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ORIGINAL RESEARCH

British-Bangladeshi Muslim men: removing barriers to mental health support and effectively supporting our community

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Abstract

In England, Bangladeshi men are amongst the lowest number of people referred to primary care NHS Talking Therapies services and amongst the most likely to have deteriorated (NHS Digital, 2020). Factors related to culture, religion and gender influence stigma and help-seeking (Robinson *et al.*, 2011). Furthermore, a lack of knowledge from services and professionals on cultural understandings of mental distress facilitate a failure to fully understand the needs of individual populations (Faheem, 2023). The aim of this research study was to qualitatively explore stigma and help-seeking for mental health difficulties, within British-Bangladeshi Muslim men in London. Recruitment consisted of men aged 22–59 years, experiencing symptoms of anxiety and/or depression but not accessing formal support. Ethical approval was obtained from Royal Holloway, University of London. After an online screening questionnaire, individual semi-structured video interviews were completed between May and October 2020. Reflexive thematic analysis presented six over-arching themes: 'different understanding of mental health', 'traditional cultural expectations', 'fear and loss', 'coping resources', 'barriers to access' and 'community outreach and collaboration'. Many factors were highlighted as barriers accessing support, such as stigma and trust in services. Key practice implications are highlighted for services and practitioners. Professionals must understand the factors which impact the wellbeing of Bangladeshi men, how to better meet the needs of the community, and remove barriers to help. Participants also suggested initiatives to raise mental health awareness and reduce stigma, as an inclusive approach is needed with greater listening to communities and partnerships with local authorities.

Key learning aims

(1) To better understand the needs of the population and factors which impact wellbeing.
(2) To consider the muti-faceted barriers to access mental health support, such as CBT, and how to address these.
(3) To unpack what stigma means (internally and externally) for men in the population.
(4) How to support low- and high-intensity CBT practitioners to better work therapeutically to support Bangladeshi men.

Keywords: Bangladeshi; Muslim; Men; London; Barriers; Mental Health; Black Asian and Minority Ethnic (BAME); Psychotherapy

Introduction

In the United Kingdom (UK), a disproportionate number of racially minoritised[1] men, compared with White men, come into contact with mental health services via crisis-related routes (Sainsbury Centre for Mental Health, 2006). Research highlights the influence of gender, race, perception of services and stigma in contributing to disengagement and isolation of minoritised men with mental health problems (Robinson *et al.*, 2011). South Asian Bangladeshi people in the UK under-use mental health services in comparison with White Britons (Mind, 2013), at times being described as 'hard to reach' (Begum, 2006). However, it is important to avoid seeing racially minoritised people as a 'problem' and better understand why communities may not be accessing mental health services.

The main support for people within the UK with mild to moderate mental health difficulties are NHS Talking Therapies services (previously known as IAPT, Improving Access to Psychological Therapies) (Department of Health, 2011). In England, Bangladeshi people were amongst the lowest number of referrals to Talking Therapies services (10,468) in 2019–2020, compared with people identifying as White British (1,157,582). Bangladeshi men made less than a third of the referrals (3731), with a greater decline in people who finished treatment (NHS Digital, 2020). The Bangladeshi community have the lowest rate for improvement within Talking Therapies services and men were amongst the most likely to have deteriorated (GOV.UK, 2020). A lack of knowledge from services and professionals on cultural understandings of mental distress may also facilitate a failure to fully understand the needs of racially minoritised populations (Faheem, 2023). Seidler *et al.* (2016) suggest how further research is needed, focusing on the needs of minoritised men at risk of mental health difficulties, to best inform the development of effective help-seeking interventions, sooner rather than later.

The British-Bangladeshi population

There is a large Bangladeshi population in London with physical health (e.g. diabetes, heart disease, stroke) and mental health needs (Trust for London, 2019). These needs are affected by socio-economic factors such as low income, unemployment, housing, family stress, gender differences, racism, less integration into society and language difficulties (Bisby *et al.*, 2003). Gibbons *et al.* (2012) highlights how social and economic inequalities have a major impact on mental health, and to tackle these inequalities, services must give more attention to people at greatest risk of poor health.

Stigma

Link and Phelan (2001) conceptualise stigma as the process of labelling, stereotyping, losing status and discrimination in the context of power. Social stigma exists at the community level, such as mental health symptoms being dismissed, denied, given alternative explanations or people being treated differently (isolated, ostracised, negatively judged or given labels). Self-stigma occurs whereby a person internalises societal stigma, endorsing the negative views the community holds about them (Alhomaizi *et al.*, 2018). Overall, stigma has been a reason why fewer people seek help for their mental health from Talking Therapies services, therefore reducing stigma has been a public health priority to meet the needs of under-represented populations (Department of Health, 2011).

[1]There is a vast amount of diversity that is not captured by the term 'BAME' used in the context of previous research, referring to Black, Asian and Minority Ethnic people. The researcher is part of this demographic and understands that this term can be oppressive by grouping people into one category whereas 'one-size-does-not-fit-all'. Instead, the term 'racially minoritised' is used to acknowledge how people are actively minoritised by others as a social process shaped by power, rather than naturally existing as a minority (Predelli *et al.*, 2012).

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There is a difference in the way Bangladeshi communities perceive mental health issues compared with people from the West, including high stigma, negative attitudes towards mental health and this not being a priority (Hossain *et al.*, 2014). Clement *et al.* (2015) found stigma to be associated with reduced help-seeking and disclosure concerns, especially in men, ethnic minorities, and youths. Existing knowledge about the cultural beliefs of racially minoritised communities in the UK regarding stigma and mental illness is limited (Shefer *et al.*, 2013).

Religious and supernatural narratives

Alhomaizi *et al.* (2018) found that Islamic religious beliefs could facilitate or hinder help-seeking in Arabic-American participants. People with mental health difficulties could be accused of having a weak faith and encouraged to pray to strengthen their connection with God. However, mental health difficulties could also be seen as 'God's will', to test one's strength, and could encourage a person to accept their diagnosis and seek formal help. Messent (1992) found how people could understand mental health difficulties as being due to Jinns (evil spirits) or black magic in the Bangladeshi Muslim community. Religion and supernatural explanations of mental health difficulties are factors which impact help-seeking behaviours and coping within the Muslim population in different ways, but this may not always be acknowledged or integrated within therapy (Faheem, 2023).

Gender and help-seeking

Traditionally, women may look after the home and family, and men are the sole breadwinners, with high expectations and responsibilities (Messent, 1992). In contrast to the individualistic West, the Bangladeshi culture is highly family-orientated and collectivist, with problems managed within the family (Rathod *et al.*, 2010). Vogel *et al.* (2011) found the relationship between conformity to masculine norms and stigma varying across ethnicity, which was linked to negative attitudes towards help-seeking. Men who internalised dominant masculine norms such as self-reliance, may see help-seeking as a failure and not meeting internalised standards of masculinity. Self-stigma was also a key mediator in help-seeking.

The empirical study

The aim of this empirical study was to qualitatively explore stigma and help-seeking for mental health difficulties specifically with British-Bangladeshi Muslim men, to understand how to better support the community. There is a gap in the literature as this research has not been conducted before, using an approach of co-production with the community. The research question asks: what attitudes related to stigma and help-seeking for mental health difficulties exist within British-Bangladeshi Muslim men?

Method

Sampling and participants

Women and individuals identifying as non-binary were not included as the aim of this research focuses specifically on men. Purposive sampling was used to recruit a homogenous sample, consisting of British-Bangladeshi Muslim men. Participant ages ranged from 22 to 59 years (see Table 1). The mean age of the sample was 32. Men across London were recruited using online social media (e.g. Twitter and Linkedin) and flyers disseminated in neighbourhoods within the borough of Tower Hamlets, where Bangladeshi people form the largest ethnic minority group (Tower Hamlets Census, 2013). Online recruitment used a digital version of the recruitment poster, with a direct link to the study and screening questions. This was shared by individuals and

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Table 1. Participant demographic information and scoring on the measures

Participant	Age	Occupation	Area	PHQ-9	GAD-7
(1) Abu	34	Self-employed courier	East London	18	15
(2) Bilal	32	Immigration officer	West London	8	11
(3) Cabir	59	Unemployed (health condition)	West London	20	16
(4) Dev	23	Recruitment	North-West London	22	19
(5) Ehsan	34	Chauffeur	East London	17	13
(6) Faisal	29	Banking	Central London	11	12
(7) Galib	32	Security	East London	12	6
(8) Hussein	42	Manager	East London	10	11
(9) Ishaq	29	Retail	East London	10	7
(10) Javaad	22	Graduate scheme	East London	19	9
(11) Kaysar	24	Unemployed graduate	East London	8	11
(12) Lohit	29	Healthcare finance	East London	6	11

Note: anonymous participant pseudonyms have been used.

third sector organisations working with the Bangladeshi community in London to widen reach. Men self-reported symptoms of anxiety and/or depression, with no contact with mental health services. This was important to understand the barriers to support for men experiencing common symptoms of mental health difficulties, who have never accessed formal support. All participants spoke and could read English and interviews were in English, with some participants using occasional words in Bengali, Sylheti dialects.

Reaching a saturation point in thematic analysis refers to the point in research where no new information is discovered. Ando *et al.* (2014) identified how 12 interviews provided all themes and 92.2% of codes in their study; therefore 12 should be a sufficient sample size for thematic analysis. Guest *et al.* (2006) also reported 12 participants to be enough for a homogeneous group. Following these sample sizes, and the timescale of this being a doctoral research study with limited resources available, the sample size of 12 was decided on.

Inclusion and exclusion criteria

Inclusion criteria consisted of British-Bangladeshi Muslim cisgender men aged 18 to 65 years. Men must have scored in the moderate to severe range on either or both the Patient Health Questionnaire-9 (PHQ-9; Kroenke *et al.*, 2001) or the Generalised Anxiety Disorder-7 (GAD-7; Spitzer *et al.*, 2006). Therefore, participants must have scored between 10 and 27 on the PHQ-9 for depressive symptoms, or between 11 and 21 on the GAD-7 for anxiety symptoms. Men were eligible if they could speak English or Bengali (Sylheti) languages and read English (to read the information sheets and complete online measures). Exclusion criteria consisted of people who were not from the population or were not scoring on symptomatology on the measures. People were also excluded if they were high risk (e.g. active suicidal ideation or self-harm) or had previous or current support from mental health services.

Screening and structure

The study was in two stages. Stage 1 involved completing initial online Qualtrics questionnaires (available online or via QR code on the flyers) and if eligible, stage 2 involved an online video interview. Participants were screened using the PHQ-9, which is a reliable and valid tool, with high internal consistency and scores at the cut-off of above 10 having good sensitivity and specificity for major depressive disorder (Kroenke *et al.*, 2001). The GAD-7 was also used as this has good reliability, criterion, construct, factorial and procedural validity. The cut-off points also optimise sensitivity and specificity (Spitzer *et al.*, 2006). These are both valid and reliable self-report measures of depression and anxiety, which are routinely used within NHS Talking Therapies

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services (GOV.UK, 2020). The PHQ-9 and GAD-7 have previously been used with the Bangladeshi population to assess depressive and anxiety symptoms and were found to have good reliability (Chowdhury *et al.*, 2004; Islam *et al.*, 2020; Islam *et al.*, 2021).

Pilot

The interview schedule was a set of six open-ended questions, with follow-up questions, directed by previous research and literature (Alhomaizi *et al.*, 2018; Mantovani *et al.*, 2016). Questions related to views of mental health, help-seeking, and stigma. Men were also asked for suggestions on what could increase help-seeking and reduce stigma within the community.

The interview schedule was piloted and reviewed with an eligible participant who was not included within the final sample. The wording of questions was altered based on their feedback. The reviewer also gave positive feedback on the value of this research and that he felt comfortable speaking to a British-Bangladeshi researcher. This was important for credibility and quality in qualitative research (Elliott *et al.*, 1999).

Materials

Screening was done using online versions of the PHQ-9 and GAD-7 measures in English via Qualtrics (https://www.qualtrics.com). Video interviews were conducted on a Microsoft Windows laptop with a microphone and secure internet connection via the free Zoom app, lasting approximately 60 minutes. Zoom was free to use when only two people were on the call: participant and researcher. Audio recordings were done with an encrypted Dictaphone to store files securely, and confidentiality was emphasised. Participants and the researcher found a quiet and private space to speak. Data remained anonymous and recordings were stored for between four and eight weeks and deleted following transcription, which participants consented to. Transcription was done manually by the researcher listening to each audio file and typing up verbatim on Word processing software. Flyers advertising the study were printed on A5 paper, which were posted to community noticeboards and households in East London.

Procedure

Recruitment

The study was promoted as 'a chance to take part in research looking at views on mental health and accessing help within the Bangladeshi community'. Recruitment began in May 2020 and concluded in October 2020, during the COVID-19 pandemic, with 54 people screened. Twelve eligible participants were in the final sample, with others ineligible or uncontactable after completing the screening questionnaires. Participants who were ineligible understood that their participation ended and were thanked. Some participants had declined to take part in the interview stage due to personal preference.

Ethics and consent

Ethical approval was obtained from Royal Holloway, University of London on 16 April 2020. Unfortunately, incentives were not granted for this research. Participants accessed all the information regarding the study online and gave consent for taking part and being contacted, giving their telephone and email contact details when completing the Qualtrics form. Participants knew there would be a chance they may not be interviewed, and they would be contacted for the second stage. Participants who were eligible, were told about the study again at the start of the interview, given the chance to ask questions, and to withdraw or continue. To avoid confounding results, participants were not told that the research would aim to explore stigma, therefore there

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was a level of deception. However, participants were debriefed following the interview, which involved discussing the true aim, answering any questions, the right to withdraw and being given information for mental health support in their local borough.

Risk management

All participants were provided with information at screening for relevant support services, including the Samaritans, Saneline and contacting the emergency services in a crisis. None of the participants expressed active suicidal ideation or self-harm and if they had, they would have been excluded, and the necessary action would have occurred including a comprehensive risk assessment, making a referral to the appropriate crisis service and/or signposting for information. A risk management protocol was developed to manage any risk information that arose from the interviews, including the potential for confidentiality to be broken.

Analytic approach

Reflexive thematic analysis was the chosen method of data analysis, which is suitable to qualitatively answer the research question, from asking men about their views and experiences. The researcher could consider their own position and use their subjective skills within the analytic process. Patterns in data could be identified, with the thematic analysis framework followed by Braun and Clarke (2013):

(1) Familiarise yourself with your data.
(2) Generate initial descriptive codes.
(3) Organise codes into candidate themes.
(4) Review and refine your codes and themes. Create thematic map.
(5) Define and name themes.
(6) Produce your report.

Reflexivity

Updated quality standards by Braun and Clarke (2020) were reviewed, including 20 questions researchers should consider when using thematic analysis and planning publication. The researcher is fluent in Bengali, Sylheti and time was taken during transcription to translate any words in Bengali to English. The researcher used reflexivity, as their interpretation and understanding of the material was how they made meaning of it (Eco, 2003).

Reflexivity is especially important when engaging in research with marginalised or vulnerable groups. A reflexive approach was used to critically consider the influence of the researcher's own perspective, position, and reality within the research process (Elliott *et al.*, 1999). The researcher is a member of the sample population, a British-Bangladeshi Muslim man. A reflexive diary, research trail and supervision helped to explicitly raise awareness to the researchers own position within the development of codes and themes.

Results

Reflexive thematic analysis identified six over-arching themes and 24 subthemes, which highlight experiences and beliefs related to mental health, stigma, and help-seeking. The six themes are 'different understanding of mental distress', 'traditional cultural expectations', 'fear and loss', 'coping resources', 'barriers to access' and 'community outreach and collaboration'.

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Theme: Different understanding of mental distress

Subthemes: 'priority of physical health compared to mental health', 'emotional literacy' and 'supernatural narrative'

Participants reported that within the Bangladeshi community there is usually less understanding of 'mental health', suggesting that this is a Western and foreign term. There is a lack of support offered to the community to inform people of the options. Cabir states:

> 'If people don't understand or have an explanation then they are lost. I don't understand myself what it is and people can think negatively about mental health problems, as they don't understand. There is no suggestion of what to do and what the options are for support'. (Cabir, 59-year-old, unemployed)

People may understand mental distress by attributing this to physical health as Abu (34-year-old, courier) said: 'people usually just say take two paracetamols and you will be fine [laughs]. It is like take something and you will feel better, rather than speaking to someone'. Lohit said:

> 'Health discussions in the community are monopolised by one major long-term health condition which is diabetes ... So, I can see why people do not talk about mental health ... I think mental health is a key driver to a lot of physical health ailments'. (Lohit, 29-year-old, healthcare)

Physical health is a priority and used to explain mental distress. An effective integration of physical health and mental health support could help identify mental health needs. The community need to be offered support sooner and informed of the options available.

Emotions are also not spoken about as a norm within families, with a language barrier also making it hard to express how someone feels. Bilal (32-year-old, immigration officer) says: 'culturally we don't talk about our feelings and just express dominance and this idea that "I'm ok". There is a language barrier that doesn't allow people to express what they want to say'.

Furthermore, there can be a supernatural narrative when understanding mental distress (for example, Jinns or black magic), as highlighted by Bilal:

> 'I have two cousins who are autistic, but as we grew up, when the Adhaan [call to prayer] would play on the TV we would think that they would start reacting funnily or something. We would think they have a bhut or Jinn [ghost or evil spirit] in them. Really it is not that, it is just whatever is different, they are not used to it ... In Bangladesh there is not much access to services, so if they see something different, they think it is unnatural and not human'. (Bilal, 32-year-old, immigration officer)

Mental health is constructed differently in the Bangladeshi community and understood using a physical health or supernatural narrative. The vocabulary for mental health difficulties is harder to articulate, which impacts how people understand and talk about mental distress. People may not be informed about mental health difficulties or the support options available.

Theme: Traditional cultural expectations

Subthemes: 'strong males', 'male role models', 'interconnected head of the family', 'family first' and 'generational differences'

There are traditional expectations of gender roles with men being 'strong' and the main breadwinner, who should support the family's financial needs as a priority.

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> 'I feel like if I showed that I was weak, because I have younger siblings and my mum is elderly, people would ... like I couldn't show I was weak. When my dad passed away, I couldn't show that it affected me because now I became the man of the house ... I wanted my mum to feel that everyone is ok even though my dad is gone. I wanted my siblings to feel like there is someone to look after us'. (Galib, 32-year-old, security)

There is a view that Bangladeshi men need to be 'strong' to provide and survive as Dev (23-year-old, recruitment) also says: 'my dad was so focused on making sure he could provide, I did not really see him much growing up. He would always be working at the restaurant'. Showing sadness may not be seen as beneficial, as Javaad (22-year-old, graduate scheme) says: 'like guys shouldn't be allowed to cry ... why is that? Even with my dad, as a kid, I would cry and he would say "don't do that", "don't be a girl" and for guys it is more like "buckle up"'.

As the head of the household, family should be put first and if the head is 'weak', this will impact the whole family. Galib (32-year-old, security) highlights how men 'are meant to carry everything, all the burdens ... If we become weak then the wife becomes weak'.

Findings also show generational differences with younger second-generation men trying to balance the needs of the family, but also their own needs in forming their own identity in Western society. There can be a 'culture clash' between Eastern and Western values.

> 'You've got to be an English man, Bengali man, an Islamic man and community man. Breadwinner. All of those things all in one package. That is not to say that everyone else doesn't have their own sort of packages they adhere to, but a Bengali man has quite a lot'. (Bilal, 32-year-old, immigration officer)

Theme: Fear and loss

Subthemes: 'shame', 'self-worth', 'isolation and loneliness' and 'judgement'

Participants described how the stigma of having a 'mental health problem' is associated with a loss of status, pride and social support. This fuels fear within the Bangladeshi community, with a concept that is seen as abnormal and permanent. Bilal (32-year-old, immigration officer) said 'we would say they're "fagol" [crazy] ... you think it is a done deal. There is no other thing that can be done ... [the community] think it is unnatural and not human'. Abu also said:

> 'You're gonna lose respect ... if someone hears something about you, they will talk about it and you will be the talk of the town. It is all about shame, honour, respect and that is why people don't like sharing. We tend to keep it stored inside ourselves until it bursts or something big happens, and then it is too late'. (Abu, 34-year-old, self-employed)

Men described self-stigma, shame, and low self-worth from struggling, leading to isolation due to a fear of judgement and gossip. Galib (32-year-old, security) also said: 'you feel shorom [embarrassment] ... you start looking at yourself in the mirror and think "what the hell is going on with me?" You start calling yourself a loser'.

Having a mental health problem can feel shameful to an individual, who fears negative judgement from the community, which may lead to isolation and a fear of losing respect or pride. Therefore, men may suffer in silence and avoid reaching out for help.

Theme: Coping resources

Subthemes: 'spiritual solutions', 'role of religion', 'keeping problems within the home' and 'keeping problems to yourself'

Participants reported how people turn to religious leaders and find comfort in Islam, with teachings that promote wellbeing.

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> 'Reading Quran and having the continuity of doing your Salah and Namaaz [prayer] all these sorts of things … gives you more stability moving forward and dealing with everyday life. There are things in the Quran that focus on the mind and being healthy … If you struggle with everyday life, with our religion washing yourself five times a day and keeping yourself clean … it helps you maintain some sort of normality'. (Hussein, 42-year-old, manager)

However, people may not realise other options or their own active role in improving their wellbeing, as Kaysar (24-year-old, unemployed graduate) said: 'people find solace and comfort in religion, so they pray, and I can't disagree with that but at the same time you have got to look at the practical means as well'.

Problems tend to be kept to oneself and support could be offered within the home, but this may not always be sufficient. Javaad (22-year-old, graduate scheme) states: 'we would keep it very behind closed doors … even at the detriment of helping. You would not want other people to know'. Faisal (29-year-old, banking) highlights how speaking to family is facilitated by having a non-judgemental space: 'it has taken a very long time to speak to someone outside of my family … the only person I have properly spoken about it with is my wife … Because she is not thinking negatively of me. She is not judging me'.

Theme: Barriers to access

Subthemes: 'less awareness and understanding', 'language and literacy', 'diversity of professionals', 'negative experiences of help' and 'trust and confidentiality'

There are perceptions that several barriers exist to accessing mental health support in London. Participants reported how there is less awareness and understanding as to what support is available, with Cabir emphasising:

> 'People do not understand what is there. I think everyone should know that there is a service or facility that can help you. Do not wait for it. You have to tell people; they will not come and look for it. That is your duty to let the people know'. (Cabir, 59-year-old, unemployed)

Services are seen as not being accessible in terms of language, but also having a diverse workforce:

> 'Sometimes there are no interpreters either and I would try and explain myself the best I can, using my hands too but it is hard to get my view across to the doctor. Sometimes they might pick the wrong thing up or make a different meaning. So, sometimes we do not understand, and we can struggle. The language barrier has a big impact on me'. (Cabir, 59-year-old, unemployed)

> 'I would love there to be more diversity … if you see someone who you can relate to, that just gives you such comfort and ease already. You are not gonna want to talk to someone about something to do with your culture that people won't have any idea about'. (Kaysar, 24-year-old, unemployed graduate)

Some men had negative experiences at the first point of call such as with GPs as Dev (23-year-old, recruitment) said: 'you are dismissed in about 5 minutes. They just prescribe you medicine and that's it'. Kaysar (24-year-old, unemployed graduate) also described feeling judged by his GP who might think 'he has a beard, he is one of them lot'. The importance of being able to trust professionals is seen, including issues related to confidentiality as Faisal (29-year-old, banking) said: 'people need to be made aware that whatever you talk about, it is confidential … We are not here to judge you'. Men must feel comfortable that they can speak to professionals in confidence, being understood and not judged.

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Theme: Community outreach and collaboration

Subthemes: 'structure of services and accessibility', 'community outreach and grassroots co-production' and 'link between religion and mental health'

In response to specific questions about how to improve access to mental health support, participants emphasised a need for services to work together with the community, which could help prevent men reaching a mental health crisis:

> 'I think what you are doing is good and more need to do it. Reach out to people. First time in 10 years I have spoken to someone, other than my wife about this. Because it just felt right ... Maybe someone else can benefit'. (Faisal, 29-year-old, banking)

Services must become more accessible and visible, working together using community outreach to build trust, role models with lived experience, promotion (such as social media), as well as grassroots co-production. When asked about community initiatives, Ishaq said:

> 'A role model that people look up to that speaks about their mental health and their journey ... I feel like we tend to conform. If one person speaks about mental health, that could lead others to do the same ... If they are taught early on, it might not escalate to them stigmatising others and they might be more open about their mental health and not see it as a weakness'. (Ishaq, 29-year-old, retail)

An import link should also be made between Islam and mental wellbeing, using religious leaders and mosques to bridge this gap and reduce stigma.

> 'We should educate people about mental health and religion. How to turn to religion to help with the stress you are going through ... You see a lot of men at mosque, that is the best time to tell them'. (Faisal, 29-year-old, banking)

Member checking

Once themes had been synthesised, three participants replied to say that the themes reflected their experiences. This was to check the trustworthiness of the findings (Birt *et al*., 2016).

Discussion

This research study aimed to qualitatively explore stigma and help-seeking for mental health difficulties with British-Bangladeshi Muslim men. The study and the findings are discussed, with key implications for practice for NHS Talking Therapies services and practitioners.

Stigma and help-seeking

The concept of 'mental health' can have negative associations influenced by a supernatural narrative of fear and permanent loss labelling someone as 'abnormal'. Stigma exists, as there is a fear of judgement from the tight-knit community. Any deviation from the 'norm' can spark fear in the community and isolation of the individual. Self-stigma was present, and participants said how experiencing distress can feel lonely and embarrassing. There are attempts to cope independently due to a fear of judgement, shame and not meeting cultural expectations that men must be 'strong' to support the family. This could lead to a crisis, which could lead to further isolation, judgement and distress. There is a risk of a perpetuating cycle developing and British-Bangladeshi men's mental health needs being overlooked.

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Gender

Men reported expectations to be the 'breadwinner', 'strong' and not show vulnerability due to a fear of judgement. This is influenced by older male role models who need to 'provide' and avoid being vulnerable to survive. There was a felt responsibility that family comes first, as the 'head of the household'. It was also reported how men need a non-judgemental space to trust someone to speak. Findings highlight men balancing different roles or 'hats', considering gender, culture and religion, as a Bangladeshi Muslim man in Western society.

Religion

There are many resources within the Bangladeshi community such as familial support and religion as a source of strength. Some men reported spousal support from their wives who they could trust to speak to, without feeling judged. Teachings from Islam were also valued, which promoted wellbeing. However, findings also show how people may not recognise their own active role in helping themselves and considering other ways of improving their wellbeing. This is supported by Alhomaizi *et al.* (2018) who found how faith could help or hinder help-seeking. Religious methods to overcome distress may not always be successful on their own, needing an active role of the person themselves in alleviating their distress.

Generational differences

The intergenerational trauma experienced by South Asian ancestors should be considered on the impact of communicating distress and not being seen as 'weak' due to the threats to survival. It could be adaptive for survival to keep problems to oneself or within the home, where 'mental health' could be seen as a threat, with being excluded. Men may 'do' or 'provide' to survive, with emotions expressed such as anger being more 'acceptable' rather than sadness, which could be seen as a vulnerability or 'weakness'.

Implications for clinical practice

Recommendations for therapists

On the individual level, practitioners must consider the barriers to support and factors which impact the mental health of men in the community. Time is needed to build trust, emphasise confidentiality and normalise mental health distress. A safe space in therapy is essential, where men do not feel judged and can explore and articulate their feelings. A bio-psycho-social approach can help men understand the different factors which may be impacting their mental health, and with this the different support options. CBT therapists could consider their own role and if they can support in other ways (e.g. advocacy, signposting for support, offering a letter). The Bangladeshi community have other physical and social needs (e.g. housing) that should not be ignored. The role of family could also help facilitate support for an individual, such as attending appointments or family members being informed of the best ways to help.

Within assessment, formulation and therapy an individual approach is needed to consider intersectionality and the different aspects of identity (e.g. gender, culture, physical health, religion, etc.). Considerations also include migration history, family structure, traditional gender roles and expectations. Rathod *et al.* (2019) give a framework to culturally adapt therapy. It is important not to dismiss or pathologise spiritual or religious beliefs but to incorporate this within therapy. An example could be linking religious teachings to wellbeing to promote patience, hope and proactive behaviour (Mir *et al.*, 2019). Practitioners must have the core skills and knowledge to effectively work with individual populations, such as including the resources and strengths people have within therapy. Training must be sought, and services could consider if there are more integrative and effective ways of working with Bangladeshi men.

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Recommendations for teams, services, and wider

On a service level and wider, mandatory training must be offered and completed by all staff in culturally inclusive CBT practice, anti-racism and there must be recruitment of a diverse workforce that reflects the population. Training providers must also do more to make a systemic change, as less than seven successful applicants were Bangladeshi out of 607 for 2019 entry onto clinical psychology training (Clearing House for Postgraduate Courses in Clinical Psychology, 2020). A genuine increase in representation within the psychological professions includes ongoing support and safe spaces for racially minoritised staff within the workplace and on training courses.

Professional interpreters must be used routinely, to address language barriers that do exist. Co-production within the community is essential and services must prioritise community outreach (e.g. with schools, places of worship such as mosques, GPs, community centres) and collaboration with grassroots services and religious centres; for example, makings links with local Imams to remove barriers to support but also increase knowledge on supporting the Muslim community.

Stigma could be addressed, to reduce fear, such as 'role models' speaking about mental health. Visible interventions using social media and community promotion are needed to increase awareness of what support is available and how to access this. Community talks, presence on social media and Bengali TV channels, could give further information to communities, families and individuals to support each other with psychological distress. Links should also be made with physical health services (e.g. diabetes) and collaborative working with other professionals.

Strengths and limitations

A strength of the current study is how recruitment consisted of a purposive sample of British-Bangladeshi Muslim men aged 18 to 65 years living in London. Research is needed with specific communities, rather than grouping everyone as one (e.g. 'South Asian') to help identify individual needs. Even though the sample was homogenous, individual differences must be considered. Furthermore, there was a potential bias in recruitment for mostly men who use social media. Men from a lower socio-economic status who do not speak any English, those without internet access or older men may not have been represented. Therefore, the voices of these men, who may be further isolated, may not have been captured. There were other factors that were not recorded such as if participants were born in the UK or migration history, as this may have given valuable information on acculturation and awareness of mental health services. Not including professionals providing care to British-Bangladeshi men, carers or community members may have also been a limitation. For example, Mantovani *et al.* (2016) included faith leaders, in their qualitative research looking at the relationship between stigma and help-seeking in African faith-based communities, to help inform their findings. Finally, there are some limitations of anti-stigma campaigns, with weak long-term effects and possible unintended consequences (Walsh and Foster, 2021), which must be considered regarding the practice implications.

Impact and dissemination

The researcher used wider media and news to work on a video with the BBC and live radio project with BBC Asian Network focusing on British-Bangladeshi men. These projects involved men speaking about the impact of the COVID-19 pandemic on their mental health and the link with Islam, to further highlight the needs of the community (BBC, 2021a, 2021b). This was indicated as a suggestion from the study findings, having visible male 'role models' talk about mental health. The researcher also spoke about their experience of being a 'minority' as a clinical psychologist and a need to further increase diversity within the profession (interview: '*I never saw anyone who looked like me in the profession*'; BPS, 2022).

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Future research

Further research could be done to explore stigma and help-seeking in women, non-binary individuals, older people or those who do not speak English, who may have additional barriers to help. Others involved in the community could also be interviewed, such as faith leaders, workers or carers. This could indicate further themes, strengthen current findings, and help meet the needs of different populations. Research could also review any effectiveness of community intervention, with reflection on the proportion of Bangladeshi men accessing primary care Talking Therapies services. The views of low- and high-intensity therapists could also be explored, looking at their own competence in working with the Bangladeshi population and gaps in knowledge or skill. This could lead to essential training within teams. Further research could also be developed to continue to highlight effective ways of supporting the Bangladeshi community and more widely, the Muslim population.

Conclusion

This research provides a closer understanding of mental health, stigma and help-seeking within the British-Bangladeshi male community. There is an intersection of factors impacting formal help-seeking such as the understanding of the Western concept of 'mental health' and what service provision is available. Services and professionals must work with communities and religious leaders to link and normalise mental distress with religion and raising the option of accessing NHS support. Services must foster inclusivity, addressing barriers in language but also building trust with the community. A bottom-up approach with an ethos of co-production alongside the community but also top-down service level approach may help bridge this gap of British-Bangladeshi men not being represented in mental health services.

Key practice points

(1) An individual approach is needed in CBT assessment, formulation and therapy to consider aspects of identity such as gender, culture and religion.
(2) Low- and high-intensity therapists must identify gaps in skill and knowledge to access quality continuing professional development and supervision to better support minoritised communities.
(3) NHS mental health services and professionals must do more outreach work in the community and collaboration with grassroots organisations to remove barriers to access.
(4) Services and training courses for the psychological professions (e.g. CBT/clinical psychology) must increase staff representation of different communities, to reflect the populations we serve, with ongoing support.

Further reading

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Data availability statement. The data that support the findings of this study are available from the primary author (S.A.), upon reasonable request. Documents that may be available are:

- Interview schedule;
- Participant information, consent, debrief documents;
- Recruitment poster;
- Thematic map (see Supplementary material), coding of themes;
- Reflexive diary.

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Author contribution. Primary author Dr Shah Alam led in conceptualising the research question, the design, acquisition, analysis and interpretation of data. Dr Alex Fowke was involved in reviewing the original research paper, themes and providing supervision during the research process.
Shah Alam: Conceptualization (lead), Data curation (lead), Formal analysis (lead), Investigation (lead), Methodology (lead), Project administration (lead), Resources (lead), Software (lead), Validation (lead), Visualization (lead), Writing – original draft (lead), Writing – review & editing (equal).

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Competing interests. The author declares none.

Ethical standard. Ethical approval was granted from Royal Holloway, University of London research ethics committee on 16 April 2020 (ethic@rhul.ac.uk; Application ID: 2052). Participants gave consent to take part and publish data; all data remains anonymous. The author has abided by the Ethical Principles of Psychologists and Code of Conduct as set out by the BABCP and BPS.

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