do things like that, a woman does everything (K2 376–384).

... the expectation and it's not like so much that the woman is forced to do that, she just like repeats the same pattern, you know. And I know it because my husband is [other European nationality] so he doesn't respond to me, and I'll be sometimes very silly with my, but now I'm better, but at the beginning, you know like I was this kind of motherly person you know like trying to do everything,

clean everything, and you know, provide dinner every night, at night, you know (K2 394–399).

... if you are a teenager, probably quite quickly you get into a sexual relationship, everybody does it, but until you get pregnant, it's all fine. And you get pregnant and you become a bitch, you know (K2 456–459).

... they don't have children and they are not married with children, and the reason why they are here is like because of that, that they can do that. But in Poland they would be stigmatised for the fact that they don't have children and they don't have family, they don't follow that (K2 1161–1164).

... Polish women are not allowed to be overweight in Poland. And that may be a small thing, but it's not. Because if you are slightly overweight, and I would be regarded for example now as getting quite fat ... Or people notice that I put on weight, and they would comment on it. Every time I go to Poland, women in the shop, you know like says, 'Oh, you must be living a good life in Scotland' (K2 1234–1240).

... women are always watching how much they eat, what they do, all the time it's the subject, you know every time I speak with my sister or with my mum, there is something about the weight and it comes from the guys and from the women, and it's only again towards women. So you see that everybody like from Poland, most of the people are quite slim you know. And they still have that, you know, paranoia about (K2 1255–1260).

I think that like what was the role in Poland for the woman was that when they were young, they were very slim. After the third child, they weren't any more. You know, they were sitting at home and you know, and let's say that they kept working, the women, they would never put on weight because of the workload, you know. If they stayed at home, this is when they would be. But then, it was quite accepted after 40 or something that you would put on weight. It was just about, yeah, half of your life, you need to be slim, and then you can eat. After you're, you know, you're not attractive any more anyway (K2 1268–1276).

My sister is collecting clothes, children clothes for me when I don't have any plan to have a child, you know (K2 1344–1346).

Having Access to Professional Careers for Women.

This code was developed partly through the field work, where I met many women who had trained in various professions such as medicine, teaching, and clinical psychology.

Describing Domestic Abuse in Poland.

This code was developed partly through the field work. Many workers who supported Polish migrants described domestic abuse to me, including a Catholic priest who informed me that sometimes Polish men would excuse violence towards their wives in religious terms, which he tried to discourage.

The abusive relationships are so common somehow, depends, I think that like people just take it or used to take it as a normal thing whereas like I don't know, I even heard like the story of, you know, like that the psychologist would be saying, 'Better that it's such a father than no father,' and like 20, 30 years ago (K2 418–421).

Experiencing Stress, Disadvantage and Stigma as a Result of Gender Norms.

... usually for men, it's a shame to say their wife, 'I've got a problems' (C2 354–355)

... I mean until very recently, it wasn't common to get divorced even if the situation at home was horrible. You wouldn't talk about it much, so I think just stay in the relationship, you know like as long as, and quite shameful for the woman much more than for the guy. And as well I suppose if the woman does get divorced, like is a single mum for a while, and then finds another partner, that's also not seen very well by the society (K2 408–413).

R: ... what about mothers who have babies on their own all along? Like somebody who became pregnant and then became a single mother?

P: All right. That doesn't happen very often. People get married. To cover up. And the guy would be chased up by his family, he would be forced to get into marriage against his will. Because his parents forced him to do that. And that's in a village, I'm not sure how it is in the cities to be honest. But there is lots of, like in my village and the villages around, there's lots of marriage like that and they knew each other for two months, the girl got pregnant and then they had to get married.

R: And if a woman, if the man were to refuse or it wasn't possible to track him down or something, what sort of, how might the community treat that woman?

P: I think she would move out. And get somewhere, probably that would be the best idea, but I don't know an example of. Maybe there would be another friend who would like to marry her, you know, or something like that.

R: That's the sort of options they'd be looking at, uh huh.

P: In cities, I think it is sort of different, but at the same time, this is still exist there. So even if the society doesn't treat that person in any way, she still feels ashamed. But she still feels bad with herself, and she wouldn't speak about it, you know, she has new friends and she wouldn't easily share with people that she's a single mum or. Mm hmm. Very different when the guy dies (K2 434–453).

Coping Through Gendered Practices.

... usually for men, it's a shame to say their wife, 'I've got a problems' (C2 354–355).

... in Poland, I had a partner who was alcoholic. And he demanded my help and my advice, and he demanded me to be with him and help him to get away from it, to become normal. But it was very difficult for me because I did try to help him. But I didn't see much, many signs from his side that he wants to do the same thing ... I had the partner who was alcoholic and when I was struggling so hard to help him and it didn't work (C3 438–445).

... her problems developed because of her husband being alcoholic. And lots of nasty things were happening in the house (C4 296–297).

... in situations when the stress is bigger than normal, I love to listen to music and I put my favourite music on and it helps me to calm down. When I feel like I have listened enough to it, I switch it off and this is normally the time by when I have calmed down. And in very difficult situations where the stress is the worst, I basically let myself cry and sob as much as I need, and after that I do feel better (C4 333–345).

... At first when I worked very hard and was all stressed out, I just kept going because I knew that's something I've got to do. There's something, there was no other option (C6 207–209).

... they feel they are going to expose themselves and they don't want to show the family problems. A lot of, especially women in kind of different difficult relationships they don't want to talk about things (C7 1302–1305).

... he had another bout of therapy when he decided he was drinking too much. And he stopped drinking. He went to special therapy for people with addictions (C7 844–846).

... he's drinking. Not, not badly, not violently or anything. He just has too much sometimes and she's finding it kind of difficult (C7 899–901).

I think that like if the Polish guys, but usually guys would be having drinking problem, they'd drink at home or with their friends in their homes. They would

drink probably vodka or beer but like all of that like in this home setting sort of thing (K2 211–214).

Feeling Liberated from Social Pressures in Scotland.

... I was just thinking about my particular group of friends and that's people they are all my friends are single at the moment. Apart from myself. And they don't have children and they are not married with children, and the reason why they are here is like because of that, that they can do that. But in Poland they would be stigmatised for the fact that they don't have children and they don't have family, they don't follow that (K2 1159–1164).

It seems that lots of people come here as the couple. Then they split. After a while. Because of the woman's freedom and her feeling about herself (K2 1232–1233).

Rejection of Difference.

Highlighting Discrimination Towards Particular Social Groups.

... Scotland is a better country to live in. It's easier here, especially for lonely mothers who raise their kids alone (C3 201–202).

The help and advice that we've received in Poland has been very, very different. Everything is much better here. In Poland if one disabled was being born, it's left to parents only, and it's like all family's worries and hospital or doctors don't take care of child's overall wellbeing such as not only medical help but also social and you know, things to do for education and wellbeing in general (C4 131–135).

P: ... all the information is up to families to find out, there is basically lack of information, no-one tells you what you're entitled to, what you can ask for, what you should be getting. We had to go and knock on the door, on many doors and you know, find out information ourselves only. In cases when you ask too much, some of the, I don't know, officers or the representatives of institutions can be even rude, and once I was told by one of them that I have [my youngest daughter] so that I can get more money.

R: Right. That's pretty shocking.

P: And sometimes, and sometimes it is easier for them if people don't have access to all the information because maybe their work sometimes is somewhat easier. He basically has told me that I have given birth to a disabled child so that I can get richer. I was shocked. I was so shocked, and I felt so weak after he has told me these things, my entire body just felt so numb as if I was, I don't know, after drugs, although I have never taken drugs in my life and I don't know how it feels, but I actually felt so different than normally. And I have this basically reaction to my body after I had heard it. And it's basically

very, very humiliating. It's just hard to comprehend that someone can say that.

R: Yeah, yeah. So it sounds like a really horrible experience that you had in Poland.

P: This person, he worked for the organisation that helps disabled people and families which have disabled members to adjust their houses for the needs of these disabled people. So they would help you widen the doors or install some equipment in the bath or install some handles all over the flat when it's needed, so it is a specialist organisation that is supposed to help people. For me, it took three years to write different letters with requests to adjust the doors in the bathroom for [my youngest daughter], so throughout three years, all of my requests were rejected. And then after three years, finally they did agree to help me. But at the requests have been same visit, the same meeting, I have heard what I have said already before.

R: And that, the sort of attitude that that man had and the very rude way he behaved, have you come across many people who've been like that or was he quite unusual?

P: I have never met anyone other people as rude and hurtful things, however I am always I am aware that they have disabled child and people don't let me forget about it. In Poland the case is that disabled people are not really on the streets. They normally stay in their houses. They don't participate in social life as much. They're very intimidated and very closed and there is not much of acceptance in the public for them. If people on the streets see someone disabled, they make some nasty remarks. They make fun of them. They are not educated in that way to respect them. And it's very difficult for disabled people to do really anything, it's pretty much impossible to get jobs. Even for those that are fully healthy but for example cannot walk if you're on the wheelchair, you have slim chances of finding employment even if you have all the skills and abilities to do that. Also, it's difficult to sort any things in institutions or the council. You can't sort your own documents because all the big institutions have lots of steps and there is no easy access to places. So life for disabled people in Poland is very difficult and basically, if you have a child like this, it's your problem. This is the attitude.

R: OK. And are the attitudes that you've found so far in Scotland similar or are there differences there?

P: We don't go out a lot with [my youngest daughter] mainly because her pushchair is not well-adjusted, it doesn't have a cover and it rains a lot here. So we do not go out as much with her. But we did go to the medical centre once and what can say is that no-one stared at us as they would do in Poland. We didn't feel like everyone was looking at us or that someone is trying to say, 'You come from the spaceship,' or something, because this is getting back to the people we have in Poland. So we didn't feel different than other people, no-one stared at us and we felt actually normal, as one of the normal people (C4 184–242).

They see gay rights, you know, campaigners in the street. And they say, 'Oh, you know, ugh' (C7 723–724).

... it is really, really deprived area. People are, they basically leave school sometimes after just a few classes. So they can barely read or write. They don't really, well they don't watch television, they would say, 'I watch soaps.' They don't read anything. So they don't know anything about the world ... they're biased against anything, anything, everything they think is like, 'Oh, you know, ugh. This is horrible, that's horrible and he's done this,' and they take umbrage very quickly and they're really kind of angry (C7 759–768).

... I don't think they're gonna discriminate you more for being depressed than for having like for example that child out of the marriage or something like that, you know what I mean. Or the person who has a learning disability and the person who wears weird clothes. It would be the same level of discrimination, you know what I mean. So I think there is more understanding towards the distress than towards any kind of difference from norm (K2 586–592).

It comes with all the, that would be in the city, in the like, I don't know, if you're overweight, and you are in high school, it's just the most awful time I can imagine for you to be and that's gonna create your identity with this feeling, I'm not attractive, I'm, nobody likes me, everybody calls me names, I'm, you know, I'm not worth anything. Only because of the people's attitude around you. And your family and everybody like, it's like kind of national paranoia (K2 1249–1254).

... maybe old people are more discriminated (K2 1277),

... they don't, they don't go out. There is not much going on. Out there for older people. And older I mean after 50 more or less. Cities better. At least you've got like theatre or cinema or something like that. But people don't go to parties, people don't go out, you will not have fun, the people don't go dancing when they are after a certain age. Maybe once a year, two years starting or something like that, you know. You know. So there is some kind of different concept of, of getting old (K2 1281–1287).

Being Assigned a Stigmatised Identity as a Result of Contact with Services.

... I think migrants workers are very shy to say, 'I've got some mental problem,' or something like that. So maybe that's why I don't know nothing about it (C2 287–289).

... depression is a Poland, it's shame (C2 325).

That's a total catastrophe and you can't even admit that you have any mental problems. If you go to psychologist, it's pretty bad. If you go to psychiatrist, you are straight away the dumbest people in the world. You have, you're basically, I'm looking for the good word, because I'm using a slang word, which is like, sort of like you're a total idiot, something like that. And there's no respect for you whatsoever. People that go just to talk with the psychologist when they have

some, when they would like to talk to someone, they never talk about this. They never tell their friends. They only keep it to themselves. It's the biggest secret and no-one should know about it because you will get criticised straight away. And these two professions, psychologist and psychiatrist, are really bad professions in Poland and the people are very resistant to seek help (C4 276–286).

...I have one friend who is being treated by a psychiatrist. She has deep depression and some kind of nervous illness as well. And she's hiding it as much as she can. And I suppose that if she told her workmates, she would be discriminated against at work. She would have no understanding from her co-workers, and it could go as extreme as to the point that her employer might try to get rid of her and fire her just because she has this problem. And her problems developed because of her husband being alcoholic. And lots of nasty things were happening in the house. So this was the main reason for her problem, that even though there is an explanation for that, people probably will criticise her and discriminate against (C4 290–299).

... if someone who is look completely healthy would go and seek that kind of help, would be like known as someone mentally ill and people would treat them differently. Well maybe ostracise them even. So people do not really want to do that because of this (C6 99–102).

... we lived in a small well, it wasn't a big town, it was a kind of well, larger village, but it was still a village. So the moment something happened, you know, immediately half the village was talking about it, well two women met at the shop, and you know, tongues got wagging. So people, but people were disapproving of anyone going to psychologist and talking, you know, there must be something wrong with them. But even going back earlier to the 80s when it was a real stigma going to a psychiatrist (C6 123–129)

... there is another group of people I work with which are contract workers. They come here just to work and make money and they drink and they don't, they're not very nice people. They might not like the idea of someone going to seek that kind of help (C6 163–166).

... people in the street could have it a bit more difficult to get the right, and yeah, and the stigma of the whole thing. There's still, it's still there, people still (a) either don't believe in the existence of ADHD at all, and they say it's just bad upbringing and nasty kids and horrible parents and all that. Or they think, OK, maybe there is ADHD, but you know, we don't have to put up with it, you know, put them away. Lock them up. Because they're not normal, you know (C7 101–106).

... apart from watching uh, soaps on the television, the other thing is to, to gossip probably. So anything, it's go, 'Ohhh, did you hear about him? We went to the psychologist!' You know, 'Oooh! I wonder, he's probably going off his rocket, you know. Oh! That's exciting!' (C7 746–749).

... probably if you talked to them about some of the things, they would just go (in gruff voice), 'ADHD? What is this? And, aagh' (C7 791–793).

... he was leaving the hospital. It was the, obviously there was something wrong with him the, maybe they had to increased his medication or whatever. He was just really nice, you know. Em, yeah. [My friend] says, 'Oh no, he's fine. We've been playing cards. He's OK.' And said, 'Could you give him a lift?' I said – (laughs) – you know? 'What if he takes a knife?' (C7 941–946).

... we're trying to avoid disclosing where she was. It was not disclosing where she was, you know, not telling the family. But the family I think, well realised. Because she was scared that her ex-husband's family might use it to take their son away from her. But fortunately, it didn't happen. He was kind of, it all kind of, yeah. But it worked, yeah. She was really furious at first. She was really furious saying, 'Why did you do that? They won't let me out now' (C7 960–966)

... I would agree with the thought that there was a stigma attached (K1 437–438).

... I think the idea of being in psychiatric hospital or maybe a private psychiatric unit in that hospital is quite stigmatising and quite difficult. Once people is there it is quite difficult to forget ... When something happened, once that person was associated with the staff of psychiatric services it was there in the memory (K1 445–450).

... they would be like quite horrible maybe sometimes, maybe the children would be laughing at that person (K2 563–564).

Discussing Historical Antecedents of Discriminatory Practices.

... the whole structure was so different and was all about who you know and who you don't know, who you report about, who you report to things like just going on. And like, I think that lots of gossiping or lots of things which I'd rather spell about that or I think is coming out of that because you had to report things. In the past ... You were sort of probably very much forced to observe others because you never knew like, I don't know, I know more that from the stories from my parents and my grandparents, but for example you would be asked in the middle of the night to go somewhere and they would be asking you, "What did you do ten years ago with that other person?" And that was maybe your, I don't know, schoolmate. And you went out fishing. But they want to know the details, what he said, or with it, so you know, so it would become quite, how to say, you observed, you tried to remember what was going on with others (K2 25–39).

... it's like funny to speak about it, it's like everybody had their kitchen in the same, arranged in the same way. Everybody had the same furniture because it was such a limited choice. It was whatever they were actually was selling in Poland you know so all the families had the same wardrobes in the whole region

you know like. That was like ridiculous you know like and we didn't even know about it until you went to somebody's house and you saw oh, this is the same (K2 904–910).

Viewing Emotional Expression as Culturally Acceptable.

This code was partly developed from the field work, where I observed that members of the Polish community appeared to be quite emotionally expressive and would communicate their opinions and frustrations frankly and openly.

... it was interesting to read about the levels of emotional expression acceptable in Poland ... it rings true, especially comparing to the UK – even watching Polish news provides examples, with sometimes very emotional arguments between politicians (K1, email commenting on findings).

... in Poland, if somebody screams at you, that's quite normal. You know what I mean. Or if somebody is a bit more emotional, then usually that's quite normal there as well. So until that person's, I don't know, like basically the society is probably more tolerant, which is quite surprising. In terms of emotional distress, you know. It's a different sort of work and life, you know here I think that if you come to work and you start screaming at everybody and it continues or you, it happens from time to time on a regular basis, you, that would be addressed quickly. And maybe you would start them in counselling or maybe that, or maybe that. In Poland, people wouldn't. They would just say, 'This person is sort of crazy. We'll need to just put up with it somehow,' you know (K2 233–242).

I suppose what I sort of mentioned at the beginning that I feel that in Poland, people are more understanding towards the nature of distress in general, and I'm not sure if that's good or bad. Because you need to pull up you know like, cope with a lot of things at work, let's say, but like have of the theme and people are very distressed, if somebody's distressed and somebody cry, is crying, and somebody's angry, you know, and you need to sort of deal with this somehow (K2 596–602).

I think that in Poland maybe people have more tolerance for distress (K2 765–766).

Judging Reasonableness of Behavioural and Emotional Reactions.

R: ... what sort of person do you think might end up becoming depressed?

P: Every kind of person. Every kind of person, you see that can be a teenager, it can be a retired. It can be a factory worker or a manager. Everybody can have the depression. Just depend what they, what experience they've got.

R: Yeah, uh huh, uh huh. And sort of experiences might lead to depression?

P: Some stressful things. Some stressful things or for example if somebody wanted to try the best what he can for a family and he can't do that because he's got some barrier. He can feel bad. He can feel down. You see, and that's the start of depression in my, in my personal view (C2 331–340).

... I know that these pains are related with the stress I have and with my life, it is quite rocky at times, so I kind of knew what was the reason for it ... (C3 163–165).

... when I'm more active and more people are around, I do feel quite normal. But then I get really sad and depressed in the evenings, but this is the time when no-one from the outside is around me (C3 281–283).

... I do see a reason why I am like this right now, because I am aware I need to make a very difficult decision, decide where to live, and I simply don't have the strength to do this difficult decision at the moment (C3 291–293).

...in Poland, I had a partner who was alcoholic. And he demanded my help and my, my help, my advice, and he demanded me to be with him and help him to get away from it, to become normal. But it was very difficult for me because I did try to help him. But I didn't see much, many signs from his side that he wants to do the same thing. So it's not, it wasn't depression that you know, just comes and you just don't feel good. I had the partner who was alcoholic and when I was struggling so hard to help him and it didn't work, that was when I decided to see a psychologist (C3 438–445).

... I have one friend who is being treated by a psychiatrist. She has deep depression and some kind of nervous illness as well ... And her problems developed because of her husband being alcoholic. And lots of nasty things were happening in the house (C4 290–297).

I've got a son who is eleven year old and a person who a few weeks ago he was a very hard bullied at school. And he everything covered, and he wouldn't like say to me what has happened, but I observed him. I was shocked that something happened at school. Very wrong, and when I press him, he said me everything. And when I went to school and ask, talk, when I was talk, when I spoke with the, with head teacher, I received very, very concrete help from them and everything was spoke. But just now for example, my son has a problem because he is quite nervous (C5 642–649).

We've got regular money with, that means we're calmed down, we don't have to worry about things, there's no more we're worried about the financial side of things (C6 173–175).

... I know people with real issues. I've got a friend. He had a very bad split from his ex-girlfriend. He's now happily married, they've got a child, and another on the way and he's, he's OK. But he had years of therapy after that. He was really poorly (C7 841–844).

I've got another friend. She's had terrible childhood. She told me all about it. She was like, her parents got work in Africa. And they took her with her. And she stayed there for a couple of years. And she loved it ... And then they came back to Poland and they got another assignment, the same place. And they only took her sister. And they left her with her grandparents, who were not very nice. And she had the abandonment issues, you know, she felt, for a couple of years, she really had problems. And then she had a bad relationship when she started studies. She, as a result, she stopped, you know, she dropped out of university (C6 868–880).

... if somebody would have problem after getting divorced, and got very emotionally disturbed and needed to go to the hospital, the person would go to the hospital, came back, got some medication, and probably after a few months, she would be fine. She would never go back to the service, you know, and nobody would mind that she went and I suppose understandable, you know (K2 127–131).

I think that people's knowledge in Poland about psychology and mental illness, it's not very, very wide. You know, like they would say they would be two categories, these people are a bit crazy. Or something. Or hysterical maybe like, but they don't have much of the concept of, I think it will relate things with the life events. And something like that. And usually you can actually see it as well, you know, like something will happen and that person isn't well, you know (K2 573–579).

... people live with the neurosis or something, then they do their things, and like the family accepts that they've got that diagnosis, it doesn't mean anything, you know like, they've got like people would have like very kind of not very developed concept of what it means. Like for example, neurosis would usually be seen as a person is a bit nervous. You know. This is the concept of neurosis. If you've got like depression, yeah, that person is a bit sad, you know. So that's the concepts people have (K2 645–651).

... quite a few people who get that diagnosis and still I think if they were able to get back to normal, they would be OK. Society would be OK and they would forgot that they ever had that diagnosis, you know. Diagnosis is like, I don't know. They, people just don't, they don't give a shit, you know, what it's about. And they kind of like diagnosis, like any kind of label like from the psychological psychiatrist, it's like almost like detached from like (K2 705–711).

Urban-Rural Class Divide.

Describing Urban–Rural Divide in Poland.

... all these areas that used to belong to Russia, they tend to be less educated, less industrious kind of people, less business acumen. They're trying to break the stereotypes, but the stereotypes are there because of something. I mean it's not like completely, you don't have smoke without fire as they say. You know, there is something, there is it. They try to do something, bring people up and try to maybe put more money into those deprived areas, but basically, people living in those places tend to be a bit more closed and less eager to accept newfangled stuff (C7 735–743).

... most people there don't have any work. No work at all. They, well they do temporary or seasonal jobs. But mostly, they go when their money's finished and don't have any money for vodka, go to work for a while. Sometimes they won't even finish. The moment they're paid, wheesht. They disappear. And on Sundays when I went to visit my mum, they would be lying. In the ditch. Along the road. Sometimes five or six of them you would pass. Lying there. Oh, you know. Out of this world. It is, you know, it is really, really deprived area. People are, they basically leave school sometimes after just a few classes. So they can barely read or write. They don't really, well they don't watch television, they would say, 'I watch soaps.' They don't read anything. So they don't know anything about the world (C7 752–762).

Describing Life in Poland as Stressful and Difficult.

... in Poland the life it's really stressful and the young people start working and you see in Poland that's a poor country, still economic down. And young people's got a lots of problem, lots of things to do, lots of worries. And that's so stressful (C2 171–174).

Financial trouble usually financial problems, economics problems, you see for example, if it's family, five members, well obviously have three, and three childrens, and one of he's a got a, for example, seventeen or eighteen, and the other two are younger, that's always want try help the parents, so he try find a job. If he's find a job, he's got own money, so you see he's got then hard choose because just now he's got own money, he must help the parents, own parents. He must go to school as well, continue education and that's the things you see. They are tired, but they think they must help the parents. They won't go with their friends for example to some pubs or some parties, so they need the money. If they go for a party, they lose that money, they can't the parents. Or for example, if they, you see the teenagers got the absolutely different, different way of thinking. They must, they want show other people how they are good, they won't wear good dresses, they won't go to the dress around good pub, but in home are poor you see, at home they need the national help. So they got hard choose what they can do, that's the stressful, and they see in the school obviously, in Poland it's a

depression also standards are a level higher though. So they must learn not only in the school six hours but they need a lot of learning at home. But you see, if he won't learning at home, he's got another choose to go to the work or learning. If I go to the work, I've got the money. If I go to the school, I need waiting for a money next ten years (C2 208–227).

It's hard to do that and that's a little sad that they young people must start to get, because their parents can't provide all, you see. For example, if both of them working, they cannot have time to, they cannot have time to spend with their children. With their children, you see. The children grow only yourself, and the, they don't know a lot of things. And for example if the parents won't provide all to their child, children, own children, they lost something like a good culture or something like that. Then boy who's got fifteen or sixteen can you see can go for street and I don't know, try to earn decent money for example selling drugs or something like that. Or lose his school, leave a school because he go there to make some money because parents can't provide him nice trousers or something like that. And the young parents obviously who's got the twenty-one, twenty, twenty-five, you see they've got wee babies start buy, they're good family, they try start will take you by the good family, and they've got a lot of barriers, usually that's the financial barrier. So you see they've got some credit cards to pay, some credit, some loans, they must, I don't know, improve own home, they must buy for baby, they must eat something, and they've got only two, and you see they've got only a jobs, they must co-operate how many time can spend with their baby. With yourself obviously, and that's a very stressful, because you see they want to provide all the best for baby for other part of marriage. But they can't (C2 233–252).

It's easier here, especially for lonely mothers who raise their kids alone. And I have this, I am aware that in Poland in some cases, it would be better, but I wouldn't get, I wouldn't be entitled to so much and yeah, different kind of help that I am here (C3 201–204).

... I do know that if I lived in Poland, I would have to work so hard and such long hours that I would not be able to see my baby as much (C3 264–266).

P: The most important thing that's changed for us is the stabilisation that is provided by work. We've got regular money with, that means we're calmed down, we don't have to worry about things, there's no more we're worried about the financial side of things, which means we can have a car, we can go out, do things and have normal life. Something that we did not have back in Poland because of the financial problems. Most people coming to live in Scotland, that's their aim. To be able to work and live normally without having to worry about what's having to happen next.

R: And when you were back in Poland and you did have financial worries, how did you cope with that?

P: When we lived back in Poland, we did have financial problems. My salary only lasted barely from the first of the month to the first of another month. It was all very, very tight. We did get some payments from social services and

my father, he died, he's dead now, but he used to live with us, and he helped us a little bit as well, plus living in the countryside is slightly different than living in the big city because you've got your field, your garden, you can grow things. So we did manage, but it was always very nervous, and we never knew what was coming, so it was really very, we didn't have, couldn't afford a car. We didn't have lots of things that we would like to have.

R: And what impact did that have on you as a person?

P: I always felt worried and I was always like nervous and I felt helpless not being able to do enough. I worked nine to ten hours a day, sometimes on Saturday as well, it was still not enough. So finally I started thinking, what can I do, where can I go to have work that will make me able to provide for the family.

R: And when you were in that situation when you were working really hard and feeling very worried, how did you manage to keep going? What things did you do?

P: At least one thing before, one of the worst thing was also the worry of losing the job. I was always scared that I might lose the job cause the unemployment's quite high in Poland and it's quite easy to, for that kind of thing to happen. So the lack of stability at my work (C6 171–202). .

I used to have a lot of ailments back in Poland. Nothing life threatening ... I had colds all the time, and I just coughing. I was feeling sometimes then they said, I went to the doctor and said, 'You must have some sort of allergy or something.' But when I left, well yeah, I was trying to look for something, maybe in my flat. But also when I went away and stayed with friends, I also had it. So I don't know what it was. I was kind of allergic to Polish air! (laughs) But no, I'm joking. But there was something there was making me ill. And I had problems with my heart. I had the palpitations like the very fast heart mutters and things that you know. And I was really, it was nothing serious, I did go and I was tested, all possible tests. And the guy said, 'You're completely healthy, you don't need a cardiologist, you need a psychologist.' (laughs) Because there must be something, you know. And maybe, you know, maybe it was a bit nerves. Because that was before I moved, so maybe I was already thinking about the move and, but the moment I moved here, pff, disappeared ... I think it's just general atmosphere that's being created of you know (C7 617–637).

... in Poland, there is more of, life is very stressful in a way (K2 769–770).

Migrating for a Better Life.

I am coming here because my friend was here, they need a translator actually. So that's why I come. To help them and obviously for a better job (C2 27–28).

... young people's got a lots of problem, lots of things to do, lots of worries. And that's so stressful. So if they come here to make a better life (C2 174–175).

... during my five years' experience with the immigrants workers in Scotland, it's much better (C2 272–273).

I came to Scotland as most of the people for money for work (C3 7).

I tried to gather information about the services when I was there, also talking to other people and trying to find information about the services from the services themselves. But the information available was not great in Ireland or Sweden. But it was quite good, even leaflets and information that was published and even in Polish and readily available. Plus whatever I find out from other people living and working here. But my work was also important for coming here. Being able to find work (C6 22–28).

... the change in my life was forced by what happened. My, the factory I worked in got closed down. We were given three monthly notices and I had to do something to, would not be without work. And I'd been thinking already about going abroad, and I started looking, wanted to go and work with a good company so I've got the stable work. And I started looking in Ireland and Sweden and Scotland as well for finding work, that's how it happened (C6 209–214).

... most of the people here that I've met, they definitely their reason for moving was, yeah, financial basically ... if they had right money in Poland, they wouldn't go. Because it's leaving the family and all that. But then, because he knows that there, they would struggle. And here, they've got money they can, as I said, live normally. And afford a car. Go places, do things. And the family, you know, they're don't have as I said, they're better, and don't have to worry what's going to happen. And I think that's the most important most people say that. They would like to go back to Poland. But they don't think they will. Because there's nothing waiting for them. Apart really from friends and families but not in terms of lifestyle. No lifestyle. No car, no house or sometimes old house somewhere in the middle of nowhere or even very nice. But here, they are kind of, you know, they're kind of starting to live (C7 1328–1340).

... some people come here just here just for work. But some think, you know, Scotland can give them something else. And they are seeking to learn new skills and do new things (C7 1388–1390).

... when I graduated, there weren't, the Polish economy was in a debt for maybe two or three years and there weren't that many jobs overall (K1 226–227).

Probably if the situation was different, if there was, if there was a job I could take after graduation, I prob, I might not move. I won't say I won't, I wouldn't definitely, but I don't know, but I might have stayed there (K1 234–237).

... people also noticed that over here, you, well you basically can live even on a lower paid wage, especially Scotland you can afford small things, you can afford going to the cinema, you can afford new outfit (K1 288–291).

Migrating to Gain Freedom.

... I think it give me really good experience to be able to work in different system and to be able to (...) I think it very opens your mind when you're working with different people from different cultures (K1 239–242).

I think what I didn't like personally from being in Poland or living in Poland was some kind of difficulty in doing things the way I want (K2 12–14).

... one of the reasons why I left Poland was that I didn't want to feel so dependent on others (K2 251–252).

... for me personally it was just independence. And this is why I'm still here. Because I know that if I ever would go back to Poland, I would need to rely on family. And I don't want that, you know (K2 329–332).

... people who just come for the adventure, for I don't know, for having fun, because it is one of the stops in their travel, you know, it would go more for studying you know, they maybe want to study and prefer to study here (K2 1223–1227).

Thinking Different Demographic Groups Settle in Different Areas.

... we lived in a small well, it wasn't a big town, it was a kind of well, larger village, but it was still a village (C6 123–124).

R: And most of the migrants in your experience that you've met in this sort of area, where would they be mainly from?

P: But obviously they would be, they would be, they would be mainly from Poland B. I would say from the kind of poorer areas with higher unemployment rates (C7 1324–1327).

... that's the area also that there used to be a lot of factories, quite a lot of Polish parents would live. And well one of the explanations I thought could be that if people were looking for different types of jobs and if people knew that there was that job in a factory in these types of employments, then they were looking for the same job, then maybe it would be people from the smaller towns, and otherwise there were a lot of qualifications, and people with that type of experience, they

never wondered they could transfer it here. In terms of people working professionally, these would be the people that would work for just in their specific areas and they would be more likely to move to the areas where that particular work was available (K1 377–387).

... somebody found a job. With 11 years ago whenever it was, you know. Got another, like they found out that there is another like let's say three vacancies next year. So he goes like his uncles or his cousins or his friends, and they came over. And then they brought families. And then, and other people came over hearing about it and they were all from some sort of one region or something like that, because there is quite a lot of these kind of small environments of Polish people that hear that they, I don't know, let's say [local bus company] have cleaning, you know, like that's a big, or there was a cookie factory and there was like everyone, lots of Polish people and they would be like coming, friends of the friends of the friends, you know. And staying there. Like for example, from my early job, lots of people went to Ireland. And there is maybe 70 people in Galloway from my town, like they leave my town. And they live there, and they are happy and like half of my village emigrated as well. And I am sure that these people are very much about planning to maybe go back to Poland in ten years' time or something like that, or maybe not. And they would preserve all their traditions, and they would live the same lifestyle as in Poland (K2 1207–1223).

Employing Help-Seeking Strategies in Line with Social Class and Urbanicity.

... I think in Poland it really depends where you're from, and if you live in a big city or in bigger towns there'd be the opportunities for seeing psychologists would be much, there'd be more opportunities for seeing psychologists and I'd say probably people would be more open about seeing psychologists rather than in the small towns. But the provision would be less likely to be adequate as well (K1 8–13).

... I remember when I graduated, there weren't that many jobs in psychology, and the jobs that were, they were in big towns, well in bigger cities and towns. There weren't that many jobs available in rural areas. So I think that's one factor. The other would be the people in the rural areas would probably form quite close communities and people would know about each other, so I think seeing the psychologist still might be seen as something, people wouldn't like their neighbours or their families to know. And this would be more likely if you are from the small town and living in those communities (K1 44–52).

It would probably all have some impact but, all impacts on the knowledge of psychology, of what is psychology about and people being more open about their accessing psychological services in bigger towns (K1 164–166).

... I think it could have, that possibly could be also the reason why the smaller communities would be less likely to seek psychological services themselves comparing it to the bigger cities (K1 450–453).

I suppose that definitely more educated people would go in the cities, they would go. They would have more access as well to the psychologist (K2 96–97).

... if you are quite rich you would go there and that would be even quite cool to go to the psychotherapist or something like that (K2 477–479).

EXPERIENCES WITH SOCIAL INSTITUTIONS

Experiences with General Health Services.

Feeling Disappointed with Scottish Health Services.

Just waiting go to your doctor, you're ringing in the morning, while here, it has to be, if it's emergency it has to be before nine, or you have to go to A&E in the hospital. In Poland, you know, you can just appear and to, like to be seen by a doctor and you will be. So there is not a problem, and I just think there is, you've got your GP, sort of general practitioner right, and can help you with anything and just give you, how do you call it, when I talk to the different specialist, a referral to a different, you know, to gynaecologists, to any sort of, you know, doctor (C1 40–47).

... my husband he, well, he lost two teeth, and they wouldn't be, they said they would just pull them out instead of you know, how do you say, I don't know, put the fillings in or you've lost two. Where in Poland I think he would have them done and fix them, yeah (C1 70–73).

I think they just you know, giving a Paracetamol for every single unless it's just, you know. It's strange ... I never been offered so many, you know, times to take a Paracetamol or Aspirin or whatever (C1 98–102).

... I just don't take it. Because you know well I know if something's wrong with me, you know, my sense is telling me that something more serious than just you know taking Paracetamol and I know that the system here is rather you know, doctors are not keen to give the antibiotics as often as maybe as in Poland (C1 105–108).

... sometimes you know, you're thinking it's something worse and you're going to the GP and the GP gives you the Paracetamol you know while you're thinking, OK, I shouldn't get something you know stronger to that (C1 122–125).

She wasn't getting nowhere here. And after she came back from Poland, and obviously she had the documentation, everything on the paper, you know

translated as well, and well, she had the document as a proof, so it just started from that (C1 273–276).

I think there should be more contact with, direct contact with the specialist, you know. I think well for all of us, not just for Lithuanians or Polish people, you know, I don't know how you're finding, but you know for me, especially if I was in you know English or Scottish I would like to see you know the specialist whenever it's needed, you know, when required. Instead of waiting months you know (C1 411–416).

... sometimes it's a little strange because you see we've got different experience. Usually Eastern Europe worker, their health services are a little different. For example, in Poland if you need to go to the doctor, you could visit in the same day or the day after. That's usually you can't wait one week or ten days like here for a visit to your GP. Or sometimes that was a little strange and that's a strange for other people who come into Scotland, they can't understand why that's happened if they need a help urgently, they should get it. But you see they come for NHS 24, they've got only advice to take a Paracetamol, something like that, that's so strange (C2 40–48).

You see I was angry. Because you see somebody has some health problem and you need the help, should get it as soon as possible. Even it's only sore throat or high fever, doctor should see him or her and give some advice or something like that, not waiting a few days. Because that doesn't make any sense for me because if I've got a high fever today, what's the point to visit a doctor next week? (C2 51–56)

... they don't trust actually doctors here because for example, if my colleague got a problem with the stomach, and she go there and the doctor don't even touch her, don't go to gastrology department or something like that, just tell her, 'Don't drink the hot drinks', or 'Eat healthy, eat the wrong foods. Don't eat fatty foods,' or something like that ... (C2 71–75).

... it's big difference actually. Because that's what I try say, if you go to the doctor in Poland or probably in Lithuania normal, or somewhere else, you've got appointment in the same day, you don't need to wait one week or longer and after visiting your GP, the GP doctor give you who can say you something, you see GP doctor can talk to you, 'Oh probably you've got in your stomach, it's something wrong, we need do an X-ray,' or something like. Here doctors say, 'You don't eat fatty foods.' That's the difference (C2 89–96).

...if somebody goes a twenty-five years or even thirty years and know from own experience what's the problem with the throat. And only method who can help can take amoxicillin for example. And he know that because he usually used that in Poland. If he go to doctor in Scotland and say, 'I've got a problem with the throat. I know for last three, four days I can lost my voice. Could you give me an antibiotics?' Doctor here say, 'No. Take a Strepsils.' That's the, that's why

migrants workers here don't feel good with their GP, with the health service (C2 112–120).

... in Scotland, if you go with the problem for example chest pain, stomach pain, or I don't know, leg pain. GP try do everything here. You see, just say, if you've got a problem with the legs, give you some creams, if you've got problem with the chest, give you I don't know, or say, 'That's muscle pain.' Don't even touch you. He say, 'That's a muscle pain.' If you've got a problem with the stomach, he say, 'You don't eat fatty meals' (C2 127–133).

I've got half year ago I've got a problem with my chest. And I took a chest pain. And phoned to NHS, and obviously ambulance will come to my house, take me to the hospital and take, do that graphs and take my blood. But on the graphs was everything all right, on the graphs. I waited one hour, then after doctor will see me and say to me, 'You've got twenty-eight years. You shouldn't have any problems with the heart.' You see, he don't even ask why it happened, when that's happened or something like that. And with my blood tests, he put in the bin. So that was shocking, absolutely shocking. Because you see if somebody, even you've got twenty-eight years, can have a heart attack. Or even there's something wrong with the heart who, what can be in the future worse for me. And after my visit to the hospital, he don't give me any medicine, nothing like that. Not even Paracetamol or Ibuprofen. That's common in Scotland, very common. But he don't give me any, he putted my blood in the bin, said I'm too young to have a problem with the heart and after that, obviously I back home, was very angry, I even want write some complaint, but I haven't a power to do that. And you see I back to the ward and after a week my pain back. Then I go to the GP and say, 'I was in the hospital and there was something like that and I've still got that pain. I can't even sit, move my hands or something like that, you see he don't even touch me. Don't even ask me to take out my coat. He just say, 'That's a muscular chest pain,' and give me a seven day's notice for my work. That's why migrants worker feel here (C2 141–162).

If come over here and try find the help, and he can't. Because doctor say to you, you are too young to have a problem with the heart. Exactly with the dental. You see my sister's got absolutely painful problem with the tooth. And I phone to NHS 24 and say, 'She's a tooth problem. She want to extract that. Where we can do that at this time?' It was nine o' clock or ten o' clock. So some lady who sit there said, 'How many Paracetamol has she taken?' I said, 'About ten.' Because that was very painful from seven a.m. for example, it was nine a.m. So she told me, 'Go to the hospital. To [local town].' And we go there to think they extract her tooth. But no. They do a liver checks. And give her another painful killers. You see, we waited in that hospital four hours and they give her one tablets of Co-codamol or something like that, or some stronger things. And for extract of tooth, she's got appointment for next two days. So my first thing was, where is the point to keep a patient with the pain tooth for four hours? Where is the point to send a patient for a check liver if she's taken a ten Paracetamol? Then after this give her another strong one, painkillers? That doesn't make any sense (C2 178–193).

I personally, from my point of view, would expect that if I go to the doctor, I want see a doctor today. Because I've got today problem, not next week. And if I go to the doctor for example with some skin problem, to the GP and show him a problem what I've got. He give me some cream. And that doesn't help. And I go again. He give me another cream and that doesn't help. I think on the first visit, if he's not sure what is it he should send me to hospital to see a dermatologist or something like that. But believe me, I'm living here five years and I never heard about it. If you've go to GP, they send you to other doctors. Never here (C2 546–554).

... if you go to the, to Poland to the doctor and say you've got a problem at five o' clock and the surgery will close at five o' clock, believe me doctor will see you. But if you come here quarter to five and say you've got a problem, I won't see a doctor, they give you appointment next week (C2 575–579).

... if you've got a problem today you should help, you should give the advice and help today, not next week. So you see I'm laughing because in Poland average length of life for Poland mens it's about sixty years. Sixty-three just now probably. But for the woman, slightly longer, for about seventy years. And but here, it's much higher. And we just, we sometimes laugh at how it's possible. If you go to the doctor with the health problem and they give you a Paracetamol, why men here living eighty years or longer. So that's the things (C2 584–591).

... if you need to see a, for example, a pregnant woman in Poland. They've seen a doctors a few times during their pregnancy. But my wife was pregnant here and born here our son. And she didn't see a doctor. She didn't see a gynaecology. She just see a nurse. And a midwife. But in Poland, if you are pregnant you see a doctor twice or three times during your pregnancy. And if you, if you're born a baby, a doctor is with you. But here, if you born a baby, it's only midwife with you (C2 600–607).

R: And how did you feel about that when your wife was pregnant and she didn't get appointments with the doctor?

P: Sometimes I was noisy you see, sometimes I was noisy because that was our first baby. And obviously, we are scared a little, about baby and about her own health. And for example, because when my wife was in the last stage of pregnancy and she start feeling that pains. On her bottom. I phoned to hospital and say, 'My wife is in last week of pregnancy. Actually date got born past five years, with five days ago. And what I should do?' And if you phone with that questions to Poland, believe me, after ten minutes would be ambulance at your home. Or they ask you to come to the hospital. But here when I phoned, they told me, 'Do a warm bath for your wife. And come tomorrow. If somebody, if something happened worse, come today. But if everything will be all right, come tomorrow.' So that's the things.

R: And how did that feel, being given that advice, just to run a bath?

P: I was angry. I was angry, I start screaming. I start screaming, you see. And I think a lot of people do exactly the same way. That's why on the doors of GP, it's that great black ad, 'Don't be angry. Don't be angry. Don't use violent

abuse. And we are working here, we want quiet,' or something like. So you, and they do that posters, they know what they do. Because believe me, probs, 99.9 person can be angry after this advice (C2 615–635).

... here, if you go with the heart problem, GP give you a Paracetamol or something like that (C2 643–644).

... I think should be the specialist should be more available for migrants worker (C2 650).

... if that would be possible, they give you an appointment tomorrow. Not ask to wait one months or two months. Because if you've got heart problem and you wait two months, believe me you can't go on other appointment, because you can be on the underground (C2 670–674).

... people can be a little bit discouraged when they are seeking information, because I am trying to get a coil? A coil. And it's been four months and I still didn't actually get because the difficulty is that I am being sent from one office to another office, from one institution to another doctor, my GP has sent me to go to the family planning clinic, and they have sent me to different office, so especially because I don't speak English, I'm being moved to all the different specialists, and it takes way too much time I believe. And now it's been four months (C3 122–128).

... the system is a little bit confusing and you can get lost in it. It's a bit complicated, especially sometimes to reach your own GP, you do and have visit with him, but then they don't, it's like not granted that they should take care of this person ... So it's a bit of a waiting and they don't always take for granted that you really need it, so there's a little bit of doubt and if they should be the ones that should help the patient (C3 133–138).

... the contact with the GP is a little bit more artificial in the way that they don't help you as much directly as the patient could expect. For example, in Poland, if I go to my GP, he will at least do the main checks, he would listen to my heartbeat, check my, I don't know, temperature and things like that. Whereas here, GPs tend to refer you to other specialists without having exact look at you and they don't prescribe medicine as quickly, they refer you to other specialists which makes you wait as well, so it's a bit more like they (...) For example, I am a bit worried because I did go a few first contact doctors and I told them, at least three of them that I have chest pains. And it's just a bit worrying me. And none of them have told me anything very specific what I should do. So I still feel like do have the pain and I'm getting a bit anxious about it, but I have no clue what's wrong with me ... my request was to prescribe me some calming pills, because I know that these pains are related with the stress I have and with my life, it is quite rocky at times, so I kind of knew what was the reason for it, that's why I asked for those calming pills, but the doctor disagrees to prescribe them to me. And I don't remember what exactly said, but he might have asked me if I want a referral to

another specialist, but there was nothing specific, no specific help I have received (C3 149–168).

In Poland once you see a GP, it seems that the Polish GPs are more, have the broader knowledge about all the issues, health problems, about the patient themselves and they would be able to help more quickly and directly. At the point where they are not able to help you any more, then they would consider referral to a specialist. Whereas here, when you see GP, they don't actively help you. They more just get confirmation that you really are unwell, and they don't help you, they don't give you this first help straight away. They, well in some cases, they do refer you to a specialist, but not even always that (C3 380–387).

They probably would wait until you come back again just to prove that you're not well. So if I was to come a few times and consistently, persistently you know come back for a visit, they would probably either change their mind and do something. But if, yeah. Not the first time (C3 398–401).

I hate to say but for example especially me, I've got a, because, I don't know how, it is a quite personal, but from eleven years, about eleven years, I've got a [health condition] for example. And in Poland, I always used our service and when I came here and when I try get a help for me, for example, it was probably the most horrible experience. I didn't, I really didn't have a good experience with this area. Because the health system here in UK is working definitely different back in Poland. When I was sick for example, or I've got a problem with my hip, especially in this area like rheumatoid arthritis, I just call directly to the, our [condition] specialist, and I make an appointment for next week or next week, something like that. It wasn't, it is very, very easy access to get a specialist advice. Here it wasn't. I need to, I need wait here, really, really, over half year. And it was very, very terrible for me, because I feel quite bad here. And I waited and waited for a doctor's. And it was very, in this time, it was, I was very, very surprised. And when for example, I've got a woman's problem. I need to go to the, like gynaecologist. And I'm, go to the doctor. And he said to me, I cannot give you advice. I can check you, something like that. I was very in the shock, because usually, for example in Poland, if I got a, definitely it's a woman's problem, I go direct to the gynaecologist, never GP can check me. Do you understand? It is very easy. I can't say that it is worse, but is definitely different. Can you understand, after that, after a few months, I start to understand how health system here is working and became a patient patient, and patient. But at the start, definitely I was very surprised, very impatient ... (C5 96–117).

... if somebody have an information, like a woman's information, something like that, then you need to go the doctor immediately, either one week for example. And I remember when I didn't, I couldn't speak English. And I couldn't manage with everything, it was quite, a very personal problem, and I went to the GP, I said, 'Please, please will you give me a help?' And the doctor said, 'All right, I arrange for you an appointment with gynaecologist.' But I'm really waiting to hear over half year or something like that. And I feel very pain inside my body or something like that. It was terrible. I couldn't really believe in something like

that and I know that is a problem with my language because then now if I've got a problem I need to just press I need, and definitely I need, and they need to give me something like that. They need to give me a help, something like that. But in this time, nobody turn around. Not for that is a very, very, very necessary to give me advice. And my personal impression is, when I went to the doctor as a foreign person, without any good language, I think that maybe it is quite painful what I say, but I think that doctors, he didn't take me seriously (C5 131–146).

P: ... I can compare the like a GP system here in Poland. Because are quite definitely easier access. Definitely easier access. And the doctors check us generally, if we've got some problem, they check us general. If I said I've got a, for example, a very bad headache, for example, from ten days or something like, doctor don't say to me, 'Maybe you've got a, for example, a migraine,' something like that. He send me to make a like, och, what is a, like a (speaks to interpreter in Polish).

I: Specialist? No, no.

R: Like a radiologist or something?

P: How you say (speaks to interpreter in Polish)

I: Scan.

R: Like an MRI?

P: Yes. Uh huh. And present, they are, they looked, they're looking for us wrong reason for which one is causing my problem. To time when they find it, you understand. Never they send me, maybe it's past, something like that. Never they keep give me a present of painkillers. Usually when I've got even a problem with my children and me, when I am, even today, I'm very disappointed. Because sometimes when I feel very unwell, I'm resigned from going to the doctor. Because I know that if I will go to him, if I go to him, he gives me a just a Paracetamol. Because already it's sad what I said, but is true. In Poland for example, when I would like, when I've got a more serious problem, GP know about it. He directly said to me, if he cannot recognise for an example, you need to go to the gynaecologist or rheumatologist or different cardiologist, something like that. He send me directly and I can go even next day, next few days ... (C5 159–181)

I think personally, from my experience, that GP doctors, they don't have a really too much, I think enough experience. I think that our doctors, in like GP doctors, they are of course not everybody, but usually I talk very generally about everything. They've got a more experience. They've got a more responsible for decisions or they give for a patient. Do you understand? I am sure for example, in Poland for example, I've got to the ten years. Because I've got a quite serious and I, to get all years, I've got like some of kind like a, it was like a certificate that I am disabled for example. But here, when I tried to receive something like that, I, and I feel a lot of work for example. This form, for example, contains a lot of, hundreds of very, very personal questions. Which one, they touched me really, really too harsh. Because it was for example, a question, for example, asking, 'When you go to the toilet, can you manage, for example, with paper,' things like that. It was for me a really, very, very disappointed for me. And finally, the doctors arrange me an appointment to tell that everything is OK for me. An

appointment for example, this time, when I've got a very painful, for example knee. I said to the doctor, 'Don't touch too hard my knee, because it is very painful.' He didn't even notice it. He made me sob. I feel very pain. I've got a tears in my, I was very, very angry for him. And other for example, discussion for end of our meeting, he was very, very like, he was very, very cold and when he went out, I said to him, because he was, he tried not to meet for example, and I said to him, 'Don't try and be nice for me, because I know that you answered me unpositive. And I know about it.' Really he answered me unpositive. And when I said, 'I have a certificate for nine years in Poland that I am disabled person, a recommendation not one doctor but a few doctors who making like a commission, and they checked me, took my history of my illnesses, and here is my paper from hospital, something like that. All of them decided every year that I am entitled, or entitled to receive it would be, to have, have a certificate that I am disabled. You answered me no. I don't know why.' And I said, 'Maybe it's a different, everything is a different,' but I'm, for example, I'm lost any hope that I anywhere I'd receive for example, as a person with a [condition], I need to work very hard, physically hard. And I know that this work hard for example broken my body, broken is. It isn't good for me. But how can I manage for example if, you understand, whenever I try and receive for example any help for, always it was like close the door for me. It was right no. Something like that. And I don't know. Something, maybe it is like if I am unhappy, I am quite unhappy about it (C5 212–247).

... I'm even going to the doctor who, [specialist] who is for example Polish. And he quite write me for example two years ago for a medical, biological medicine. Is one that is very expensive for example. But I'm, he said me, 'All right. You need to wait. You can get because you're,' and he said, 'quite like you to get this medicine. You need to for example wait just now. It's queue. And you need to wait half year.' But I'm waited one year. Over one year after that. For example, doctor in this moment, had I dared to check me, check my adrenal glands. And they didn't work. They didn't work. And he said to me, 'You can get this medicine because your adrenal glands not working. You need to take a steroids for end of your life.' And was very surprised. And I was very angry. When I'm, and he cancelled me all my, because I asked all assessment to get this biological medicine, and I was really nearly to get it here because I've got, for two weeks I should receive that. But doctor cancelled everything. And after that, when I went to the Poland and finded my doctors and a specialist who, where they, I, who they rang the same programme in Poland, the clinic like to give, they for people with [condition]. This, the same medicine, I ask, they, I said to him my story and I said to the doctor, 'Check my adrenal glands,' and then he said me that they did, they didn't work and they don't work, and he cancelled by biological medicine. And the doctors, three of them said, 'He shouldn't because even we've got a lot of experience and we're working with patients like you,' something like that, 'and in the same situation, even when they, your adrenal glands just stop working and you've got a, you've, you are taking a small part of steroids, you are able to take, you know, for example, biological medicine.' And they've got a disagreement of his decision. But when I went to the doctor and because I repeat after a half year same test for adrenal glands and they're working quite better and it is quite

better. And I ask him, 'Now, when everything is a quite better, can I get this medicine, the biological medicine?' He said, 'No.' Because the NHS don't refund it now. You understand. And I said, 'That's mean that I've lost my cure, for example. I've waited two years for this medicine and passed everything. I spent a lot of time, still came here and like a meeting with you, and I didn't answer really nothing.' And I think that when I was speaking that decision, doctor spent too much time just for talking to, everything is done very slow, they've got time for everything, but over here, we live still for me, it's every month is very, very, every month is very, very important, because every day I take a steroids. But one day, they are very, very, for example, dangerous for me. And he, how will I say? How can I take a faster, a biological medicine that is better me? Like save my life? Where is my health? Something like that. But doctor have a lot of ill people and he doesn't hurry for example. He make me every appointment every half year. For example, he know that he received a last in my result of my blood test about everything in there much. But he made me arrange an appointment in the end of, for example, in September. It was over half year. I waited just for a answer if it's OK or no, you are able to take this medicine or no. You understand. It's horrible. I couldn't believe it. For example, in some situation in Poland, I can get a, I can make all process which one I passed here in just a few weeks. Three, four weeks, and I've got sorted everything, a hundred per cent, I am sure. Because I went to the doctor, I say, 'I am going to, can you help me?' And doctor has said, 'Of course. We've got a, this idea to help you. That one, that one, that one.' And then they realised everything point after point. It is working maybe very similar but very slowly. Very slowly. And maybe that I am person who shouldn't give a notice for everything but tshhh. I think that NHS lost a lot of money for something like that. It isn't very useful for patient. I lost a lot of time. I didn't, I am in exactly in the same pattern. Over two years been here. I am in the samepoint, like I came here two years ago. Over two years ago. In the same. I didn't do doctor, I really didn't do nothing to me in the future. You understand because just talking, talking, nothing more. Nothing more (C5 256–311).

... Here, the doctors, if you go, if there's nothing really very much wrong with you, they would just give you like Paracetamol or Ibuprofen or something, would just send you home, say you know, 'Drink a lot, take this four times a day, and if that doesn't improve after five, four or five days, you know, come back and see me again.' People say, 'Well how, why, that's not what I wanted. That's not, you know, I could have taken that myself. I don't need the doctor to tell me that!' (C7 6–12).

... I know this case that doctor was just sending a child off with no medication, with just Calpol. And you know, drink a lot, Calpol, and keep warm, whatever. And after two or three visits, it turned out the child had to go to hospital because he was dehydrated and it was not, it was something, it was some sort of infection that was not treated (C7 19–23).

... I can, must say I did not have enough contact here. I'm saying not enough, because I did ask GP for referral, and they said they would send a letter. And that was like four months ago, and the letter's not arrived (C7 35–37).

... from the information I've got from people, is that they're not giving out enough drugs. They think they're, as I said, they're being fobbed off with Paracetamols and they thinks like, you know, Paracetamol is sold in every single shop. In the cornershop. So why did I go all that way to see a doctor to get Paracetamol? (C7 470–474).

... I think it is connected with one thing which is very, and which I agree with, is that you just don't go here. Because you know what you're gonna get. You know like, you're gonna get Paracetamol, and then you would be sent home. And that's it (K2 492–495).

I think that the health care, I mean definitely from there what I've taken is that the one thing I agree with is this yeah, physical health bit and I don't know like, in here, which is so different from Polish way. And I don't know, I'm not sure which is better, which is worse, but here, I'm, they're all thinking very frustrated, because I know that like if I've got a back problem, they are gonna prescribe me Diazepam and that's it. You know, or and so you need to sort of deal with the physical illnesses by yourself and that's something what you've never had to do, you know, like you would be going to the doctor, get a prescription, get a good diagnosis, could read about it in the internet, and here you go, and like they won't explain you, they won't examine, and there's really frustration but (K2 1390–1400).

Questioning Health Services' Motives.

... maybe that's something economical. I don't know. You see, health service in Poland, it's absolutely, absolutely cramped. You see they cannot in money for nothing, but the patient there is in the first place, I think in UK it's a different one. First economic (C2 104–107).

... here probably that checks are too expensive ... (C2 167)

... maybe that's why UK got the strongest economy. Because they save for health services (C2 595–596).

... maybe that's why health service in Poland are poor. Because they've got a big problems with the money, health service. That's the one of main problems in the Polish economics. They've got absolutely big problems with their money. But you haven't a problem with the doctors there (C2 678–682).

... here I feel that the government has just the agreement with the that and that, for you know, so you don't get any other medications, just this particular one you know like, you've got Fluoxetine, and that's it. You know like, not any other market name for it, you know (K2 516–519).

... the government targets and things they, what they get funding for. Because for example now, all the smoking thing, you know, like they got so many phone calls from my doctor, from the nurse, if I want to give up smoking, you know, they wanted to make an appointment with me and were talking a lot about it, you know. Or there was something else like some time ago about some other illness that they just like sort of focused on it and it wasn't anything else they were asking me about ... (K2 1412–1418).

Avoiding Contact with Services Unless Absolutely Necessary.

... I got registered with my, first with my surgery actually when I really needed. It wasn't the first thing on my mind to go and get registered ... (C1 10–11).

... I was never so ill to need the services (C1 15).

... I do have my family dentist in [local town], but well fingers crossed you know my, I've got very good teeth so I don't have to be seen so often (C1 68–70).

... when you're healthy, you're healthy and you don't think about it unless, so unless something happens (C1 82–84).

... I would rather solve the things myself (C1 135).

... even you know they are afraid to go and get registered because you know they're scared that they won't be understood by the receptionist. And I don't know, they would rather suffer at home, or if it's serious, they would rather go back to Poland, you know (C1 141–144).

... I just think if you feel sick, you go and see a doctor. You know, if you feel all right, you just don't go (C1 240–241).

Help yourself just now, if will be worse, book another appointment for next month (C2 101).

... go home and try medicine on own and try yourself (C2 483–484).

I would first try to go through it somehow myself, maybe take some pills (C3 433).

We did not have many opportunities to really use the services because the children are quite healthy (C6 10–11).

... we know that if anything happened, our children would get good care. Well hopefully, well so far we have not had too many opportunities to check it. Because our children are quite healthy (C6 59–61).

... most of the time, I just treat him, because I know that the first thing I'm going to get would be Paracetamol, so I do that. I do Ibuprofen or whatever, you know

just for the fever and drink a lot and maybe a cough syrup or something. And only if I would become you know really concerned if he was not getting better, I would go to the doctor (C7 28–32).

Preferring to Use the Private Sector in Poland.

... in Poland you can just go and see directly. Especially with here you don't have many private governance, private surgeries, and in Poland you've got many in any specialities. You can just go and pay and be seen (C1 47–50).

... always when I went to Poland, I use, I went to the private specialist. My rheumatologist, like a gynaecologist to take their professional advice. Because I couldn't get as fast here as I can in Poland if you understand (C5 119–121).

I think in terms of accessing specialists, if you would like to see a specialist in a certain area, in Poland, you would be quite likely to see that person privately and wouldn't have to go through all the referral processes (K1 534–538).

Having Access to Services Determined by Social Class in Poland.

I know people who go to some hospitals obviously with the lack of funds they're restricted to some drugs, to the painkillers, you know during the pregnancy. While here, that's a good thing. Whenever you go into labour, every single hospital in the island will give you that. While in Poland you know, because they're not you know the hospital for example wasn't funded to give the epidural or whatever you know the mothers in labour, they won't get this, they will have to give birth naturally or just with the pain (C1 420–427).

R: And when you said in Poland they wouldn't have kept you in for so long in hospital, what would have happened instead in Poland? What would it have been like there?

P: If you paid for extra stay, you would have stayed.

R: Oh right, OK. Uh huh.

P: But it all costs (C3 372–377).

... Ritalin was then registered in Poland, and doctors could give it, but it was quite expensive ... (C7 89–90).

... going back to the medical side of it, as I say, I did receive quite a good care there but only because ... I had the connections. So people in the street could have it a bit more difficult to get the right (C7 97–101).

... in Poland, very often people, but people, only people who have the money, but in my case, in my family and my friends, who were kind of middle class, middle you know quite all the way but kind of enough money to seek help would go privately. To all sorts of professionals. Their practitioners. They would go to,

normally you have to go to GP and get referral to either heart specialist or something. And it's so much easier just go and pay and it's not such a lot of money (C7 377–383).

... if the problem's serious, if you do have the money, you just go privately, because you can be seen the same day or the next day (C7 398–400).

In Poland you just pay for the medication separately, each, every single, yeah, it's all, the prices are added up. But then if you're insured, your, some of the drugs are covered by insurance. Not all of it ... getting all the prescriptions from the GP when you go, it's like, you know, some people just like, aargh! But they don't buy everything. Sometimes they say, 'Please, you know, cross out this or that' (C7 404–413).

... I think that probably the middle class up and like even upper working classes parents or anything like that, skilled working class, they would use the private systems. Not just the public one, the state one. I think like the richer you are, the more you rely on the private system and everybody would prefer to be treated only in the private sector rather than the state one (K2 470–474).

... very poor people ... they wouldn't probably very often buy medication because they wouldn't have enough money to buy them (K2 483–485).

I think that like in terms of the very poor people, they don't go very often (K2 490).

... there is no visiting nursing or nurses or any community nurses, anything like that. So, but luckily they both have quite good pension because my grandfather was working for majority of his life and also abroad. So he's got like high, like lots of money for, so he can pay privately for someone to come out and help them (K2 1316–1320).

Describing Corruption in Polish Healthcare System.

... in Poland obviously in my opinion, the doctors just do too much, they write too many, too many prescriptions for too many expensive drugs (C7 12–14).

People will be spending a lot of money on sometimes unnecessary drugs. I know there is abuse of antibiotics in Poland ... (C7 15–17).

That's a kind of, you would call it definitely grey area. Not very well defined. Just it keeps coming up. You know, there's people just try to evade the law. Just do things that would kind of, they're not illegal, but then you, if you start thinking about it, it's not morally right as well ... So I've been following it. It keeps coming up, because someone discovered some unofficial secret information from the pharmaceutical company. For example, to instructions inside the company, you know, say this to doctors and say that and all that you know. So they'd teach them

techniques to manipulate as well, which is kind of, you know, some of it is not illegal. But it's so (...) Especially that it's about people's health. It's not selling you know, pans or shoes. It's something that's really kind of yeah. So hopefully if they've time maybe it'll sort itself out. But Poland's still a very fresh country. It's still dealing with things. It's still, people have come out from communism with a lot of baggage (C7 417–431).

P: ... doctors are underpaid in Poland. And they're trying to make some additional money. It is morally (...) you know, kind of unclear, but then they've, they've got an explanation for themselves. They say, I'm just trying to make a bit more money for my family. Because I'm not being paid.

R: So do they get money from the drug companies for selling things?

P: Well no, they're usually not money, because there you can't be paid. That would be illegal. But they can get other things. Like as I said, holidays. Which were actually not holidays, would be like, they're called training courses or you know, conferences or whatever somewhere nice. And officially, that would be put as you know, doctors going to learn about new developments in the pharmaceutical sector. But in practice, they would just maybe go for half an hour's lecture, then for three days, they would be lying on a beach somewhere. And of course you would want to do that. So if the only way to do that is if you do sell enough of that particular drug, you would try and prescribe it to every single person that you think you know, of course, you wouldn't give it to anyone you think it might harm or hurt or do anything bad, but then you'd say, 'Well, they're coughing, yeah, I'll give them the antibiotic,' or whatever it is, you know (C7 448–466).

... just kind the whole atmosphere is like they, of course the doctor if they're to sign, to their, to kind of write out a block prescription, they're got to justify it. So they'll tell you know, 'This could happen, that could happen. Blah, blah.' So they would give you those things. And sometimes they make mistakes. I mean, my son, he was quite young, he was something, there was some sort of infection, and the woman said, 'I'll give you an antibiotic which is like in a spray.' I said, 'Fine, that's easier to administer.' So then I came home and opened it. And I read the instruction which I usually try to do. And they said, 'Do not use on children younger than (...)' And I said, 'My child's younger!' Because of something could happen. So I came back and said, 'Look.' You know, to the doctor. 'You should not have sold me that.' 'Oh I'm sorry, I'm sorry. They should give you a refund' ... And I think maybe someone else went to the doctor really, well soon after me, they've got the same thing ... It was a new thing in the market. And I think the company was trying to push it. And they got her hooked on this. And I was, I was, yeah, I was kind of upset, because I could have hurt my child, well because of her (C7 559–580).

There's lots of scandals. And there was a big scandal about a doctor who was absolutely brilliant transplantologist. He really had a big success rate in his operations. But someone tips you know secret services, you know, ones that kind of you know it's anticorruption services that he was taking bribes from patients for his operations. And someone accused him of doing something that caused a

death. So he was accused of bribery, of well taking bribes of killing patients, something. It was a whole thing. And it ended up that he was cleared. He did take presents. He said, 'Yes I did, because see those people came to me really grateful with their, you know, I couldn't say no, so I took them. Alcohol they gave me sometimes. Sometimes even they gave me envelopes. I just, with money. I sort of just, I didn't do it for money. I made a mistake of you know, not being able to refuse sometimes things.' But maybe in cases he did not be it, but he was not a murderer or anything. Yeah. Lots of his former patients who he saved came forward. But yeah, I think that that happened cause there's still, yeah, there, you wouldn't think of that kind of thing here too. But chocolates and a bottle in other, you know, something in your pocket and go to see a doctor here. In Poland, the people still think you've got to show your physical gratitude, you know. In the old days, it used to be like that Colombian coffee someone brought from abroad that, you know, you couldn't get proper coffee in Poland. So you know, or nice chocolates, or something. It was a real kind of, you know, valued thing, sometimes they were really difficult to obtain ... (C7 1254–1275).

... you've got like the whole healthcare system which is very corrupt, the state one. That's why people sometimes prefer to go to the private. Because it's gonna cost you more or less the same. But you get a better service ... on the paper, you shouldn't be paying for a state service and you don't. But if you want to get a good doctor, you need to pay him like you would sort of give ... an envelope or something (K2 803–812).

... people prefer to access to the private sector. Get money and give the person money, get a bill for it, I don't know. And you pay for, if you know what you pay for, and you know what to expect. Whereas in the state, you don't know. You give that envelope and you don't know at the end what is gonna happen. You know. And it's quite abused as well I would say. That's how these people wouldn't admit you to the hospital if you don't give them envelope, or they wouldn't treat you and like there is lots of horrible stories around it as well I suppose (K2 814–820).

Appreciating Benefits of Scottish Health Services.

... Scotland's fine and I think the services, I'm quite happy with them (C1 3–4).

... there wasn't a problem because I had the National Insurance number so whenever I needed actually I was always had the appointment on time (C1 13–15).

... in [local town] I was lucky because I had fantastic midwife, honestly, fantastic. Helped me a lot, a lot. The second labour was much easier than the first one, so that just, it was just straightforward to get it done and yeah, quite good, quite happy, generally you know (C1 462–465).

... I don't have family here, I was alone during the stay in hospital, during the delivery and afterwards, and the health and the care was very good and all the

specialists, they let me in the hospital to stay as long as I want to because I didn't have ward to leave straight away. So they were as kind as that, to leave me stay longer (C3 31–35).

The main time when I remember it was the care was very good and helpful was again when I was pregnant and when I was supposed to deliver. And I was still at home, I gave a call to NHS saying that I was start to have contractions, and I knew it was a bit early to go to hospital, but I was in lots of pain and then decided to go there anyway even though I got different advice on the phone, because they'd told me to wait. I then goes to hospital and they didn't send me back home, they really took a, they considered that I was not feeling confident alone, so I stayed, they let me stay there. I got a special room where I could have stayed and waited until the proper time came for my labour. And in my case, the entire labour took lots of time, and throughout these long hours, there was always someone who was helping me, I was asked every few, I don't know, minutes, how was I feeling, I was never alone. So someone was having an eye on me all the time, I also had interpreter, and it felt very good that people were taking care of me really well ... Everyone was very nice and helpful and the interpreter couldn't stay with me all the time, so at the times when I didn't have interpreter's help, but I wanted to ask something, they took their time to understand me, they would send me one nurse that knew a few words in Polish, so she would come and help to understand me and everything. In other cases, the nurses would bring me printed information from internet which was already in Polish so I had information in my language given to me, and otherwise, they would spend their time taking time to talk really slowly to make sure I understand everything (C3 51–73).

... from what I've heard from my friends who for example had one baby in Poland and one in Scotland, they normally say that Scotland, Scottish services were better (C3 77–79).

... when I went with the baby to Accident & Emergency, they did take care of us very quickly, and everything was very smooth and really good service we received (C3 140–142).

... this doctor who's leading entire [my youngest daughter's] case, he also advised another institutions or organisations that would be involved in her case, such as how to get help for disabled children, and he has notified everyone relevant to this case so that next time, if there's anything happening with her, we can just come straight to the hospital and people will be ready, they'll have all the information about her case ... I am very happy with all the help and advice we have received. It was much better, there is nothing to compare it to ... So it was actually excellent, and I have no worries about it whatsoever (C4 119–129).

... we are amazed by the quality of services and by all the help we received, all the people are really supportive, so we couldn't ask for more and everything is really good (C4 370–372).

... if I go for example here, and I get prescriptions, I always just a small amount of money, not much ... these things is very, very good for people (C5 197–201).

... we had one incident when our son broke, but it was a suspicion that he might have broken his wrist. And they took him, well we took him to hospital and he was examined, he was seen very quickly, the doctor came, they took an x-ray and the verdict was it just a sprain. But he was, we were very, very satisfied with the service. Another situation happened here, not in the hospital. Our daughter fainted at school. And the school immediately notified us and she was taken to a GP and everything was done very quickly and very efficiently. We were really satisfied with the service (C6 11–18).

I have noticed that we have been shown leaflets in which everything is explained and we know that if anything happened, our children would get good care (C6 57–59).

I know there is abuse of antibiotics in Poland, and here, that's something that's a think most cases avoided because of that kind of approach, then antibiotics only given when there is a serious problem (C7 16–19).

I went to the doctor once last year, I had a serious infection with a lot of coughing and it turned out to be bronchitis. And I did get an antibiotic for that (C7 25–27).

... my general observation about hospital staff is like here, they're absolutely lovely (C7 1001–1002).

The nurses, the nurses here were really, really nice (C7 1127).

... going back to the staff of yeah, of the hospital. Here, I went as a, not as a patient, but I went as interpreter with one girl. She had to have an operation on the breast ... the staff were really nice ... They explained everything and really, and I, then when she, after the operation when she was still waiting for the results of some test or something, they came and they said, you know, 'Tea? Biscuits?' They offered me tea and biscuits and kind of there was a chair I could sit it and kind of you know, it was really comfortable (C7 1156–1170).

Perspectives on Mental Health Services.

Having Little Contact with Mental Health Services.

R: And do you know anyone who's actually been seen by mental health services?

P: Mental health services? No (C1 148–149).

I do not think the NHS if I would have some mental problems with myself, I would feel down or distressed, I think I would just try to, you know, try to sort things out myself instead of using someone else's help, you know (C1 182–184).

I think they would just, you know, put me more down when I went to see someone, you know (C1 192–192).

... to see a psychologist, just you know, someone that I would rather personally avoid (C1 199–200).

... I haven't any reason to go to see and I never been interest with this, I have, even nobody from my friends probably. (C2 278–280).

I'm not sure in relation to how things in the Polish migrant community over here, I'm not really sure, I'm, I have to say, I don't really know that many that would access services over here (K1 13–16).

... I think that there is not so many people who use these services in Poland ... (K2 90).

... basically in Poland, people don't use services very often. And I'm, I was trying actually a lot to think about it, and I think that this is really because they don't, they wouldn't need it as much as in here (K2 122–125).

... most of the time, if you experience some of kind of emotional distress, you wouldn't, you just, that wouldn't come up to your mind to go to the, to a psychiatrist or to the psychologist or to whoever ... (K2 132–134).

... I've got an impression, and I don't know where it comes from, it's nothing very like objective, it's just that it would be more like is that there's more [Scottish] people are here using the services ... (K2 153–155).

Distrusting Mental Health Professionals due to Association with Communism

I'm just thinking, psychology was one of the, I'm just thinking in terms of training and in terms of universities and what kind of people were lecturers at the universities. If the subject was very technical, something like physics, mathematics, you would teach, you'd know what you'd be teaching for that particular subject, it would be something very specific, something very concrete. Biological sciences, medicine. But in terms of social sciences, there was much more room for maybe adding ideas that were not exactly psychological. I mean, ideas that were in line with the official politics (K1 418–426).

... I think well there were psychologists or psychiatrists that rose quite well on mental health and people and humanity, and all the issues about, around psychology and psychiatry at that time (K1 442–445).

P: ... people would be a little bit mistrustful of psychology and psychologists. Because it might have been viewed as almost as a tool that the government or the party was using to work with certain groups of people that they might find a little bit difficult.

R: And what sort of groups of people might have been targeted in that way?

P: Well people with mental health problems. Homosexuals. I'm not sure about older. I don't think so. Probably people, I think the other thing that might have been happening, I know it used to happen to some extent, I'm not sure what extent the people, depending on the psychiatry maybe even more than psychology, it had been used as a, for example, if a particular person was a kind of, was a threat.

R: In political terms?

P: Yes. It might have been considered psychologically unstable or having mental health problems. And on the basis, on that place in the mental institution (K1 481–496).

Accessing Mental Health Services in Poland.

It was services such as advice services. And specialist who would listen to you and then tell you something at the end of this talk, but there was not as much action taken. So I know people who use these services, and I did myself as well back in Poland (C3 301–304).

I have one friend who is being treated by a psychiatrist. She has deep depression and some kind of nervous illness as well (C4 290–291).

P: ... I pushed her, I recommend her to make appointment with psychologist. And luckily for her, after a few meetings, the psychologist discovered that this boy has, oh, God what does mean for English, like autism?

R: Autism? Uh huh, yeah, yeah.

P: And this boy who has autism, not very heavy but light, and just now, he is using this service (C5 340–345).

... the simplest and the quickest way is to go private. But if not, then you go to your GP who then refers you to a psychologist or psychiatrist if need be (C6 65–67).

In my experience, a lot of people I've heard about going to psychologist or psychiatrist would be people who wanted to avoid something like a punishment. You know, having committed a crime. They would seek that kind of well, some sort of opinion from a psychologist or a psychiatrist, yeah, from mental services ... I can give you an example of what, without naming any names obviously, the friend, he would for example steal something and the punishment for that would be two years in prison. Maybe suspended sentence, but still there. But if psychologist provided them with a diagnosis of some sort of disorder, they would then not go to prison. They would for example in exchange, they would have

some sort of, undergo some sort of treatment. They would avoid prison (C6 69–79).

... I've got an example of a family that kind of did that kind of thing. They all had problems which were mainly resulting from the fact that they were, they did not have work. They did not have enough money. And there were complaints within the family. And they both had depression and they were really poorly. And someone, a GP probably, referred them to a psychologist for therapy, for family therapy. And they went to that for six months (C6 103–109) .

... the child himself has a, can get some help from psychologists, but it's mostly the parents and people around him that can control his, him very well by giving him right, you know, things to do and kind of switching things off before they happen and all that so well that's why I did the course. It was three months' course, every week I had to go for three hours in the evening. For three months. And there was like people, there was some lectures about things, but there were also like workshops where people had to, you know, given tasks and said, 'What would you do in this situation?' And we had to discuss in groups and all that. It was quite good. It was psychologists and psychiatrists from that hospital that have got a lot of clinical practice. Because also apart from working with outpatients let's say, they also work on ward with very severe cases. So were the people with experience of both. And they could tell us a lot of, yeah, a lot about how to deal with things and gave us advice and we received a lot of materials ... It did explain some of his behaviours, the mechanism behind it, why and what and all that was discussed. But also the kind of basic, well not tools but kind of, yeah, what to do in a severe situation, how to react, what never to do. What would exacerbate it. So basically, it teaches you that you've got to start working on yourself. Not on your child. Because if you control yourself and you behave in the right way and you do right things in the right moments, the other, we were taught about you know the fact that reward is much better than punishment. And that children very often play up because they seek attention, and negative attention is better than nothing. So all that, all you know, Supernanny stuff, but kind of a bit higher level (C7 127–156).

We were given lots of techniques. Well, things like maybe trying and do a chart of things to do and parents then rewarding him for things to do (C7 171–173).

... we took her to a hospital, psychiatric hospital. And she had, she didn't remember some of it. She remembers some of it, but she had this kind of you know, a fit, an attack there. She started scratching and screaming and hiding and people had to restrain her. So she had really a trauma there (C7 920–923).

... that was the moment when she had to realise it had to stop. And then they referred to therapy. That was free. So she did that. She found it difficult, because there were kind of long sessions and they had to do lots of things she did not, and while she was in hospital they had to go through lots of therapy. And they had to do things, you know, like write things or draw things that kind of, she

told me at the time, I can't remember exactly what they were but they do have to a lot ... (C7 927–933).

... they said, you know, 'We've got to keep you in and observe you and see what happens,' because the, yeah, the say if someone's taken in and they're, they thought they were taking drugs and all that, they've got to keep them on observation. There's something like that, yeah, there was, because she had this kind of psychotic moment there, kind of behaved really oddly and all that, kind of she was out of it completely. So they kind of, yeah, they can. There's a certain period they can keep her against her will to observe. So they did that (C7 966–973).

... I must say that psychiatric hospital itself was scary ... it was pretty much, it was an old building. But not old old, because it's a kind of 70s ... Concrete, kind of, yeah. Not very nice. And the atmosphere was kind of depressing. They were, they were doing some of refurbishment, and there were big banners hanging, 'Strike!' Because they were yeah, the, I think nurses were striking or something. And they were kind of you know a big thing. But it was like long, dark corridors. You kind of, you get that feeling in old hospitals, like from the 70s something is, sometimes underground, you go somewhere. You just feel it's, you just expect someone to come at you like an old horror film, you know. I just, and you know, very basic as well. Not shiny, clean, they were clean enough, but kind of old things. Old chipped beds, you know, metal with chipped enamel, and kind of old floors, and the walls kind of, bit depressing (C7 984–1000).

There's more, more and more kind of organisations that help to, so like probably you would get maybe a group that helps women with problems. And they would probably refer, they would have their own psychologist, or they would refer you to a social kind of services psychologist that would kind of be pro bono, you know, they wouldn't pay. But you've got to get there first (C7 1298–1301).

... in my area there was like a centre of psychology, created by psychologists. I don't know whether everybody was going there if they had a problem. So it wasn't so bad. In terms of other services, you would need to go to the psychiatrist first and be referred to the psychologist but getting a psychologist is clearly not, it's like very unstructured, lots of centres like for example for addictions. And that's like quite developed area in Poland, to deal with things. So you have like addictions centre, like rehabilitation centre and they have the clinic. But in the clinic, there would psychologists who help out with the aftercare (K2 98–106).

... in Poland basically the service is limited to the psychiatrist and the outpatient clinic which is psychiatrist or psychologist or in hospital mostly. There wouldn't be any another, and the addictions. And now maybe they open up more specific things. As well as lot for teenagers and children. And usually they, that one would be more about people with ADHD or these kind of diagnoses, so like dyslexia and things like that. And this is like more or less it (K2 163–169).

... addiction services in Poland are very much drug focused. There are alcohol treatments obviously, but people don't do that (K2 206–207).

Viewing Assistance from Mental Health Services as Effective.

... the biggest help and support that she gets from this visit, first it was with psychologist, now it is with psychiatrist. And this does help her a lot (C4 304–306).

... overall I know that just talking to the specialists has helped her a lot, and also she was prescribed medicine that has helped as well (C4 310–312).

... this boy who has autism, not very heavy but light, and just now, he is using this service, and it is very, very helping him, because it was at the beginning of the school, and they in very good time, they told school for more preparation of school for some kind of children. And he is developing very, very well at this time (C5 344–347).

... it was a really good time to help him with that. In interest, you can, even you can get, give you help for some kind of it. But he is, he will be a quite really a better, better and better you understand (C5 372–374).

... finally, they sent him to a doctor and I find, I think that was in our school was very, very like intelligent woman who knew, who has that experience how she can help some kind of children. And he spoke with mother of this boy and she, and you understand, she said to her everything that why it is a good idea, why she should do something like that, and finally, she did something like that, and this boy even a few months, he start, he went to normal, college school, so that. How I fought before everything. He wasn't, he was really unhappy in this school. Because children couldn't understand him, the teacher wasn't a good prepared to have some kind of child, children in school. And he could, he didn't, she didn't have enough patience for this boy. She didn't have enough understanding for this boy. And finally the other teacher, who was very, very good experience in, she gave a really good advice to this woman, and she said, she, my parents sent his son to very professional school who is like a, who is a school for a children with a problems like autism something like that. And just now, this boy is very, very happy. Very bright and he would like go to school. And before that, he wouldn't like go, because he always, 'Mummy, I would like to stay at home.' He cried before he go to school, and she always ask him, just now he is happy and he can develop, he can laugh, he can always, he can talk to me, everything is really, really better (C5 388–406).

... someone, a GP probably, referred them to a psychologist for therapy, for family therapy. And they went to that for six months. And they were really pulled out. And they really stood on their legs and the guy set up his own business. And they started making money and living as a normal family after that (C6 108–111).

... they had therapy, they called it psychoanalysis, and they were given some sort of medication, but I could see that my neighbour immediately after you know they started that, started feeling better and started to have the will to live and do things and started getting ideas, so they helped to find work after that, get ideas, and started to do his own things as well. So kind of that was, that was the story (C6 116–120).

We did lots of other therapies. Who was the one? Sensory stimulation. We did the whole, which I think was really great ... (C7 67–68).

... I saw him when he started doing the exercises, and when he finished, he could balance on those boards that just a few strings. And normally you would just shoo, and fall off. And he was like balancing brilliantly. He could walk on things and you know he just, absolutely brilliant. But I think that's something everybody should do. It's absolutely lovely ... So I thought, I thought it was really great, and that helped a lot (C7 76–84).

... he had another bout of therapy when he decided he was drinking too much. And he stopped drinking. He went to special therapy for people with addictions. He said it was different addictions. Not everybody was addicted to alcohol, to other addictions there as well. So it was kind of general, you know, a group for people with, with this kind of problem. And he's not drinking (C7 844–849).

... there are some people who, I don't know, undertook the treatment like for example my schoolmates from the high school, some of them like got ill, quite addicted and they undertook the treatment and they did that and they'd back and now they work (K2 580–583).

... always some kind of psychological contact will be helpful for person who's seeking for it (K2 1101–1102).

Discussing Benefits of Therapy.

... at the end of the talk, I would hear from the specialist something that was very obvious, something that I already knew, but the fact that the person said it made it somewhat easier (C3 304–306).

This lady specialist, the psychologist, she listened to me and as I said before, she just told me again something I knew, because throughout our talk, I would explain my situation and problems, and I would give myself arguments for and against ... And so throughout the talk, I was kind of having point of view, and at the end the psychologist, she just agreed that what I think is the right thing ... I think it was very helpful, because she gave me strength and confirmation that what I was thinking was the right thing so I had more energy and strength to actually go in and do it (C3 315–326).

... I needed someone who knows these issues better to confirm and to prove to me that this is right thinking that I should leave him. And it could have not been my friend or family member, it must have been a specialist, and that's why I went to psychologist. They did say that what I was thinking was the right choice. And in the end, I left my partner. But I needed that confirmation from someone more like specialised (C3 454–459).

Thinking that Motivation for Recovery is Greater in Poland due to Fewer Secondary Gains.

The people, they can say, 'It's true, I've got a problems, I've got depression, thank God' ... So I say that's a little strange (C2 327–329).

I guess there is this kind of thing and maybe it, I've read it in the papers here that there are still an opinion which is probably also justified, it's quite a lot of parents would use that now that they've heard it somewhere, they've got something. 'Mm, mm. My child has it! That's why I can't manage him.' So they would use that as an excuse not to be a proper parent. And say, 'I can't do anything. You take him. Because he's, he's got ADHD. Untreatable, you know. Do whatever you want. You know. I can't help it' (C7 686–692).

... I think the determination to get better is very high in Poland. They like this kind of mask that you need to get better for the children, for that, for your family, for your friends. You know. I think that's the drive that people have. And they try to get better themselves (K2 147–150).

There is no social services in Poland as such. There are social services, but they are very limited. I mean, they give you some benefits, some help, some money, and that is basically it ... So, and I think maybe it is because of economical situation, maybe it is because of the value of family that I know if the teenager's ill, escapes from home or something like that, the family is always very, very involved. In making the person, trying to find ways to make that person be OK. They don't usually want, and people cannot just move out, you know so (K2 180–188).

I would feel that like it's quite difficult for me here as being like working as well in services to cover as a service the social network. You know. So the person is lonely and gets better doesn't have anybody to relate on his private life, that's a really difficult situation ... even if the service continues, it's quite artificial, you know what I mean. I go to work because I'm paid for it. I'm not that person's family, I'm not that person's friend. And it's really difficult (K2 272–283).

Discussing Benefits of Scottish System.

... the information's not there [in Poland]. It's not like you to go a doctor's surgery, they've got leaflet lying about you know psychologist there. 'Are you

feeling depressed? Do you have problems? You know, well call this number and we'll help you free of charge.' Right. No. I mean like you won't find anything like that (C7 1314–1318).

... there would be lots of situations where you could easily get some help. You know, like they could speak to their GP that, you know, a bit depressed. Or at work, or at school I suppose, you know, like everybody have some kind of earlier intervention (K2 264–267).

... I think it is very hurtful for some people that they have mild experience, mild distress, they can get better easy in a shorter time. Less disturbing, because they would get some help, they would get better, they would go back to their lives and that's fine. In Poland, there is no such a thing, so there is no professional help they get (K2 284–288).

Viewing Formal Intervention as Necessary in Some Circumstances.

R: And what would be the sort of signs that it would be sort of time to do something like that [seeing a psychologist]? How would you be able to tell?

P: It would be at the time when I would be crying more than not crying, you know (C3 333–335).

If I decided that I am not able to help myself nor closest people to me couldn't help me, I would definitely go and seek some help from specialist (C4 349–350).

... I've got a neighbour who has, who was born a boy and after, when he was three years old, when I observe him, because I have got a daughter who is in the same age as him. I observe that he is not developing as well as my daughter. It doesn't mean that he, my daughter is a better something like that, I noticed that he's a slower, he's speaking in this, in his age, it isn't correct, something like that. And when he start, when he finished five years, I definitely said, pressured his mother, I said to her gently about my opinion ... And I pushed her, I recommend her to make appointment with psychologist (C5 332–341).

... I suggested to his mother that he has a problem with this boy, because I feel very, very sorry for him, for example. Because for him, it was a problem. But it was a really good time to help, help him with that. In interest, you can, even you can get, give you help for some kind of it. But he is, he will be a quite really a better, better and better you understand. And when I, this mother of this boy said everything for a mother for blow, she was very angry for me, you understand. And she said, 'No, he's a hundred per cent good. He's OK.' And he start even cried. And I am ask, 'My dear, why are you cry? If you send him to school, you can't cover everything' (C5 370–378).

... I said to this woman, because it was a quite old woman. 'If you would like, really help to him. You need to send him to the psychologist' (C5 384–385).

... she was drunk, and we, she was behaving really strangely, well we're all absolutely sure she took drugs. And because she was drinking heavily, we thought something could happen to her. You know, even not medically, I mean psychosis of some sort. Because that can sometimes happen. So we agreed something that we thought was, there was a few girls who were her friends. Something, you know. I'm not proud of, and I really told her, she forgave me. But I felt really bad about it. We did, we took her to a hospital, psychiatric hospital (C7 914–920).

... there are obvious situations that people go to the psychiatrist, psychologist or whoever. And it was all mostly because of some direct harm, either that they tried to complete suicide or they tried to harm somebody. And so this will definitely that person would go. In terms of psychosis, I think that my, it all has to be like kind of very acute stage that people end up in the services. Or cannot perform tasks like before like they don't, they can't work any more because they've been so bad with themselves (K2 140–146).

Preferring to Seek Private Therapeutic Assistance.

... in Poland was that, it's not, there's not much available, with, for free. But there are some things, but they're usually, they're not very good. There's not very good. Cause they're overloaded, not enough psychologists wanting to work for the state. It's a very badly paid. So everyone wants to work privately. That was her, so whatever there is, it's not brilliant (C7 887–891).

... you mentioned the quite developed private practices in Poland. I think that would be the case, and a lot of people after, after completing their Masters in Psychology would go onto training to do a further two, three, four, four years training in a specific model of psychology, they would then qualify in psychodynamic, or gestalt, or short-term CBT, or in areas of psychotherapy that they see themselves in. And they would, they will have their own practice and then they would work in maybe private service. I think the other thing to remember is that there are private health services as well. A psychologist might be employed as part of that private really (K1 172–182).

I think mostly people would use psychologist in private service and kind of setting (K2 83–84).

... they also have psychotherapists, and they have a private practice usually. So people go to them as well (K2 106–108).

Communication.

Experiencing difficulties as a result of language barriers.

... they are afraid to go and get registered [with the GP] because you know they're scared that they won't be understood by the receptionist (C1 141–142).

... she doesn't feel comfortable because she doesn't speak English. So that's the main problem for her (C1 282–283).

... I went on the website, NHS website, I just wanted to look for something. And you could see there were like plenty translations in many different languages, you know, but not the Eastern Europeans (C1 389–391).

... I know the language, so I can ask anybody you know go to even some offices and ask how I can do that. So they give me some advice as well (C2 23–25).

... they are in a foreign country, if they've got a language barrier, they fall down (C2 360–361).

... the system in Poland is different than the NHS system here, and of course the main barrier for not accessing this information is language ... (C3 91–93).

... we would be a bit reluctant to ask for information and mainly because of the language barrier (C3 106–107).

... it's definitely a different culture here, different everything but for me, for example, personally it was the most difficult at the beginning. Just now it is quite easy because I knew more English and I can understand what is going, what has happened as it's happening ... (C5 8–12).

... for me the biggest barrier it was my language. I feel very, very lost here, and I felt that I couldn't do my job, I couldn't do my job here. And I feel very closed here, very, very closed, like talk and something like that (C5 26–29).

I think that for people who came here, they don't understand much English. Because if you understand, if you understand a little, even a little English, there is a quite easier. Even if something is different, it doesn't feel worse. But it is different. We need to know how it's working, something, any problem, any councils, everything. You can know it. We can read information, we can follow after everything. But if we don't speak English, it is very, very difficult do everything (C5 77–83).

... they are a bit, they are a bit isolated. Because of the language (C7 1340–1341).

... they don't go to theatre or concerts or cinema or anything like that, but language probably one thing ... (C7 1352–1353).

Language barrier must be, would probably be a barrier, would probably quite a challenge for some people. I think understanding rights and possibilities or

opportunities and extending their rights as a police. Being aware of what they're eligible to in terms of work and in terms of their rights for help over here. I think probably working through the NHS system. I don't really, probably that something that's come up for all the people who move away or migrate is fitting in within the culture and then integrating with, I think (...) that again, I'm not speaking for a big group of people, I'm speaking from my understanding, but I think there might be a trend for especially if people have difficulty communicating in English for people from one nationality to stick together, and if that happens, I think it's quite difficult to, for these people to integrate into Scottish society as a, I think that's one of the difficulties that might happen (K1 330–343).

Communicating through interpreters.

... I know my friends in Scotland, Falkirk, they all have to wait for the interpreter to arrive (C1 30–31).

... you need to get registered through the practice and being seen by the nurse, then by your doctor you know, and every single time they will need to have someone with them to interpret, to do the interpretation (C1 326–328).

Having friends act as interpreters.

... it's not, it's just not comfortable you know talking about your personal problems in front of you know maybe the friend, maybe be there with you, but I don't know. It just feel awkward to help with them ... (C1 328–331).

... I'm very, very often go for a translating to a GP surgeries and my, help my friends (C2 431–432).

... my husband took her to the medical centre that is quite close to here and they asked this lady [name], Polish lady, to go and help understand things, interpret (C4 48–50).

... I went as interpreter with one girl. She had to have an operation on the breast. She doesn't speak any English. And she was really, well she knew she had to do it. She was kind of, I could feel that she was scared. Because she didn't, you know, she was on her own. Nobody, her sister and mother and didn't go with her and nobody else would do that. So I said, 'I'll come with you. And I'll interpret' (C7 1157–1162).

Contrasting Scottish and Polish communicative styles.

... people [in Scotland] are predictable. That's the important thing that makes you ooh, get rid of the stress. Because you know what to expect (C7 1398–1400).

... here [in Scotland], you seldom, sometimes you see someone who is going a bit faster or doing something silly, but basically people just, you know, they stop, and they let you in, and they give, you know, they smile, they wave, 'Thank you,' 'Oh thank you.' Ooh, it's so nice. In Poland, you'd be nnyy nnyy. (both laugh) So it's like, I like that kind of thing. In shop, people are kind of always nice and smile. You get the bus. The bus driver will say hello. In Poland, everyone (pulls glum face) (C7 1408–1414).

... Polish people are still not kind of, lots of people there are kind of yeah, they're all vacant. And they, they're not, they don't mean anything wrong by it. But they're not taught to kind of react to the people. And they think it's kind of weird if someone smiles at you and says hello or something. They're kind of, uh? 'What did you say, I don't know you.' You say, 'Hello,' just you know when you're passing in the door or something or you know we're going same way generally if you just you know, people are kind of, yeah, if you smile at someone on the bus or something. 'Weirdo.' (C7 1424–1433).

... people [in Scotland] are a bit more, maybe it's all kind of artificial. Because if they smile, it doesn't mean they're going to love you and kiss you, they're just being nice (C7 1457–1458).

... if you have to call an office or if you have to deal with somebody in the office and the services, people are usually quite polite [in Scotland] and quite, it might not necessarily be, people might feel a little bit differently in Poland and I think that's the main difference that was quite noticeable at the start. And that's something that [my friends] mention to me now, that they notice when they go back home sort of thing (K1 270–275).

... here [in Scotland], everybody will more or less behave in the same way. And if somebody is a bit different emotionally, like expresses a bit more or, I don't know, talks about their personal stuff at work, that becomes unprofessional and that can cause a problem (K2 602–605).

... this concept of customer service of that, you know like everywhere, and it's great for me, honestly. For me, it's just makes your life so much easier (K2 764–765).

Here [in Scotland] people maybe more respect each other ... (K2 848–849)

Losing meaning in translation.

... if somebody told me eh, I've got a problem, some mental problem or something like that, from my personal view, I'd be scared to translate that ... because I can do something wrong. You see, I can do something wrong, with the translating it's very hard. Because in this problem you to translate everything exactly what he say it or how she say it. And that's a different way when you feel your patient with the mental problem, when you hear directly, not by other person (C2 434–441).