

ALCOHOL USE AND THE TURKISH-KURDISH COMMUNITY: A THEMATIC ANALYSIS

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Abstract

Drinking alcohol to excess has been identified as a problem in the Turkish-Kurdish community in Hackney, East London. Whilst NHS services work to be inclusive, with the use of interpreters for example, there are still barriers, preventing this population from seeking help, which need to be explored and further understood. The single piece of research identifying the needs of the Turkish-speaking community in Hackney made recommendations for a more culturally appropriate care package, a more balanced range of effective therapies, and a more active role for BME community members in the training of health-care professionals.

This study aimed to understand more about alcohol use in the Turkish-Kurdish community by collating the opinions and experiences of members of the community and the health-care professionals that work with them. Three focus groups were conducted: one with men only, one with women only, and one with health-care professionals only (mixed gender). A total of thirteen participants contributed to this research. Analysis was conducted within a critical realist epistemology using thematic analysis.

Three main themes were identified: explanations for drinking, impact of drinking and help-seeking. Participants identified personality type, stress and culture as relevant to why an individual drinks alcohol. The impact of drinking was described as predominantly harmful, but positive accounts of drinking were also given. The findings suggest a need for NHS services to offer further support in helping the community to access services for alcohol treatment, but also to work alongside the community in creating more culturally appropriate services and to help reduce stigma associated with seeking help. A need to address wider societal concerns, such as unemployment, was also deemed important by the participants when considering factors that influence drinking alcohol. Future research might investigate how the impact of gender roles on help-seeking can be addressed in service provision planning.

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CHAPTER ONE: INTRODUCTION

The present research aims to understand more about how the Turkish-Kurdish community in Hackney, East London experiences alcohol use and its perceived problems. This thesis hopes to contribute to a better understanding of what motivates members of the community to seek help for alcohol-related problems and what barriers exist to prevent help being sought.

Drinking patterns in the UK, London and amongst the community in question will be discussed, followed by a consideration of factors influencing alcohol use and seeking help. A literature review of journals and books was conducted using EBSCO, PsycINFO and PubMed databases. A search of books was carried out in the UEL and British Library databases. The journal reviews focussed on the last 50 years of publications and the main search terms included; 'alcohol use UK'; 'alcohol and immigration'; 'alcohol and help seeking'; 'alcohol and motivation'; and 'focus group and interpreter' (See Appendix A for full list of search terms used). Searches were conducted on English articles and those that had English translations available.

1.1. Alcohol use and associated harm

In the UK since the 1950s, alcohol consumption has nearly doubled and it is estimated that more than ten million adults in England drink more than the recommended daily limit set by the UK government (3-4 units for men, 2-3 units for women), with a quarter of those drinking more than twice the weekly limit (total weekly units recommended are 21 units for men and 14 units for women; Alcohol Concern, 2011). One unit is defined as 10 millilitres of pure ethanol in the UK (Science & Technology Committee, House of Commons, 2012). It is reported that children in the UK are starting to drink earlier and are drinking more, with children aged 11-13 years drinking 50% more than their compatriots in 2007. Furthermore, compared to the rest of Europe, UK teenagers are most likely to report adverse effects of drinking such as intoxication and frequent heavy drinking (Hibell et al., 2007).

According to Alcohol Concern, the total cost relating to alcohol harm is approximately £20 billion each year, with a cost to the NHS of over £2.7 billion annually. Over 150,000 prescription drugs for alcohol detoxification treatment were prescribed in England in 2009 by NHS primary care services and hospitals; an increase of 12% from the previous year. Over 8000 deaths in England in 2011 were recorded as being directly caused by alcohol use. Over 4000 of these deaths resulted from alcoholic liver disease.

There have been various ways of attempting to categorise patterns of alcohol use and drinking levels. Historically, the World Health Organisation advocated the use of 'hazardous' and 'harmful' drinking to define levels above recommended limits but below those associated with alcohol dependence. More current literature (e.g. Khan et al., 2012) uses the terms 'lower-risk', 'increasing risk' and 'higher risk' drinkers to indicate levels of potential harm. Increasing risk' drinkers or hazardous drinking is defined as drinking above the recommended guidelines and potentially putting the drinker at risk of harm if this level of use is maintained over time (Saunders et al., 1993). Higher risk drinkers or harmful drinking is defined as drinking an amount that puts the individual at risk of causing harm to their body, harm to their mental health or harm to others, for example by being violent (Saunders et al., 1993). In terms of alcohol units, higher risk drinkers consume approximately 50-100 units for men and 35-70 units for women. Above these levels, it is likely that an individual would show signs of being dependent on alcohol (Kaner, 2010). In London in 2007 an estimated 27% of men and 16% of women were hazardous or harmful consumers of alcohol (NHS National Statistics, 2009).

There is debate about what it means to be physically and/or psychologically dependent on alcohol (Widiger & Smith, 1994). However, it is widely acknowledged that increased tolerance to alcohol and the presence of withdrawal symptoms during abstinence are two key components in the diagnosis of alcohol dependence.

According to the Diagnostic and Statistical Manual of Mental Disorders (DSM IV, 1994) alcohol dependence is diagnosed by the presence of three or more of the following seven symptoms:

- tolerance
- withdrawal symptoms
- use in larger amounts or for longer than intended
- persistent desire or unsuccessful efforts to reduce use
- time spent obtaining alcohol or recovering from its effects
- social, occupational and recreational pursuits are reduced or stopped as a result
- use is continued despite knowledge of harm (psychological or physical)

DSM V is being published at the time of submitting this thesis (May 2013) and it is noted that the criteria and diagnoses for alcohol dependence and drug addiction in general are due to change with a move away from the term 'dependence' with a preference for 'addiction'. In a press statement, the American Psychological Association (APA) stated that "eliminating the category of dependence will better differentiate between the compulsive drug-seeking behaviour of addiction and normal responses of tolerance and withdrawal that some patients experience when using prescribed medications". It is thought that the term addiction will therefore replace dependence but the criteria for having an alcohol-use disorder will remain largely the same, as outlined above (O'Brien, 2010).

The exact pattern of alcohol use is not of central concern to this thesis, thus the terms dependence, addiction, abuse and misuse are used interchangeably to depict an individual who consumes alcohol to a level that has caused a degree of physical and/or psychological dependence.

In 2007 in London, 13% of men and 5% of women were found to be dependent drinkers (NHS National Statistics, 2009). The London Ambulance Service (LAS) report that the borough of City and Hackney (where the present study was conducted) has the third largest percentage of alcohol-related incidents in Greater London (3027 incidents for period 2010-2011). In the last few years,

LAS have responded to an average of 188 emergency calls per year relating to illness, injury or death associated with alcohol consumption. Hospital admission attributable to alcohol has increased in Hackney over the period 2006 to 2011 by 8% for men and almost 4% for women (Local Alcohol Profiles for England, 2011).

To date, the majority of data collected in London on alcohol use is derived from services where most clients describe themselves as White British. Whilst this often reflects the make-up of many boroughs in London, it does not adequately reflect the populations of others. The London Alcohol Statistics Project (LASP) collated data from alcohol services across London and found 67% of clients were 'White British'; 9.9% 'Irish'; and 6.5% 'White other'. However, in Hackney for example, 12% describe themselves as 'White other' and only 44% as 'White British' (London Councils online). The LASP also highlighted that alcohol service users are more likely to be 'White' than drug service users. Additionally and perhaps related, the majority of referrals to alcohol services come from GPs (23%) whereas drug users are twice as likely to self-refer.

The social cost of alcohol has been less thoroughly researched than the impact of alcohol on individual health but studies highlight how alcohol affects families and the wider community. Klingemann (2001) argues that children of a parent who drinks to excess suffer abuse, neglect, insecurity and isolation more than those in a family where drinking does not exceed recommended limits. He also proposes a link between alcohol use, marital breakdown and domestic violence but highlights that it is difficult to ascertain exact figures due to the private nature of the occurrences and reluctance in reporting. Other authors argue that it is in fact marital breakdown that causes consumption of alcohol to commence or increase (Caces et al., 1999). Alcohol has also been found to play a fundamental part in all crime, but in crimes of violence in particular. Studies that have compared figures internationally have found that assaults and homicides have the highest rate of alcohol involvement, ranging from 35% in Canada to 85% in Sweden (Single, 1997).

1.1.1 Socio-economic status (SES), alcohol and coping

Socio-economic status is an extensively used construct in social science research that aims to measure the relative wealth of an individual, family or group. Most studies quantify SES using measures of occupation type, parental education or family income (Bradley & Corwyn, 2002). Many studies have found a relationship between low SES, poor health and shorter life expectancy (e.g. Currie, 2009). Van Oers et al. (1999) found the greatest frequency of alcohol-related health problems amongst those with low SES. They analysed the association between SES and alcohol consumption and found that for men, “very excessive drinking” (harmful levels or more) is more prevalent amongst those categorised as having the lowest level of education. This was not found to be true amongst women, but instead “symptomatic drinking” (drinking to alleviate symptoms of low mood and/or anxiety) was found to be highest for women with the least education. However, there is also literature to support the claim that higher levels of drinking are found amongst those defined as having high SES. The research suggests that higher SES groups drink more often and persistently over time whereas those with lower SES consume larger quantities of alcohol but less regularly (Casswell et al., 2003).

Jones-Webb et al. (2006) examined the relationship between SES and alcohol use in Black and White males. SES was defined by income, education and occupation. Black men with a low SES reported a greater number of drinking problems than their white counterparts. However, more problems were described by the more affluent white men than the more affluent black men. Thus it is essential to consider ethnicity when looking at the relationship between SES and drinking problems.

Drinking alcohol moderately is widely regarded as acceptable behaviour within Western society but in communities whose cultural norms differ or where religious practice excludes the use of alcohol, the picture may be very different (Kouimstidis et al., 2007). Context must be considered when implementing a treatment plan for those who are alcohol dependent, in the same way that co-

morbid mental health problems must be addressed. Co-morbidity with anxiety, depression and low self-esteem is common (Curran & Drummond, 2006). Weaver et al. (2003) looked at the possibility of co-managing substance misuse services and community mental health teams (CMHTs) because research suggested there may be a significant cross-over in diagnosis and treatment pathways. The authors found that 85% of alcohol service clients had received a psychiatric diagnosis in the past year and 44% of CMHT clients were using alcohol at a harmful or dependent level.

Whilst the effects of poor SES can be moderated by factors such as social support, the well-being of families with little access to social and material support and those who have suffered stressful circumstances such as immigration, can suffer the most and use coping strategies such as alcohol more frequently (Bradley & Corwyn, 2002). Schiff et al. (2010) found that within minority groups who have left their country of origin, men are far more likely than women to drink alcohol as a method for coping with the associated stress. Higher perceived discrimination by minority groups has also been found to correlate with increased heavy drinking (Kim & Spencer, 2011) and how people react to such stress has been linked with personality type and personal coping strategies (Williams & Clark, 1998). Personality constructs such as sensation-seeking and cognitive motivation have historically been associated with drinking (Stacy et al., 1991) but more recent studies demonstrate a complex interplay between personality domains, style of coping and social factors in motivation for drinking alcohol (Kuntsche et al., 2006).

1.2 Western theories and models

This section will outline the context of alcohol treatment in the UK, with particular regard to the dominant theories which attempt to explain how, why and when individuals seek help.

It is essential to consider the context of the present study as it takes place in the UK, where alcohol dependence is classified as a psychiatric disorder, where millions of pounds are spent each year in the prevention and treatment of drinking above recommended guidelines, and where certain models and

theories of why people drink and what treatments are effective, dominate. This section aims to outline the prevailing ways of thinking about, and working with, individuals who drink excessively and the following section will critique these ideas and look at wider discourses. Truan (1993) argued that addiction is a social construct that is used to define out of control reward-seeking behaviour. He states that Western understanding of addiction (he researched in the USA) is very much located in time and place and that it is society's institutions that maintain how addiction is viewed and indeed how it is pathologised.

Psychiatric terms such as addiction and dependence are used in this thesis to reflect the dominant discourse in the literature. It is noted that this way of writing can be deemed as labelling and pejorative and will be used to describe mainstream theories but used with caution thereon. This thesis assigns relevance to any harm that is caused as a result of drinking alcohol, whether or not it is a result of dependence on alcohol.

1.2.1 Motivation

The term 'motivation' is used widely in psychological models to help explain human behaviour and can refer to: a physiological state (primary drives such as hunger); a behaviour based on need and incentive; or a psychosocial state that seeks to explain complex learned behaviour (Sansone & Harackiewicz, 2000). Theories of motivation have been prevalent in psychology for many years and largely encompass the explanation of intrinsic (internally derived) and extrinsic (coming from outside the individual) motivation, from Festinger's theory of Cognitive Dissonance (1957) to Maslow's Hierarchy of Needs (1943).

In the alcohol and drug literature the term motivation is used not only to describe models of consumption (Cooper et al., 1995) but also in terms of understanding how people decide to make changes and what stops them from doing so (Miller & Rollnick, 2002). Motivation is the main focus in many of the prevailing health behaviour change theories and particularly in the field of addiction. The research suggests that motivation is an internal state where the

locus of control¹ is within the individual, and by over-coming inner ambivalence the individual can then make changes (Vitousek et al., 1998).

1.2.2 PRIME theory

In an attempt to derive a theory that encapsulated the ideas of pre-existing models, and that explained the processes an individual goes through to reach their goals or desires, Robert West proposed his PRIME theory of motivation. Motivation is seen not simply as 'reasons' for doing something but as a hard-wired brain process involving impulse, drive and intention (West, 2006). The model describes five levels or interacting subsystems that each requires varying levels of time and mental resource. The acronym PRIME is derived from the five levels of the motivational system:

'P' represents plans, which are intentions manifested as mental representations of an individual's future actions and which are accompanied by various levels of commitment. This is the highest level of the motivational system which is directly altered by the input of the lower levels of R, I, M and E.

'R' represents the response level, the lowest level of the system that is responsible for starting, stopping or modifying actions.

'I' represents impulses and inhibitions, which both work against each other. The CNS pathway is activated which leads to action whilst the inhibiting pathway acts against it.

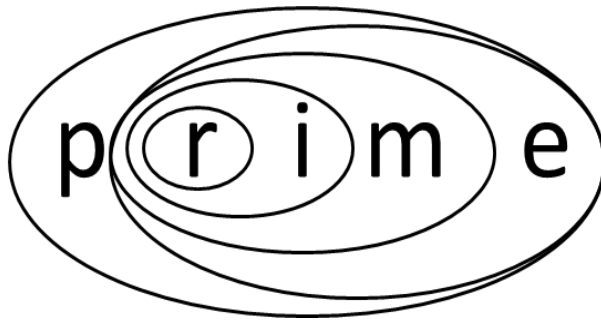
'M' represents motives, where an individual's wants and needs are met by imagining a future state (if action were to be taken).

'E' represents evaluations or beliefs about what is useful or not (functional), what is right or not (moral), and what is pleasing or not (aesthetic).

¹ The extent to which individuals believe they can influence the events that affect them (Duttweiler, 1984).

Figure 1 below depicts how the different levels of the system interact with each other. For example, plans cannot directly influence actions (R – responses) but they can do so via evaluations, motives and impulses. So, a plan will not be executed unless the motive is currently in place, the evaluation of the situation fits in with the plan and the situational context generates the impulse to act.

Figure 1: West's PRIME theory model



PRIME theory suggests that making changes simply on the basis that we 'ought' to is not sufficient. 'Oughts' can only bring about long-standing change if there is some interaction with the notion of identity, to generate wants and needs. This theory regards identity as key to changing behaviour. West defines identity as "our disposition to form mental representations of ourselves and the feelings attached to these." The major elements of identity include labels (e.g. teetotal), attributes (e.g. health conscious), and rules (e.g. I don't smoke). In order for change to be successful and permanent, these elements must be altered with clear boundaries thus preventing any opposing wants or needs from being formed.

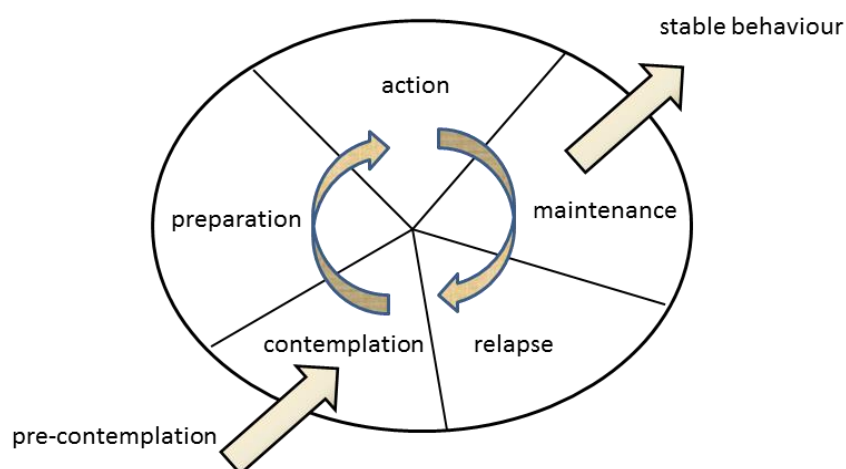
Therefore in order to make lifestyle changes, such as stopping smoking or drinking, an individual must be without disruption to any of the five levels of PRIME theory. Actions are influenced at any one moment by urges, desires, plans and evaluations that change over time and help explain why an individual who wants to change may repeat the behaviour they have always done.

1.2.3 Stages of change and motivational interviewing

A dominant model of motivation in addiction (and wider health behaviour change) is the Transtheoretical Model (TCM) or Stages of Change Model (SCM) proposed by Prochaska & DiClemente in 1984. The SCM differs from West's PRIME theory as it proposes a more systematic process of change. The model is cyclical because, according to the authors, the nature of change-making is not simply a one-off event and the various exit and entry points in the cycle illustrate that it is not a linear process.

The SCM explains change behaviour arising from a pre-contemplation stage, through a contemplation stage, to preparation, then action, maintenance and potential relapse. Pre-contemplation refers to a state where the individual has no intention of making any changes to their lifestyle. Contemplation signifies active thought about the pros and cons of making changes which is often characterised by a state of ambivalence. The preparation stage refers to the time when an individual is getting ready to make a change, for example confiding in friends. Action signifies that change has occurred and the individual is working to strengthen their commitment to the change. Maintenance involves sustaining change in the long-term and being aware of situations that could cause relapse. Relapse occurs when the individual returns to the old, typically unhealthy behaviour.

Figure 2: Stages of change model



One study found that from a population of alcohol-dependent patients admitted to general hospital for reasons not relating to alcohol, 11% were 'pre-contemplative' and 85% were in the 'contemplation' or 'action' stage (Rumpf et al., 1998). There was no significant relationship found between stages of change and previous help-seeking behaviour suggesting that even those who had sought help on multiple occasions, were not necessarily at the 'action' stage. The SCM highlights the importance of determining what stage an individual is at in order to best target those who can be offered treatment and those who may only be thinking about making a change and so on. This model has proven to be beneficial for implementing change with a number of different health behaviours including weight loss (O'Connell & Velicer, 1988) and physical activity (Marcus et al., 1992).

Whilst the SCM remains a useful tool for clinicians, its limitations have been noted by the originators themselves amongst others. Prochaska et al. (1992) proposed the SCM to be most helpful when thought about as a spiral of change where the individual does not have to go back to stage one if they relapse, but can instead learn from the process and re-enter at various stages

Teaching for clinical psychology trainees and specialist training for psychologists working in addiction services often comprises 'Motivational Interviewing' (MI) skills (Miller & Rollnick, 2002). MI is based on the above idea that a client can be helped through conversation in therapy to move from a contemplative state to that of action. Thus treatment methods often start with an assessment of ambivalence to change. Kouimtsidis et al. (2007) wrote a treatment planner for clinicians working with addiction and state:

“Overcoming ambivalence about change is often the major barrier for many clients, even when the need to change has been recognized. The principles and techniques of MI can be effective in reducing risk behaviours such as substance misuse.” (p.81)

This way of working places the locus of control with the individual 'needing' to make the change and of course places emphasis on motivational techniques

and language as being the precursor to change. It is therefore important to question the notion of motivation being primarily about the self and whether this concept and the techniques used in 'western' psychology can be helpful to BME groups. Whilst there is more research to be done to address this concern, many clinicians have highlighted the caution to be taken when imposing what are primarily US and UK concepts on diverse populations (e.g. Patel et al., 2000).

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1.3 Alternatives

It is important to consider the context of the individuals who may necessitate different ways of working, thus the Western models and treatment methods may not be relevant. These issues will be explored in depth below.

For many years the definition of when mental health turns to mental disorder has been debated and the notion of normality has seen many changes (Offer & Sabshin, 1966). Fernando (2002) goes further in summarising the complexity of defining what is normal once culture is brought into context:

“Not only do we need to recognise that each culture has its own norms for health, for ideal states of mind and for the functioning of individuals in society, but that these norms are perceived through race-tinted glasses.”
(p. 38)

1.3.1 One size fits all – Western theories in diverse populations

Conversations with NHS members of staff prior to commencing this thesis identified a necessity to further understand the needs of the Turkish-Kurdish community who were under-represented in NHS services compared with the ethnic make-up of the local population. It is widely acknowledged that some BME groups are under or over-represented in treatment types and services in the UK.

Historically, evidence of this is clearly seen in the high proportions of black inpatients in psychiatric services when compared with the population statistics (McGovern & Cope, 1987). Indeed, in Hackney, East London one study found that stereotyped attitudes led to assumptions that “a) Electroconvulsive therapy

(ECT) is suitable for non-depressive reactions in black patients, b) black patients require more ECT and c) intramuscular medication is more efficacious in black patients” (Littlewood & Cross, 1980). More currently, Fernando (2002) highlights the importance of recognising racism within the psychiatric system and warns of ‘culturising’ problems; giving meaning to difficulties by attributing them to ‘their’ culture and laying the blame with ‘them’, the “cultural aliens”. Fernando cautions those with power to step away from the idea of teaching ‘them’ how to use services and instead to look at the organisation of the services themselves.

Research that focuses on BME populations states that different cultures have different concepts of the self and this can influence the nature of experience of the self, including the understanding and experience of motivation (Markus & Kitayama, 1991). However, very few studies describe these different experiences within cultures. One study in America compared an immigrant population to a native population and found that heavy drinking was linked to low religious participation and high perceived discrimination amongst those born in the US, whereas the main risk factor for those born elsewhere was being male (Kim & Spencer, 2011). The authors highlighted the need for services to be mindful of immigration status when considering interventions and alcohol reduction strategies.

There is however some evidence to support the use of MI with minority ethnic groups. In meta-analyses where MI is compared with various other treatment methods, researchers have found MI to be significantly more effective, particularly amongst African-Americans and Hispanic groups (Hettema et al. 2005; Lundahl et al. 2010). Findings suggest the MI might be particularly effective with some minority groups as it offers a more client-centred and supportive approach than other psychotherapy treatment options (Lundahl & Burke, 2009).

1.3.2 Turkish-Kurdish People

Kurdish people come from Turkey, Iraq, Syria and Iran, and the majority of Kurdish refugees and asylum seekers in London live in the boroughs of North and East London. Most Turkish-speaking Cypriots, Turks and Kurds were forced to migrate either as economic migrants or political refugees. The Kurdish-Turkish population in the UK is currently predicted to be around 100,000 (Tas et al., 2008) and Mugerwa (1997) estimated that there were 24,000 refugees from this community in the borough of Hackney. Hackney is one of the most culturally diverse boroughs in London, with Turkish-speaking communities across the region, but particularly in Stoke Newington, Newington Green, Dalston and Green Lanes. Whether they define themselves as immigrants, asylum seekers or refugees², these groups of people who have undergone migration have experienced highly stressful circumstances moving from one culture to another, possibly as a result of war, torture or abuse. Trauma as a result of this suffering seems inevitable and two-thirds of refugees experience anxiety or depression (Burnett & Peel, 2001).

It is believed that 138,000 people living in England and Wales do not speak any English but there is no similar data on numbers of people from this community (Office for National Statistics, 2011). Health beliefs within this community were studied by Ozmen et al. (2003) and they found that almost 87% of Turkish participants believed environmental factors to be the cause of depression. Just fewer than 70% felt that depression could also be caused by having a 'weak personality'; almost 95% believed that it could be treated and over half thought that anti-depressant medication had serious side effects.

Media focus has linked the Turkish-speaking community in East London with gangs or 'mafia-like' organisations and to wider networks of alcohol and drug use (Townsend, 2009). It has been estimated in the past that 70% of the heroin

²Asylum Seeker: One who is fleeing persecution in their homeland and on arrival in another country has made themselves known to the authorities and exercised their right to apply for asylum.

Refugee: One whose asylum application was successful and who is allowed to stay in another country having proven they would have faced persecution in their homeland.

Economic Migrant: One who has moved to another country to work (Refugee Council, 2011).

coming into the UK is imported by ethnic Turkish gangs based in London (NCIS, 2006). This situation has been made more complex as community cafés have been linked to supplying alcohol and to criminal activity such as illegal gambling. Gambling is also a growing concern within this community and it has been reported that problematic gambling is more common among people with alcohol use disorders (Grant et al, 2002). There is a dearth of literature on the potential link between alcohol and gambling in the Turkish-Kurdish community in London despite the clinical observations from local organisations and charities.

Where this thesis refers to Turkish-Kurdish people, it indicates Turkish speaking people who identify as being Turkish, Turkish-Cypriot or Kurdish.

1.3.3 The Tas Report

Tas et al. (2008) carried out a study entitled 'Voice of Men', which was an assessment of the mental health needs of Turkish-speaking men in Hackney. This is the single piece of research looking at experiences of the Turkish-Kurdish community in Hackney, with particular reference to mental health and substance misuse. The study found that alcohol use was a significant concern for the population despite there being little statistical data about alcohol consumption within the community.

The Tas report also highlighted the issue of community members feeling isolated and choosing to return to Turkey to receive "culturally appropriate services" for alcohol use. Rising levels of reported psychological distress including high rates of suicide in the community have led to a need for further exploration of alcohol use and the well-being of Turkish-Kurdish men. In 2005, Derman (a voluntary organisation in Hackney, discussed later in section 1.6.1) received almost 500 referrals and almost a quarter (24%) reported having attempted suicide or having suicidal thoughts. In the same year four men from the Turkish-Kurdish community in Hackney ended their lives (Derman report from World Mental Health Day Conference, 2006).

The research team found that participants reported psychological problems including depression, anxiety, loss, psychosomatic disorders, PTSD, isolation and addiction. These difficulties were often reported to be a direct result of being refugees and asylum seekers. Participants who had lived in London for ten years or more reported problems relating to adaptation and cultural conflicts, and participants who had lived in London for five years or less reported distress relating to their journey to London and the asylum application process.

Currently there is very little research looking at the needs of this community with regard to alcohol misuse and any research conducted with this group needs to be sensitive to the significance of racial and cultural issues, and not simply focus on biological explanations of mental illness or addiction (Fernando, 1995). One of the key recommendations from the conclusion of the Tas report was to deepen the understanding of the cultural issues faced by Turkish, Turkish Cypriot and Kurdish communities for mental health professionals working particularly in primary and secondary care. This would help reach the targets set out by the Delivering Racial Equality in mental health care (DRE) plan which was set up by the Government to address discrimination and promote equality for BME groups. These included providing a range of effective therapies and pharmacological interventions that are culturally appropriate, and providing a more active role in training, planning and the provision of treatment for BME service-users.

This thesis aims, like the Tas report, to hear the 'voice of men', but also to hear the voice of women and the professionals that work with the community.

1.3.4 Meeting the needs of the community

It is clear from the Tas report that there is a need for services to acknowledge and address problems and to provide appropriate treatment. Patterns of help-seeking are difficult to assess because the Turkish-Kurdish population is not provided with relevant information about how services are designed, organised, and accessed. Therefore, what may appear to be a lack of motivation to seek help may not always be the case; the situation is evidently more complex. Further research is clearly required here to assess the nature of motivation and

help-seeking amongst this community before one can even attempt to apply models such as PRIME or SCM. 81% of participants interviewed said they did not have any information about mental health services (Tas et al., 2008). Furthermore, the difficulty of finding appropriate interpreters and advocates adds to the language barrier, making accessing and receiving treatment from existing mainstream services more difficult.

Research often demonstrates that people from most minority ethnic groups have higher rates of abstention and lower rates of consumption than the White majority. Looking more closely at this generalisation, drinking varies greatly both between and within BME groups and across gender and socio-economic group. The relationship between alcohol consumption and resulting 'harm' amongst various ethnic groups is complex (Thom et al., 2010), thus an assumption that there is no need for BME population service provision is inaccurate and adds to the stereotype that, for example, certain religious groups abstain from drinking alcohol (Williams, 2004).

It has been noted in the Government's strategy on alcohol: 'Safe. Sensible. Social' (Department of Health, 2007) that there is a need not only to assess service provision for BME communities but also to develop the provision of these services. Hurcombe et al. (2010), in a review of alcohol use and ethnic minority groups highlighted that, although people of the Islamic faith drink less, Muslims who do drink tend to drink more heavily when compared with other non-white groups. This review also emphasised the high levels of alcohol dependence in BME groups, despite a lower overall average, when compared with the general population. The study concluded that there was a need for greater understanding of cultural issues associated with alcohol use and dependence in order to create better provision in mainstream or more specialist services.

1.4 Help-seeking and Gender Roles

There are many issues to consider when exploring why people chose to seek help and why they do not and gender is one of the most important factors. How gender and related factors influence decisions to look for treatment will now be explored.

There is a growing body of research to indicate that men are less likely to seek help than women for problems such as depression, substance use and stress (McKay et al., 1996). Lower treatment rates for men are not due to men having fewer health complaints but could be explained by a difference in perception of health and help-seeking behaviour (Moller-Leimkuhler, 2005). However, there are also significant studies indicating that gender is not the determining factor in help-seeking behaviour. For example, one study in the UK found that income was more important in predicting behaviour than gender and therefore sex differences are best understood by the behaviours and attitudes associated with lifestyle decisions and context (Emslie et al., 1999). Dominant social discourses implicitly blame individual men for risky or antisocial choices but there is little awareness of the role of social constructions in men's choices (Lee & Owens, 2002).

In one study, an increase in help-seeking behaviour was found to be predicted by the following factors: men of a younger age, those employed, those with more severe and/or more social and health consequences of drinking.

Symptoms from drinking or level of intoxication were not found to be helpful predictors (Hajema et al., 1991). Galdas et al. (1999) conducted a review of the literature associated with men and their help-seeking behaviour for mental health and alcohol-related problems. They expressed concern over the lack of understanding about the variations in help seeking amongst and between different ethnicities despite the majority of research highlighting that differences do exist. Similarly the authors point out that 'masculine beliefs and traditional masculine behaviour' are often associated with a delayed response in seeking

help in men but there is little explanation as to what this constitutes in various ethnic and religious groups.

Thom (1986) interviewed men and women to determine their help-seeking styles. He found that men felt their main problem was the amount of alcohol they consumed when compared with women, who presented a range of social and psychological issues. Both sexes regarded the main barrier to seeking treatment as a fear of being labelled an 'alcoholic' or a 'psychiatric patient', but more women than men reported a positive experience in reducing symptoms at primary care level which increased their likelihood of seeking help at a 'higher' level, for example, detoxification treatment.

Gender differences in the Turkish-Kurdish community are rooted in cultural norms and religious practice, with the majority describing themselves as Sunni Muslims (commonly referred to as the orthodox version of Islam). Turkey, for example has had equal legal rights for men and women for almost 100 years but the family is still structured around a strict patriarchal hierarchy, particularly in rural regions such as Anatolia (Manço, 2004). Since Turkish-Kurdish migration to the UK has occurred from mainly rural regions, many cultural ways of living still exist in inner London such as marrying someone from the parents' native village. Safarian (2007) suggests that despite changes in the Law in Turkey, equal rights are still not being enjoyed by women in rural areas, only those living in urban regions:

“Reforms have actually opened the way for the Turkish woman to speedily penetrate nearly all domains of the Turkish public, political, and economic life. That, however, has been the case for mostly urban residents, particularly the metropolitan area. In the provinces the woman's situation still remained very distant from freedom. “The Beauty of Anatolia”³ was not yet aware of the rights awarded to her by the new political system of the country, for she was, first and foremost, illiterate.

³ “The Beauty of Anatolia” refers to a poem entitled ‘Anadolu’ written by Mehmet Emin Yurdakul 1869-1944), a Turkish writer born in Istanbul.

She knew of only one authority, the authority of man, who exploited her as free labour". (p. 151)

Tas et al. (2008) found that men were less likely to seek help for their problems because of the associated social stigma and cultural understanding that men should not display or feel shame, guilt or embarrassment. Such feelings were found to act as a barrier for men to seek help. Furthermore, men were found to underutilise services because of the lack of culturally appropriate services or lack of information.

1.5 Relevance to Clinical Psychology

Clinical psychologists are currently employed to work in addiction services across the UK. Clinical psychologists working in other fields, for example, primary care, physical health teams, psychiatric inpatient units, community mental health teams and so on, often find that alcohol is part of the formulation of the client's difficulties or that alcohol is being used to manage symptoms. Dependence on alcohol and the potential consequences of drinking over the recommended limits must therefore be understood by psychologists in all domains. More widely, this research highlights the need for clinical psychologists, particularly in London, to explore better ways of working with minority communities, particularly with those for whom English is not their first language. Over 300 languages are spoken in London with more than one million people living in London speaking a language other than English at home (Hastings, 2003).

The City and Hackney Alcohol Service is the borough's NHS-led provision for alcohol treatment. Over a 12-month period, 29% of clients seen in the service were of BME background; 72% White, 21% Black or mixed race, 3% Asian, and 4% other (City and Hackney Alcohol Service website (2009). The London Councils statistics (2010) indicate that 59% of Hackney's residents describe themselves as 'White', potentially indicating a disproportionate number of people from this group being seen in the alcohol service. Of course, how individuals define their own ethnicity is not clear and the Turkish community in

question may fall under the category of White, being 'White Other' or, lacking an accurate description of their heritage, simply tick 'Other'.

Specifically, clinical psychologists working in alcohol services in Hackney would benefit from understanding more about the Turkish-Kurdish community's alcohol use, their motivation to make changes and barriers to seeking help. It is noted that NHS services may not be the most appropriate service for these clients but as long as the NHS is providing a service to the community, it has a duty to be accessible to all. Moreover, clinical psychologists would benefit from thinking about problematic alcohol use in the context of the culture in which it occurs and understanding the diverse issues that lead to alcohol dependence when deciding how best to offer treatment options.

1.6 Collaboration

The completion of this thesis was not possible without close working with an interpreter and Derman, a service for the Turkish-speaking population. It was also important to be explicit about the reasons why this area of study was of interest (to me, a white British female) and why there was a curiosity about this community in particular (see section 2.1.1). Participants were told about my interest in conducting research in the field of alcohol and addiction and how this led to conversations with NHS members of staff in Hackney who identified a necessity to further understand the needs of the Turkish-Kurdish community who were under-represented in NHS services compared with the ethnic make-up of the local population. Clinical psychologists working in the NHS introduced me to the staff at Derman where I explained my interest about how psychology and NHS services can better understand the needs of minority communities in London. In particular, I was interested in working with communities where languages other than English are spoken and the populations have complex needs resulting from immigration and being at risk from marginalisation.

1.6.1 Derman

Derman is a voluntary organisation for the mental health and well-being of the Turkish, Kurdish and Turkish-Cypriot community in Hackney. It was founded in 1991 by members of the community, in partnership with local GPs and health authorities. Derman is a registered charity which currently provides health advocacy, counselling, outreach mental health support, welfare rights advice and domestic violence outreach work.

Prior to commencing the research I had conversations with Derman's senior staff to gain an understanding of what would be most useful to research for them as an organisation, how we could collaborate, and to gain a greater understanding of what challenges the organisation and community face. These conversations continued throughout the research process.

1.6.2 Interpreter

Traditionally, people who do not speak English have been excluded from psychological research or, where they have been included, their input has not been fully explored or documented, particularly in terms of the challenges involved when the researcher does not share their language (Wallin & Ahlstrom, 2006). Whilst some literature on psychologists working with interpreters exists (e.g., British Psychological Society 2008; Tribe & Raval 2003; Mahtani 2003), little attention is given to the presence of interpreters and their influence on the research process in qualitative psychological research. By conducting research with only English-speaking participants, clinicians and researchers risk missing out entire groups of people and potentially include only those who are acculturated⁴, who may not represent their non-English-speaking peers (Esposito, 2001). Thus this research aims to study an under-represented group by using the native language of the community.

The importance of conducting this research in Turkish has been outlined above and therefore the use of an interpreter was essential. Working with an

⁴ Acculturation is the process of "becoming adapted to a new or different culture" (Neufeldt, 1998, p.9).

interpreter poses a number of challenges in terms of practical ways of working with interpreted material (and analysing it) and being mindful of the trust and power dynamics that inevitably arise between the interpreter, myself and the participants. Whilst this study does not make claims of overcoming all of the various ethical and methodological issues that arise from working with an interpreter, these very issues and how the interpreter was involved will be made explicit and transparent. From the outset, it was hoped that this piece of work would not add to the body of literature containing 'invisible interpreters' who are not recognised in the write up or collation of research (Turner, 2010).

Just as the researcher has a 'position', a way of seeing the world with sets of values, beliefs and preconceptions, so does the interpreter (Temple & Young, 2004). It is therefore essential to collaborate with the interpreter and have discussions about the impact of both professionals on the research. Arguably interpreters are doing more than their job description when enlisted to help with cross-cultural research, they are more often than not taking up 'a cultural consultant role' (Freed 1988). They give clarity to the researcher about the culture being studied, the nuances of the language being spoken and enable understanding of the context of the topics being discussed (Raval & Smith, 2003).

Shackman (1984) wrote about the importance of communication with an interpreter and the participant in terms of using first-person language as if the researcher is communicating directly with the participant. She describes the use of making direct eye contact with the participant and advocates in clinical settings that the interpreter should in fact sit behind the researcher. The present research endeavoured to use a collaborative stance between all involved and thus whilst first-person language was used and the researcher spoke 'directly' to the participants with language used, body language and eye contact, the interpreter sat with the group (in a circle) as an equal contributor.

The interpreter with whom I worked was a male employee of Derman (aged 40), working as a Mental Health Outreach and Support Worker, who also held professional qualifications in interpreting. He was not regarded as 'invisible' or

‘worked through’ (Swartz, 1998), but conversely ‘worked with’ and was considered a crucial part of the success of the research. It was decided early on in the research that the interpreter would be a collaborator, providing not just a ‘bridge’ between the researcher and the participants in terms of language, but also providing cultural information and communicating culture- or language-specific nuances.

The co-worker model (Patel, 2003) advocates that equal relationships should be created (as far as possible) between the researcher and interpreter, and the purpose of research must remain transparent. This model does not ignore or simplify the obvious power imbalances that do exist within the relationship but acknowledges the researcher as the main ‘driver’ of the research whilst providing a framework for the interpreter to help ‘steer’ the research. Thus, we had many conversations during the research process in order for me to explore my aims of the thesis, what the interpreter felt was most appropriate and how we would go about the ‘data collection’ together.

1.6.3 Focus Groups

This study aims to answer the research questions more fully by hearing about multiple perspectives and therefore enable participants to have a conversation within the focus group setting, rather than via interview. It is thought that this would allow participants to talk more freely about their thoughts and experiences. There is also benefit in using focus groups because hearing the experiences of the community and the staff who work with them will enable this research to be used to help direct future service provision. The purpose of recruiting from the community and professionals who work with the community was to explore the various experiences, challenges and perceived reasons for why community members who drink alcohol seek help and what motivates them to do so.

The use of focus groups allows the researcher to use interpersonal communication to help highlight group norms (Mkandawire-Valhmu & Stevens, 2010). By identifying shared and common knowledge the focus group can be a technique particularly sensitive to cultural variables (why it is so often used in

cross cultural research and work with BME groups). Furthermore, it has been reported that the use of focus groups helps researchers to examine why different sections of the population make different use of health services (Kitzinger, 1994).

For this thesis, the impact of having a female researcher with a male focus group was noted as was that of having a male interpreter with a female focus group. In particular the researcher was aware of how this might impact on and influence the issues raised in the groups and what and how topics were asked. Derman advised that they had held groups of a similar nature and this gender difference did not seem to pose a problem. It is hoped that by making the purpose of the focus group and the research transparent, the participants would feel able to discuss sensitive topics. The importance of having single-sex groups was also deemed important, in light of the topics being discussed (gender roles for example) and to approximate to a more naturally occurring conversation than would be had in the community (Wilkins Winslow et al., 2002).

Furthermore, focus groups can help individuals who may be reluctant to speak out, potentially making it easier to discuss negative experiences such as racism and oppression when such issues are identified as common problems (Culley et al., 2007). Focus groups have been found to allow access to community responses to an issue, allowing the researcher to explore and more fully understand group norms and values that would be potentially difficult to determine during a one-to-one interview (Waterton & Wynne, 1999).

The use of one-to-one interviews was considered and discarded for a number of reasons. Primarily, staff at Derman felt that recruitment and participation would be easier if participants were invited to talk in a group rather than in an interview setting. Focus groups, albeit artificially, could help replicate the more culturally appropriate settings of men and women meeting (separately) to talk in groups (e.g. men in coffee shops). The sensitive subject matter and particularly the involvement of myself the researcher, not a member of the Turkish-Kurdish community, meant that more natural and open conversations could be had in a

group setting. This outweighed the potential for single interviews to gain potentially richer material from a smaller number of individuals. Furthermore, the importance of including professionals to hear about their accounts of alcohol use in the community meant that using groups could allow for more people's experiences and perceptions to be heard. The need to hear from men, women, and professionals fitted well with a focus group set-up. Thus three separate focus groups of men only, women only and professionals only were used.

1.6.4 Language and Power

Despite the challenges of completing research about a 'different' culture and in a different language to the researcher, for the reasons outlined above, work with minority communities is essential in order to inform clinical practice.

Psychological distress can often be a result of immigration, poor housing, unemployment and so on, but also can be caused by more deep-rooted but less negotiated issues that afflict minority groups, such as power and 'white privilege'. McIntosh (1988) who coined this term highlights the vast array of ways in which power can be exercised and how this can contribute to racism. She states:

"White privilege is like an invisible weightless knapsack of special provisions, maps, passports, codebooks, visas, clothes, tools, and blank checks." (p.83)

As discussed earlier, the majority of psychology-based research is conducted by English-speaking researchers with English-speaking participants. Where studies are based on BME groups it is almost always the case that only English-speaking members of that community are invited to take part. There is however, a body of research starting to emerge over recent years involving interpreters (e.g. Vara, 2003) or conducted in other languages spoken by the researcher and interviewees (e.g. Castro Ribas et al., 2003). The present research is therefore essential to give voice to those under-represented groups.

The importance of conducting research in the language of the community taking part is vital so that Eurocentric ideas and values are not imposed, and to ensure that researchers avoid 'psychologising the experiences' of the people in

question (Vara & Patel, 2012). Fitch (2001) explores how all words are specific to a given language and words therefore “reflect an experience unique to the members of that culture”. The power that clinical psychologists hold when conducting research and shaping clinical services must not be ignored and is essential when thinking about collaboration with interpreters (Nadirshaw, 2000). The very nature of work that clinical psychologists undertake involves knowledge production and the power of taking decisions, providing or withholding information, therefore potentially having a huge impact on people’s lives. Clinical psychology as a profession is consequently at risk of abusing its power by promoting Eurocentric models of psychological distress and must confront institutional racism that exists in the mental health system (Fernando & Keating, 2009).

It could be argued that psychologists help to empower their clients through the co-production of knowledge but it is important to consider with whom the power lies in the therapeutic relationship, just as “it is not possible for power to be exercised without knowledge, it is impossible for knowledge not to engender power” (Foucault, 1980). Essentially, as English-speaking ‘professionals’ working in mental health, there is a risk that the views of the people chosen to research are excluded and the way in which sense is made by other cultures (in their own languages) is entirely lost or invalidated (Pratt, 1992).

This research has attempted to reduce the impact of power by working in the language of the participants, with an interpreter who is a member of the wider Turkish-Kurdish community. The focus groups took place at Derman, a location known to, and trusted by, the participants and the groups were positioned in a circle with the interpreter and I sat amongst the group (but not together). It was hoped that this might help reduce the feeling of ‘us’ and ‘them’ which may have been felt by the participants.

1.7 Research aims

The present research aims to understand more about how the Turkish-Kurdish community in Hackney experience alcohol use.

This thesis addresses the following aims and hopes to contribute to a better understanding of what motivates members of the community to seek help for alcohol-related problems and what barriers exist, which prevent help being sought.

Thus the main research aim of this study is:

To explore perceptions of alcohol use and related help-seeking behaviour in the Turkish-Kurdish community.

More specifically, this research aims to:

- a) Explore the cultural context of this community with regard to the problems they face and how this may contribute to the problem of alcohol use and seeking help.
- b) Determine what factors influence members of the community to drink and how alcohol affects the community.
- c) Examine how identity and gender roles of men and women impact on help-seeking and motivation for treatment of alcohol-related problems.

CHAPTER TWO: METHODOLOGY

2.1 Methodological Rationale

2.1.1 Locating myself

I am a 30 year old, white, Welsh female from a middle-class background. My interest in working with addiction and specifically alcohol dependence is long-standing. Prior to commencing clinical psychology training, I worked for a number of years in Primary Care with people who identified as having physical, psychological and/or social negative consequences as a result of their alcohol consumption. As part of the evaluation of the service I worked for, it was clear that sections of the community with whom we worked with were not taking up the service and thus BME groups were under-represented in our service data (Kambamettu et al., 2010). Conversations I had with people from minority groups centred on ideas of shame or embarrassment of visiting the service, not the lack of need for such a service. Some people described how meeting me was a last resort; they had tried seeking help from their family, community or religious leaders but to no avail.

These experiences impacted on the way I thought more widely about how clinical psychology can work with BME communities. Having friends and family who were not born in the UK, for whom English is a second language, and for whom racism is faced in many of the systems they encounter, I have become increasingly passionate about the work I do in clinical psychology being relevant and accessible for all. My methodological choices have been influenced by my awareness of the power I hold as a trainee clinical psychologist, a member of the dominant culture, and with greater access to discourse production (Van Dijk, 1996).

2.1.2 Epistemological stance

This study explored peoples' own constructions of their experiences and adopts the epistemological position of critical realism. Positioned between realism and relativism, critical realism is:

“a perspective that combines the realist ambition to gain a better understanding of what is ‘really’ going on in the world with the acknowledgment that the data the researcher gathers may not provide direct access to this reality” (Willig, 2008, p.13).

The research process aimed to examine the meanings participants held and the ways these meanings were constructed by everyone involved; the researcher, the participants, and the interpreter. This was in order to acknowledge that language and knowledge are dependent on social, political and cultural processes that are time-specific (Gergen, 2000). The study drew on ethical guidelines for research with people from minority ethnic backgrounds (Patel 1999), in aiming to be as accountable and respectful to the participants, avoiding the ‘myth of neutrality’ by recognising that each individual’s position in the social world influences the way it is seen (Temple & Young, 2004).

2.1.3 Qualitative Analysis

When compared with quantitative methodologies, qualitative methods give more freedom to participants to elucidate their ideas and respond in their own words (Barker et al., 2002). The way in which the topic matter is constructed and discussed is an essential element of the study and therefore a means of developing rich descriptions within a cultural context can only be obtained through qualitative analysis (Barbour, 2008).

The limited previous research carried out with this particular community means that an exploratory approach was needed that included open-ended questions and the opportunity to discuss issues at length. The aim of the research is to

explore personal meanings and experiences which are not quantifiable via other methods.

2.1.4 Thematic Analysis

Thematic analysis is a qualitative methodology which allows for different epistemological positions to be considered and thus fits within the framework of critical realism. It was used here as it is flexible in allowing for themes to be analysed within qualitative 'data'. The ability to observe emerging themes is important as the content of this study has scarcely been researched and therefore the data generated can be described in detail and patterns can be analysed and reported (Braun & Clarke, 2006).

It has been argued that thematic analysis can be used with nearly all qualitative methods (Boyatzis, 1998), however Braun and Clarke (2006) state that it is a "method in its own right" (p.4). Furthermore, it is:

"Among the most systematic and transparent forms of such [qualitative] work" (Joffe, 2012, p.210).

The process of this analysis involves searching across an entire data set in order to distinguish repeated patterns of meaning. Themes are then derived from "a specific pattern of meaning found in the data" (Joffe, 2012). Patterns can be located at two levels: the manifest level (directly observable in the information); or the latent level (underlying the phenomenon). Despite 'manifest descriptions' being associated with realist epistemology and 'latent' with relativist epistemology, thematic analysis draws on both. Both will be used in this study to identify themes observable in the data and those influenced by contextual factors, in keeping with the critical realist stance.

Likewise, thematic analysis can draw upon existing literature or theory (deductive reasoning), or themes derived directly from the data (inductive reasoning). Deductive reasoning is essential to have knowledge of previous literature and to be consistent with the critical realist epistemology; however, this thesis will predominantly use inductive reasoning in order to best answer

the research questions. A combination of deductive-inductive and latent-manifest approaches can arguably create the most creditable analysis (Joffe, 2012).

It is noted that there are some limitations when using thematic analysis on interpreted material, however, it is precisely these issues that prevent researchers interested in working with BME communities from exploring the constructions of their experiences. Thematic analysis also poses some challenges when applied to focus group data because of the complexity of hearing individual's experiences in a group setting but it nevertheless allows the researcher to hear multiple voices and the experiences of different groups of people (Massey, 2011).

Data will be analysed according to the methodology prescribed by Braun and Clarke (2006) which is outlined in section 2.5.3.

Thematic analysis was deemed the most appropriate method of analysis for the reasons above and because other methods did not fit as well with my aims for this study. More interpretative methodologies such as interpretative phenomenological analysis (IPA) were not used because they explore the interpretation of the meanings of people's experiences. This study was not aiming to access people's experiences but instead their perceptions and understanding. Similarly, grounded theory was not deemed appropriate because it seeks to give theory to a set of experiences whereas this study is more exploratory and its aim was to generate descriptions rather than concepts that explain certain practices.

Despite its exploratory stance, the analysis will be theory-driven because this study was derived from the accounts of NHS and non-statutory practitioners who identified different help-seeking patterns according to gender. These observations helped to shape the focus group interview schedule, hence the close mapping between the questions proposed in the groups and the results that followed thematic analysis.

2.2 Procedure

2.2.1 Participants: Non-clinical sample

The use of a clinical sample was not essential to address the research aim of understanding experiences and perceptions of drinking alcohol in the Turkish-Kurdish community. The hypothesis that those who drink within the community are 'hidden' and not forthcoming in talking to health professionals like myself would have added complexity to the recruitment of participants, but more importantly it was not necessary in order to answer the aims of the research. Following discussions with staff at Derman it was deemed most appropriate to invite anyone who wanted to talk about the topic to take part in the research. By using a community population, this research acknowledges that participants may not necessarily use language and discourses afforded to those involved in NHS services (Matthews, 2009).

A second reason for not using a clinical sample is that such a group may be biased in their views with regards to accessing treatment, or just present one angle of opinion. Personal experience of accessing services with regard to alcohol use or helping another to do so, did not exclude a potential participant from attending a focus group (see inclusion criteria, section 2.2.2). I felt that the inclusion of a group of health care professionals (in a separate focus group) further added to the diverse range of opinions and experiences. These groups had a multitude of narratives to draw upon from their clinical work, in effect bringing even more voices to the group than just their own. It was also possible and legitimate that the 'professionals' would come with personal experience and accounts.

2.2.2 Inclusion criteria

This study recruited adults aged 18 or over who lived in Hackney and whose primary language was Turkish (for the community groups). A desire to talk about alcohol use within the Turkish-Kurdish community was necessary and assessed at the point of recruitment. All health care professionals worked with the community and were employed members of staff at Derman. As above, an interest in talking about the community and alcohol use was determined at point

of recruitment. The professionals held different job roles which can be seen later in this chapter in section 2.4.

The only exclusion criterion was being under the influence of alcohol or drugs during the time of the focus group.

2.2.3 Sample size

Three to five participants were recruited for each of the three focus groups. This is deemed an appropriate number for the use of thematic analysis with focus groups at doctorate level (Vicsek, 2010). Kitzinger (1995) suggests a group should consist of approximately four to eight participants and offers this flexibility depending on the nature of the topic, the type of analysis and in order to “maximise exploration of different perspectives” (p.302).

2.2.4 Recruitment

Participants for the Turkish-speaking focus groups were recruited by the interpreter who approached potential participants during his sessions at GP surgeries where his advocacy clinics were based. He explained the nature of the research and provided them with written information (in Turkish) outlining the purpose of the research. The focus group of professionals, all of whom were English-speaking, was recruited by the researcher and the management team at Derman who explained the research at team meetings and handed out the Participation Information Sheet inviting staff members to attend.

2.2.5 Data collection

Three separate focus groups were held on Derman premises. This was deemed the most appropriate location because it was nearby, participants knew its location and it offered privacy and space to have confidential conversations. The questions in the focus group schedule were discussed with the interpreter prior to use in order to allow time for feedback and amendments to be made with regard to their cultural appropriateness and to check for any assumptions made by the researcher in understanding the community and their concerns. Each focus group was approximately 75 minutes long.

2.2.6 Resources

Interviews were recorded using two digital voice recorders (one on each side of the group to ensure recording quality) and transcriptions were carried out on a computer. Study documents included: Participant Information Sheet in English (Appendix B); Participant Information Sheet in Turkish (Appendix C); Consent Form in English (Appendix D); Consent Form in Turkish (Appendix E); Focus Group Interview Schedule (Appendix F); and Participant Demographics Form (Appendix G).

2.3 Ethical Considerations

2.3.1 Ethical approval

Ethical approval was granted by the University of East London in June 2011.

The ethics application is included in Appendix H.

Ethical issues were considered carefully, particularly as the majority of the participants could not speak, read or write English. Using the language of the participants was crucial in order to ensure full involvement and understanding of the research, particularly with regard to confidentiality and consent (Patel, 1999).

2.3.2 Consent

Participants read through the information sheet in their preferred language prior to the start of the group. Ample time was given to answer questions and the interpreter was present either to answer questions directly or to guide their questions to me and interpret my response. Consent forms were then read, signed and dated. The researcher emphasised to each participant that they had the right to refuse to answer questions, the right to leave the group at any time and the right to withdraw participation from the study. Participants were informed that I would be audio-taping the group discussion but that the recording of the group would only commence after participants had asked any questions they had.

2.3.3 Confidentiality and anonymity

All participants were made aware that information collected throughout the course of the research was to be kept strictly confidential. They were informed that names and other identifying information would be kept securely and separately from the voice recording and the subsequent data-analysis.

Participants were informed that anonymised parts of the transcription may be viewed by the researcher's supervisors or representatives from academic and professional assessment bodies in order to assess the quality of this doctoral research. Only the researcher and interpreter were aware of each participant's real identity throughout the duration of the research.

All voice recordings will be destroyed as soon as the researcher's doctorate has been awarded. Any anonymised data relating to participants will be kept for 5 years post research project submission (May 2013) according to the University of East London's 'Good practice in research' guidelines.

Basic demographic data was collected prior to the start of the group (see section 2.4 for details).

2.3.4 Distress and debriefing

All participants were informed prior to the focus group session that whilst they were invited to share personal experiences and stories if they felt they wanted to, they were in no way obliged to. It was made explicit that the aim of the focus group discussion was to elicit their thoughts about, and experiences of, being a member of and/or worker in the Turkish-Kurdish community and how alcohol affected the community at large. By reflecting on these experiences there was potential for distress.

As an experienced clinician I endeavoured to use my therapeutic skills to conduct the interviews in a sensitive and respectful manner. I reminded the health care professionals group that they could seek advice or further discussion with their clinical supervisor or line manager at Derman or contact me and I would help to arrange this. Participants of the community member's focus groups were also invited to talk to Derman staff and/or the interpreter following the group. Available resources with regard to alcohol and mental health services were outlined. Time for debriefing was allocated at the end of

each focus group session. Participants were reminded of contact details on the information sheet should they wish to make contact at a later date.

2.4 Participants

Five women attended the first focus group, three men attended the second focus group, and five staff members attended a third group.

Basic demographic data was collected from participants, including name, age, address and ethnicity. Participants were not asked to identify themselves as drinkers or non-drinkers in the focus group.

Participant demographic information is summarised in Table 1. Some information has been omitted to preserve anonymity or at the request of the participants.

Table 1: Participant Demographics

| Group | Pseudonym | Age | Job title | Ethnicity |
|---------------|------------------|------------|------------------|------------------|
| Female | Elif | 38 | n/a | Turkish |
| | Beyza | 44 | | Kurdish |
| | Selin | 29 | | Kurdish |
| | Zeynep | 51 | | Turkish |
| | Deniz | 58 | | Kurdish |
| Male | Kadir | 51 | n/a | Kurdish |
| | Yusuf | 43 | | Kurdish |
| | Enes | 54 | | Kurdish |
| Professionals | Esra | 34 | Counsellor | Kurdish |
| | Hasan | 46 | Health Advocate | Kurdish |
| | Nur | 32 | Health Advocate | Turkish |
| | Gizem | 55 | Head of Services | Turkish |
| | Ceren | 45 | Health Advocate | Kurdish |

2.5 Data analysis

2.5.1 Process of interpreting

Rather than adding weakness to the methodology of this research, it is regarded that the existing social relationships within the interpreting process were crucial (Kinzie & Manson, 1987) to the process of accessing the participants' opinions and experiences.

During the focus groups conducted in Turkish, the researcher asked a question addressed to the participants which was then interpreted by the interpreter. The participants' responses were then interpreted into English by the interpreter word for word where possible in the first-person. The researcher and interpreter decided before commencing the groups that where natural conversations or debates between participants arose, the interpreter would not interrupt the flow of the interaction but summarise the points made in as much detail as possible for the researcher when a natural break arose. This facilitated a more natural conversation between participants and careful translation from the voice recordings ensured that word-for-word interpretation could still be analysed. The researcher acknowledges however, that the presence of the interpreter may have restricted more natural discussions (Potter & Wetherall, 1987).

2.5.2 Transcription

The transcription of the professionals group (in English) was conducted solely by the researcher. Braun and Clarke (2006) state that although thematic analysis does not require the same level of detail as other qualitative methodologies, it does require a verbatim account of the interview that accurately reflects what was said. In order to maintain the way in which participants spoke, abbreviations, repetitions, pauses and verbal tics were included in the transcription (Gibbs, 2007). The transcription conventions I used when transcribing were based on elements of Jefferson's (2004) conventions, and are described in Appendix I.

The Turkish recordings were transcribed in full by an independent Translator. Unfortunately, due to a change in circumstances the interpreter was not able to also write up the transcriptions. This was regrettable as I had hoped for

continuity and continued collaboration as explained in Chapter One, but every effort was made to ensure the transcriptions were done accurately. The translator was a female of Turkish origin whom I had met during my work as a trainee. She was familiar with translating for 'psychology' work including therapy sessions and lived in North London, a neighbouring Borough to where the research was conducted. We met face-to-face to discuss the research and were able to check for cultural and contextual meaning.

2.5.3 Process of Thematic Analysis

Thematic analysis was conducted in accordance with the guidelines of Braun and Clarke (2006) using the full text, and not the interpreter's summaries as given during the focus group sessions. Historically there has been little guidance on how to use thematic analysis systematically in qualitative analysis but these authors provide coherent guidance on the steps involved in identifying emerging themes and their 'interpretation'. They propose six phases:

Phase One: Familiarisation with the data

In order to become immersed in the data I repeatedly read the interviews. The transcripts were annotated by hand at first to help draw out what was being said and to become familiar with the data. An example of this can be seen in Appendix J. This was an active process: meanings and patterns were identified and then recorded in the margins of the transcripts, an example of which can be seen in Appendix K.

Phase Two: Generating initial codes

A list of ideas about the content was then generated which helped to identify features and generate a 'codebook' (Guest et al., 2012, p.52). Extracts were collated under each code and detail around each extract was included to retain context (Boyatzis, 1998). This process of coding was carried out systematically with the entire data set and extracts were sometimes included in more than one code. Inconsistencies and exceptions in the data were also coded. During this process the codebook was developed and refined. A sample of the codebook can be found in Appendix L and a sample of a coded extract in Appendix M.

Phase Three: Searching for themes

Codes were then grouped into broader themes, as depicted in 'Provisional Themes' (Appendix N). I considered the relationship between codes, themes and levels of themes (sub-themes and main themes).

Phase Four: Reviewing themes

Level One: The aim of this phase was to ensure that each theme contained coherent supporting evidence, and that themes were clearly distinct from each other. Themes that did not contain enough evidence were collapsed into other themes and some were split into more than one theme or re-worked. Once themes were clearly defined, a "thematic map" (Braun & Clarke, 2006, p.21) was created, as seen in 'Thematic Map One' (Appendix O). Once I had finished the Level One review the six main themes were collapsed into three, as illustrated in 'Thematic Map Two' (Appendix P).

Level Two: I re-read the entire data set and considered whether the themes reflected the data. This enabled me to identify data missing from existing themes and re-structure the thematic maps. 'Thematic Map Three' (Appendix Q) was derived by expanding on 'help roles' and altering the main theme of 'cultural shift' to more fully explain what was being said in the data. 'Thematic Map Four' (Appendix R) further explores the most accurate way to capture the sub-themes, and 'Thematic Map Five' (Appendix S) illustrates the final map depicting the themes and sub-themes that best reflected the data.

The process of reviewing themes ceased once refinements were no longer deemed appropriate.

Phase Five: Defining and naming themes

A detailed analysis was conducted for each theme, considering the story that the theme told, as well as its relationship to the research question and to the other identified themes. I considered what was interesting about the themes and why they were of interest, as illustrated in Appendix T.

Phase Six: Producing the report

The analysis section was written up in a way that aimed to provide a coherent summary of the story told by the data, considering information from both within and across themes.

2.5.4 Process and presentation of analysis

In denoting speech in the analysis chapter, participants will be referred to by pseudonym and I will be referring to myself, the researcher, as 'Libby'. Included in the analysis are reports of number of participants or groups who reported certain themes; this included categories such as 'many', 'most' or 'some'. Rather than attempting to quantify data, this approach assists the reader to identify differing responses.

CHAPTER THREE: ANALYSIS

Following the process of coding, searching for and reviewing themes (as outlined in section 2.5.3) three main themes emerged; explanations for drinking, impact of drinking, and help-seeking. These main themes were categorised by further sub-themes as depicted in Table 2. Pictorial representation of these themes can be found in Appendix O.

Table 2: Themes and Sub-themes

| | |
|-------------------------------|---------------------------|
| 3.1 Explanations for drinking | 3.1.1 Personality type |
| | 3.1.2 Stress |
| | 3.1.3 Culture |
| 3.2 Impact of drinking | 3.2.1 Harm to self |
| | 3.2.2 Harm to others |
| | 3.2.3 Positive accounts |
| 3.3 Help-seeking | 3.3.1 Role of men |
| | 3.3.2 Role of women |
| | 3.3.3 Service development |

For clarity, each extract in the chapter states whether the participant is a community member (community) or a professional working for Derman (professional).

3.1 Explanations for drinking

All participants spoke about why they thought members of their community drank alcohol. A number of participants talked about personal experiences involving family and friends and the conversations primarily concerned members of the Turkish-Kurdish community who drink 'excessively'. Whilst there was no formal definition given by any participant of the quantity of alcohol consumed by individuals, many of their stories told of people for whom alcohol was an everyday presence that affected different aspects of their life.

3.1.1 Personality Type

Many participants linked drinking excessively with personality factors or reasons stemming from within the individual. Selin summarises:

Selin (community): It's also about personality; if someone is weak or their character is weak they will be more inclined to it [drink] (lines 89-90).

The concept of weakness was raised by many of the participants who described individuals as weak or not having the willpower to say no to drinking alcohol. When discussing the use of alcohol, one participant highlights that he does not judge those that drink but it is up to an individual's willpower whether they do or not.

Yusuf (community): It's automatically dangerous – and sometimes a man drinks alcohol in the street and sometimes he can behave in an ill manner and disturb people – I am not allowed alcohol so I don't drink it but because I don't drink I don't oppose others doing it, that is up to his willpower, even I don't recommend it to anyone, nor do I prevent their drinking (21-26).

Yusuf later went on to talk about having the strength to not turn to alcohol or cigarettes and cope without them. In all of the groups there was discussion about the notion of choice; having the ability to choose whether to drink or not. A number of examples of difficult life events were discussed and how some people then choose to “start consuming alcohol and some try to save their health” (Yusuf, lines 310-311). He explains:

Yusuf (community): I would like to speak about myself, I have faced a lot of stress too that I don't need to go into, but again I will speak for myself, I have my willpower I don't find the need to search in alcohol or cigarettes, I have the strength to always try and stand on my own two feet (224-228).

In addition to personal reflections about drinking, participants gave examples of others in the community who demonstrated 'weakness' by drinking. Elif gives an example of someone in a position of power and responsibility who used alcohol excessively.

Elif (community): I have witnessed this in Turkey, I was working in a company, he was a big manager, he was fasting, and he had a private office and would then go in and drink his alcohol.

Beyza (community): My boss was like that//

Elif (community): One day I said to him, <name of gentleman> (<name>'s brother): you pray and fast, and because you fast you shut down the canteen and there you are drinking alcohol at the back; you know I am very outspoken. He then said my daughter <name>, I am 60 years old and I have never heard this from anyone, you are very brave to talk to me in this manner, I said are you going to execute me for my courage, I said this is what it is. He said you have spoken to me like man, you can access the canteen. So in three days' time they are going to get money, when they fast they get more in that month. I can't fast I don't do it, I eat, I am going to get less money as a result of not fasting, but anyway this is about having a weak personality, a weak character (94-108).

Again, the behaviour that this gentleman exhibits is explained by an inherent weakness within him. Many participants highlight the ability of an individual to make a choice about what they want to do or not. Kadir gives an example of having a conversation with his GP which led to him stop smoking cigarettes. He attributed that decision to his strength to make a decision to stop, and likens it to the inability of others to say no to alcohol.

Kadir (community): I don't see it that way, maybe he has a yearning and is missing Turkey and has faced some difficulties, anyway in 1989 I went to see my doctor and I was told that I

should not drink, I don't drink anyway due to my health but after I left the doctor's surgery I took out my cigarettes and destroyed the box saying I don't want you near me again, and threw it away and never smoked again. So what I mean is, that one month later the doctor called me for a check-up –

Interpreter: Was it here?

Kadir (community): Yes it was here, he asked, 'are you drinking?' I said no, but sometimes at a wedding I may have a cigarette, friends they force you but nonetheless I said I do not drink, I have never liked alcohol. So what I am saying is that this alcohol issue is all about your own willpower, in a single word. But I think that if people have willpower they will not drink but if they don't have willpower then they will drink (158-173).

A few participants expressed little sympathy for those that 'chose' to drink. Beyza explains the horror that her brother suffered and how he did not turn to alcohol for support and Deniz highlights that everyone has different coping strategies:

Beyza (community): I think this is just an excuse my brother was also tortured but he neither smoked or drank alcohol.

Deniz (community): Not everyone is the same, not everyone can cope with it (69-71)

Deniz raises the idea here that there is perhaps something more complex than an individual's personal coping style. The groups went on to look at other factors that might influence drinking alcohol (see sections 3.1.2 and 3.1.3) and to discuss a more complex picture of the context of their community.

3.1.2 Stress

All groups reported stress to be a major cause of drinking excessively. One participant links personal weakness with stress and that an interaction of the two factors, or how one causes the other, leads people to drink.

Yusuf (community): Weak yes that's how I see it, because it's not about setting out to make men look bad here, but the men have more stress, like for their children and wife and place and when he cannot overcome it, it's like when a car does a wheel spin, he's either going to do something or harm himself (237-241)

Stress is frequently given as the reason for drinking, but many participants questioned whether it is just an excuse. Ceren summarises, "gives the excuses why I am drinking because I'm stressed" (lines 99-100). She suggests that it is often how people in the community explain why they drink but she questions whether that is the whole truth, as does Gizem:

Gizem (professional): Maybe it's starting with sadness or with happiness but when you start drinking regularly and many people with alcohol problems they say because I'm, because the stress I am under now, that's the excuse or another reason it's difficult to judge (136-139)

Enes takes this point further and comments on whether drinking alcohol really works to relieve stress and if drinking is the best method to do so.

Enes (community): It's not about a community; alcohol has a unique thing of its own, for example a man drinks and they ask him what's the problem he says that he is stressed and has problems that is why he is consuming alcohol; are you really releasing your stress by smoking and drinking alcohol? So we should drink and lose our balance and walk in the stress as a drunkard (184-190)

For some, the stress that causes drinking stems from the family, in particular within the marital relationship.

Enes (community): Husband and wife are sitting and talking, and she says, something like, you can't be like this and that. And then the stress starts (296-298).

Feeling ashamed is identified as a precursor to stress. In this example, Enes identifies that the interaction between husband and wife causes the onset of shame and stress.

Enes (community): She may say I don't have a dress you don't buy me enough clothes you don't take me out properly, you don't take me out to eat and drink. So he feels ashamed by this and due to this stress he starts drinking alcohol (248-251).

Similarly, links were made between the shame and stress that were felt by individuals who were unemployed and thus had little money.

Kadir (community): It happens...when a man is jobless he becomes very stressful and has financial problems and becomes stressful (461-462).

Marital stress was considered by a number of participants in all three groups to be an important reason for why drinking commences and for some participants, this is compounded when support is not offered or demonstrated between husband and wife. Yusuf felt that if a couple "support each other" then the environment at home is less at risk of "becoming stressful" (line 283). He identified support as existing when partners "don't behave badly" or "don't say the wrong things" (lines 284-285). In the following example, Kadir highlights the importance of support to reduce stress, particularly at times when the husband is most vulnerable or weak.

Kadir (community): Of course he expects support. Like when he is in that level of stress, and when he drinks, it's like that stress is a bit relieved, so he is expecting support from his wife, to help

him and not cause any further stress, and when he is at a weak point, not to say, we don't have this, this is missing but to show support at these times and confirm that they have everything in place. This is in my opinion (270-276)

Explanations were offered by many of the participants about men blaming the interaction with their wives for their drinking. Elif spoke about finding a "resolution" in drinking alcohol following arguments between spouses. She gives the example of a man who said "we had a fight so I went out to drink" (line 231).

The women-only focus group did not cite stress and lack of support as a cause for drinking, rather that drinking itself can lead to stress because of social isolation. Deniz summarises this point by suggesting that drinking leads to family separation.

Deniz (community): For example if someone is drinking alcohol, he is ousted by his children, and wife and family, and the community, and therefore feels completely isolated and gets more depressed without any support from the family (35-38).

3.1.3 Culture

Many of the participants, including those in the professionals group, identified themselves as first-generation immigrants and spoke of the impact this had on their lives and for those in their community. Whilst moving to London was not cited by any of the participants as the sole cause of alcohol problems within the community, the consequences of living in a different culture and a change in lifestyle were identified as difficulties that contributed to alcohol being used to cope. Some participants referred to the difference between the Turkish and English cultures and described a difficulty in integrating the two in a way that people feel "crushed between the two cultures" (Beyza, line 244). The difficulty in adapting to a new culture was raised and how alcohol can bring comfort to some.

Beyza (community): people come here and get trapped in trying to adapt to two cultures and get depressed and find solace and comfort in alcohol (51-53).

All groups spoke of the 'drinking culture' in the UK and how alcohol is much more readily available in London when compared with Turkey. Alcohol use in London was talked about as commonplace, something that everyone takes part in and a view that "all this English people are alcoholic" was raised (Gizem, line 112). Participants noted how this is quite different to the culture in Turkey.

Hasan (professional): In Turkey, like they sell in certain places but in here they are (...) they are running their own shops or they just drink it and no one realises it, but in Turkey most of the coffee shops like before they wasn't selling any alcohol until this, it was just there like pub and certain places. I know now it is spreading all over, but in England you can find it easily everywhere so it is liked. Also they, I think they are feeling like part of, to get to know the culture they are drinking as well, it is like part of adaptation they feel in that way (104-111).

Gizem explains how alcohol is not only widely available, but also part of the routine of the day in the UK. In Turkey however, drinking alcohol is something not done in public, shared with others, but something to conceal.

Gizem (professional): You know every time they leave work they go to the pub to drink and then go to their home, so I found it very encouraging to drink alcohol. But in in my childhood erm to buy alcohol was in a way a secret thing err the shop used to cover with the newspaper and then you hide it in a bag to take it to home erm my father used to drink wine, all his bottles were in the cupboard covered err in newspapers (115-121).

Some participants spoke about the difficulty of the younger generation trying to fit in with their peers whilst having a different set of values at home, within their extended family and Turkish community. Nur spoke about boys who drink to prove they are men and to integrate with the British way of life.

Nur (professional): Fitting in actually, trying to fit in. I mean even teenagers are trying to prove that they are actually men (161-162).

The impact of coming from another country and culture is far-reaching. Nearly all participants discussed the difficulties of being an immigrant who does not speak English and finds themselves unemployed.

Zeynep (community): Yes because of that...being an immigrant...this problem only became apparent here, people come here and they can't speak the language and can't find a job and fall into this emptiness, and then get used to consuming alcohol and get depressed, and they don't seek psychological support (25-29).

These financial and social problems are what many participants attributed to being the cause of some individuals to start drinking. In fact, alcohol was identified as a coping strategy that was not used in Turkey, but something specific to living in the UK. Selin described the importance of receiving money from the British government (benefits) in order to be able to afford alcohol.

Selin (community): Of course, it's continuing. And this stems from people who have not been using it in Turkey but started using it here, why, because they are getting a small amount of money from the government, they are getting a little money and with that they start by getting a small amount of alcohol and

starting like that...but in Turkey because the government does not give any money they cannot do this there (40-46).

Many participants spoke about the loss of identity which resulted from moving to a different country and trying to find a place in the new community. A person identifying him or herself as a drinker and finding a sense of belonging within the drinking community is a theme that emerged in all the groups.

Enes (community): Like to strengthen his economy, and he's not able to do things for his family or buy things for his children, and then he has problems with his wife as a result, so what does he do? So he gets confused he then goes to the Turkish men's cafes or to the Turkish community centres and he sees that there are different types of people (331-336).

One participant described being a refugee in a foreign country as "lost in something they cannot find" (Yusuf, line 328) where this feeling of being lost leads an individual to "give in to alcohol" (Yusuf, line 329). Esra summarised the position of the immigrant, in particular how the hardships lead to a loss of identity:

Esra (professional): I remember with my client he was so desperate to get help he used to say that he has no job, nothing, he doesn't feel like a father, he says, in Turkish they say 'bread-taker' and there is a small place with a group of people they can drink and they have a really strong identity. It became his identity and there's a different self there and he feels okay as long as he doesn't remember what he's not able to do (152-

The difficulties and distress that result from immigration are not unique to the Turkish-Kurdish community. Alcohol was identified as a problem for all,

indiscriminate of culture or place of origin. Beyza spoke of the far-reaching impact that alcohol has:

Beyza (community): It's not only in our community; it is a general problem in London. Generally speaking it's not only in our community it's quite widespread (22-24)

Furthermore, many participants highlighted the importance of not assigning blame to some groups or to certain experiences that are met by particular groups of people. She raises the concern of this leading to stigma within and between communities:

Esra (professional): When we, I think we need to open that a little bit up, because if we say that immigrants are drinking more than any other group it brings a provisional stigma but there are some, some facts coming to their life as they are being immigrants in exile (141-145).

3.2 Impact of drinking

All groups spoke about how alcohol affects those that drink, the people and community around them and the environment. Whilst the extent of harm was discussed, there were also positive accounts of drinking within the community.

3.2.1 Harm to self

All of the participants identified how alcohol causes harm to the individual. Harm was categorised in a number of ways in the focus groups. One particular aspect that many of the participants discussed was the psychological harm of drinking. Hasan and Selin summarised this position by pointing out the cycle of having unwanted feelings and drinking to suppress them, and then how alcohol can intensify those feelings for individuals.

Hasan (professional): It's a very heightened issue in our community, they don't want to disclose or to express a feeling especially when

they feel lonely or when they don't integrate themselves in the community or express themselves and that's another way they oppress their feelings or thoughts they think alcohol will help (15-19).

Selin (community): He drinks to suppress his psychological issues, but he doesn't realise that it actually makes matters much worse, so they both feed off of each other (237-239).

The link between feeling lonely, depressed, suicidal and drinking alcohol was made by many participants. The following extract summarises the severity of the situation for those that choose to use alcohol.

Enes (community): Some who can get it under control are OK, and those who lose their control given in to alcohol. Once they fall into this searching pit and cannot find what they are looking for, feel down and depressed and some choose alcohol and others commit suicide, this is what I know (339-343).

All of the groups discussed the impact of losing members of their community from suicide and many linked this to alcohol use.

Zeynep (community): What about that man who hung himself <name>? No one drinks in his family, but he hung himself due to alcohol problems (115-117).

The high proportion of suicides in the Turkish-Kurdish community in London was discussed with one participant stating that there have been "300 to 400 suicides" caused by "so much stress" (Yusuf, lines 320-321). Elif talked about how alcohol plays a part in causing distress. What once might have been used to help an individual to cope, alcohol has now become part of the problem and affects a person psychologically:

Elif (community): It's a very bad problem. We had a relative, for example, he distanced himself from his children and his family and then killed himself, he hung himself, all due to alcohol problems. Psychologically he became quite affected (5-8).

The young age of some of the individuals who had ended their own lives was noted and the difficulties that are faced by the younger generation were a concern for many of the participants. Gizem spoke about young people being involved in gangs and their use of alcohol.

Gizem (professional): Also you know in Hackney there is this gang culture for the youngsters and err these macho young men who drink and take drugs (355-357).

The physical harm that alcohol can cause was raised in every focus group. Yusuf highlighted how alcohol has no benefit for an individual's physical health, "bodily, it is always harmful (line 54). Personal accounts of the physical harm of drinking were given by a few participants. Enes described the first time he drank alcohol:

Enes (community): So as I laid down my stomach turned upside down, I emptied everything out of my stomach but my stomach was off for one week, it was up down up down, I went to the level where I thought I would die, so I said I will never be drinking again because it was harmful for me, I said it's not my thing; so because of this I don't drink (75-82).

3.2.2 Harm to others

The impact that drinking alcohol can have on more than just the individual was discussed by almost all participants. In the following extracts, participants highlight the extent to which alcohol can cause harm to other people.

Yusuf (community): If people drank within reason then they wouldn't be causing harm to anyone, like, people lose themselves, if a family is walking by they say bad things to the family (130-132).

Enes (community): we are aware that alcohol is harmful, for example when people drink and drive or how they attack here and there, people lose themselves, we see these things (454-456).

In particular, the effects on the family were discussed with regard to the correlation between a member of the family who drinks and divorce, domestic violence and harm to children. One participant spoke about her professional role and how women would seek her help saying "he is violent towards me and children all because of his alcohol problem" (Gizem, lines 65-66). The same participant spoke about the gravity of the domestic situation when a violent partner is under the influence of alcohol.

Gizem (professional): Erm there was a case in the past, there was a woman who her violent husband was very violent and her life was in danger and the GP and I, we were trying to convince her to leave him for safety, for her safety and her children but she was desperate to seek help err in the agency to him stop drinking, she hoped he would stop but he didn't and they finally separated so it's err in many domestic violence cases drinking alcohol is involved (67-73).

The impact on marital breakdown is raised by Elif:

Elif (community): But there are issues where people are getting divorced and having family problems and separated from their families due to alcohol problems (13-15).

Furthermore, children of a parent who drinks are affected, not only by an absent parent but also by the stigma of drinking which is seen in the way that other

children react to them. In the following extract, Beyza talks about her personal experience of the effects that her husband's drinking had on her children.

Beyza (community): This is not a good thing, my children have been affected by this very much my older son <name> was a very bright child and student he was number one in the school, but his father's drinking outside in the streets, and my sons friends saw this and they approached him about it and made fun of it, so this has really had a bad effect on him and he left school as a result, my child hasn't spoken to his father for 16 years and he only started speaking with him this year (159-166).

Harm to the environment was also raised by a few participants who gave examples of the impact that drinking alcohol can have on pollution and the aesthetics of the community. Yusuf described how his surroundings are spoiled by people who drink:

Yusuf (community): for example there is a really beautiful garden in front of my house, a man drinks beer and then he tosses the empty bottle into the garden, he is walking by and flings his half bottle into the garden, he is spoiling the nature and the beauty, it's like he enjoys spoiling the balance of beauty (84-88)

3.2.3 Positive accounts

Whilst there was much discussion about the harm that drinking alcohol has on the individual, the family and the environment, many participants also spoke about the enjoyment and well-being associated with alcohol. Furthermore, a few participants discussed the idea of drinking being an important part of the Turkish-Kurdish culture in terms of becoming a man. One participant stated "it's a man thing" (Esra, line 85). Hasan adds:

Hasan (professional): I think that's because in our culture thinking back in Turkey, in Cyprus where alcohol is accepted as a man like when you're grown up like a part of your life (81-83).

Alcohol is also part of Turkish culture in weddings and parties. Esra states, “it’s partying and having fun, the first thing that comes to mind is actually alcohol” (lines 360-361). Many of the participants agreed with Esra and spoke about events where alcohol is freely enjoyed.

Ceren (professional): When we are happy as well you know we drink at our wedding parties for example, we drink too much I mean in our community you know, and then you know we suddenly get into trouble very easily like you know when you drink alcohol and it’s not just when you’re stressed you know, when you’re unhappy. I mean it is when you’re in love (125-130).

Selin (community): In our Alevi community, there isn’t that pressure on the women that they cannot drink and men can, like at the weddings there is Whiskey and beer (131-134)

In the extract above, Selin raises the subject of religion. Her Alevi community find it more acceptable to drink when compared with other sects of Islam, for example, “the women in the Sunni community won’t drink” (Selin, line 144). Participants spoke of the fun had at weddings when alcohol was drunk and it being part of a tradition which involved particular cultural customs.

Enes (community): At the wedding, so after we drank we went to do ‘HALAY’ (*a traditional Eastern Turkish dance*) (65).

Many participants spoke about the positive messages that were given out about drinking alcohol by the media and health-care professionals. In particular, participants spoke about the messages they had heard about alcohol being beneficial and important to maintain good physical health.

Ceren (professional): He said he was watching TV, Turkish TV and the doctor said you know it's actually good to have a drink of wine because it's healthy for the circulation and blood (299-301).

Hasan (professional): And, sorry they say also beer for the kidney, and that's what they say, look I'm just drinking beer because it's good for my kidneys, it's like water. They do.

Ceren (professional): Yes, for my kidney and why you know help for kidney stones and it's like you know...

Hasan (professional): Also they say it's like an antidepressant that keeps me a bit calm (309-315).

In the above extract, Hasan highlights the benefit that alcohol can bring to an individual's mood, acting in the same way that an antidepressant might. Alcohol was also compared with the harm that cigarettes can cause. The message of alcohol being less harmful was a strong message raised by a number of participants.

Gizem (professional): When I was growing up they were warning us against smoke. Alcoholism is, err not as dangerous as smoking. Smoking is more dangerous than alcohol they used to say to us.

Esra (professional): Yes I do remember something like that. I think they do things, little things, every day in the news, in the newspapers saying that a glass of wine is good for your blood circulation. I remember my parents actually started to buy wine saying it's good my daughter (317-325).

Hasan (professional): we're not allowed to take cigarettes but now they are telling me to not take alcohol so what do you want me to take some kind of drugs. So they say at least alcohol, is better, they compare it in their minds, it's better than these

antidepressants. So if they don't hurt anybody I just drink at home so it's, I'm not doing any harm (312-317).

Some participants felt that it was important to separate the harm that alcohol can do from the benefit it brings to business and finance within the Turkish-Kurdish community. Yusuf specified the need “to differentiate the financial, business side to it and the harmful side” of alcohol (lines 93-94). Enes agreed:

Enes (community): But there is alcohol where businesses are concerned like in restaurants' our people benefit a lot from it (*I think he means from the sale of it.*) Like if alcohol isn't sold in a restaurant your business would not be going so well and doesn't add to the business takings (80-84).

3.3 Help-seeking

The different roles that women and men have within the Turkish-Kurdish community were discussed with regard to whether and how help is sought from outside the family unit. Services for the treatment of alcohol use were discussed and how the impact of help-seeking behaviours can best be considered and addressed within these services.

3.3.1 Role of men

The role of men and the role of women within the Turkish-Kurdish community were discussed in all groups. Many of the participants spoke about alcohol affecting men more than women, and additionally, that men are allowed to drink whereas women are not. Gizem spoke about drinking being more acceptable for men within the Turkish-Kurdish culture and how women are perceived if they do drink.

Gizem (professional): Men's drinking is more acceptable and in some cultures it is expected them to be but woman's drinking would not be accept all, it is more hidden therefore we err in the last 16 years I

haven't seen any woman coming to seek help for her alcohol problem...if their sons are drinking alcohol it's not a big issue but if it's a girl then it's biggest issue and also other dynamics come with it, their honour and the girl's dignity would be in question (54-60).

Some participants identified that there was not only an acceptance in Turkish-Kurdish culture for men to drink, but also a necessity to prove that a man does the things a man should, including drinking alcohol. Hasan gave an example of a family looking for a husband for their daughter.

Hasan (professional): in our culture, when you grew up they look for a few things if you are married, I was telling like if someone comes to a girl's family to say okay our son is good, he is breadwinner, he has done his army, military job, it is compulsory but still he's done it, he smoke, he doesn't smoke, he doesn't play gambling and he doesn't drink alcohol. They said oh sorry, excuse me your son doesn't do anything what other men should do. They think other men should drink alcohol, do a bit gambling, should smoke as well (188-195).

There was a dominant discourse amongst all of the focus groups about men being head of the household and the demands this role brings. Problems within the family lead the husband to "find his resolution in drinking" (Elif, line 238). Yusuf explained how the man's role leads to drinking alcohol.

Yusuf (community): For example as men are the head of the family they would be under more stress, and their lifestyle here is different, they are searching for something and when they cannot find it, they turn to alcohol as a way of consolation for themselves, this is an example (219-224).

Enes highlighted the responsibility that men face in their role as head of the house and how the needs of the family are supposed to be met by the father.

Enes (community): It's like this, I mean; a head of the house is a man, in our community the father is always responsible for everything, a father - if he doesn't educate his children and doesn't see to their needs, if all their needs are not met, so therefore his wife can make a comment, saying it's like this it's like that! (242-246).

He added later that the burden of responsibility does not end, even when his children are adults themselves; the need to provide and protect them remains.

Enes (community): so in our community everything is on the shoulders of the head of the family, even when your child is 20 years old, but you are always trying to do the best for your family (254-256).

This need for men to provide for their family is made more difficult when a man compares himself with others. The following extract highlights how this comparison causes a man to start drinking.

Enes (community): for example a man has opened up his own business and he speaks to you in a different demeaning kind of way, so that makes him feel bad and turn into himself and he says what is the difference between us, why should he be better than me? Some who can get it under control are OK, and those who lose their control given in to alcohol (336-341).

The following extract gives an example of how a husband is made to feel bad for not looking after his family and taking care of their needs, being the head of the family.

Kadir (community): An example, for instance husband and wife are sitting, we have seen this happen, and daughter goes and hugs her dad saying, baba are you going to buy me something, and at this time he doesn't have the means, then his wife says my daughter why

are you hugging your father, he is not doing his responsibilities, so then the father becomes stressful, this is an example, do you understand me? (313-318).

Almost all participants spoke about the reluctance of men to seek help for their alcohol problems. The following extract highlights why Hasan thinks men do not seek help.

Hasan (professional): But in the same time they are afraid to come to professional to get help for two reasons. One they don't want it be mentioned that they're alcoholic or that they drink alcohol even though in the religious or in their religion they shouldn't drink alcohols but they do and secondly they are worried that it may affect their family relationship (19-24).

This extract, like many of the discussions had amongst participants, states that men are worried about being labelled as “alcoholic” and about the effect on their family if they were to seek professional help.

3.3.2 Role of women

All participants reported that it is women who seek help on behalf of the men in their family. Kadir gave an example of a Turkish woman in the media who helped her husband get the help she felt he needed. However, Kadir and many other participants also felt that the support a wife offers should be sufficient to prevent the husband from seeking professional help.

Kadir (community): Yes he stopped. So he regained his composure and his family life, and the woman was happy to have won back her husband, so she went on tv to say that as she has won back her husband from the alcohol that she is great person. I personally appreciated that woman. I think that the biggest support is between the husband and wife and once that is in place I think that you don't need to go anywhere else (360-366).

Almost all of the female participants gave personal examples of helping the men in their community to seek help. For example, Beyza reported “I have taken my husband to get help” (line 173) and Gizem spoke of the men’s reluctance to seek help for themselves, “we hear mostly from their partners and families” (line 256). The male participants agreed and discussed their experience of the role of women in help-seeking.

Hasan (professional): Most of them err the wives or the children they disclose, they explain what is going on if it is really, or what do you call it, when it has come to the top and then they say yes my dad or my brother or husband has alcohol problems (35-38).

Some of the participants also spoke about women being responsible for more than simply getting help for their husbands. In contrast to the discourse about men being the head of the house, women were described as holding immense responsibility for the well-being of the family. In the following extract Gizem speaks about what women do to help the family thrive.

Gizem (professional): They do everything mostly. There are some men who also take some responsibilities but women mostly who deal with the alcohol problem for their husband or son and applying for benefits, erm making appointments with the GP for everybody and locking their house and department store all the time to move to a better housing for the family. So women are err more responsible for the family and also they are better survivors than the men.

Furthermore, a number of participants spoke about the role of a woman in telling her husband when he needs to change and to help him identify when he is causing harm to himself and the family. The following quotation summarises this:

Hasan (professional): Also it's like err putting these sort of responsibility on the women's shoulder. It is like if I become an alcoholic I will say oh why didn't you tell me, to my wife to say you know why you didn't realise I was getting the way so you have to warn me before that happened. If I'm doing all right it's you and if I am not doing alright it's you because you should tell me, you should warn me. They think in that way. That's the reality I think (394-400).

The woman's role is not just about finding the correct help but also in ensuring appointments are attended and in being the voice for their partners in explaining what problems exist:

Nur (professional): They keep an eye on the men's health a lot. They are usually the ones who bring their husbands to the GP and talk for their husbands very often (379-381).

If the women are not able to communicate directly with the GP or health professional, they will talk with the health advocate or someone who can interpret for them, as the next extract highlights.

Hasan (professional): When we walk on the corridor they said, the women, the wife says tell me, can you tell the doctor he has got this and this as well, he wouldn't say in there, every time they tell me. The men they think they are nothing in there but when the err wife opens the beans, the can, everything comes out (388-392).

Some participants spoke about occasions when men are not seeking help but wives are seeking their own support for the family's difficulties. Esra spoke about wives who attend counselling to discuss the problems when their husbands do not seek help.

Esra (professional): In counselling again, female clients come in and complain about what is not going well with their husbands, their husbands do not try to seek help (392-394).

All focus groups talked about the difficulty that families have to persuade the man who is drinking to seek help. In the extract above Esra has highlighted how this can be so difficult that it results in the wife seeking help for herself and Elif spoke of the complexity of finding a way to encourage help-seeking behaviour:

Elif (community): If the situation continues and the person doesn't accept what's going on, then there is a need to ask for professional help from a doctor or a psychologist, but one has to find the pathway to persuade the person. (149-152).

3.3.3 Service development

The need to further develop NHS and voluntary services was discussed by all participants, many of whom talked about the reluctance of people within the Turkish-Kurdish community to seek help. Participants such as Gizem and Esra spoke about how bad an individual's problems have to be before help is sought.

Gizem (professional): Also if someone gets ill err because of alcoholism, lung cancer or something that encourages people to come and see us (279-281).

Esra (professional): And also I think regarding the alcohol for someone to go and seek for help they really need to see that everything is collapsing in their life (264-266).

Many participants talked about the stigma associated with seeking professional help and the importance of health-care professionals in thinking more about what can be done to prevent people from being "branded as an alcoholic" (Hasan, line 261). Hasan said:

Hasan (professional): I think first of all it's about stigma they have like for alcohol or other things. They think that if somebody, if they go to the doctor and they will say oh you are mad. At first it was difficult to bring them to the services or to provide them, for alcohol it's the same as well, oh they'll say tomorrow it was her son or his daughter or her husband is alcoholic so it's getting it, that's why at the first they have to break this stigma and then they will say actually yes oh I have a problem I can get the help and it's helping here (240-247).

Almost all participants spoke about the importance of raising awareness of the dangers of drinking alcohol, and the crucial role that education played in delivering that message. Nur spoke of the effects of drinking on physical damage to an individual's body.

Nur (professional): I think they are not aware of the serious effect it's putting on their body and the damage it's doing, so maybe awareness, raising more about this issue (286-288).

For many of the participants, education was seen as the most important factor in helping the community to understand more about alcohol-related harm.

Nur (professional): Yes education. Because it's the new generation that we worry about most. Maybe education for the parents, for parenting, for raising awareness about alcohol and then can educate their children in that area would probably be very, very useful.

There was consensus within all the groups that giving the right educational messages in school is essential to help future generations understand the effects of alcohol.

Hasan (professional): She was telling me no daddy at school they tell us you know it is not good for you; it's as bad as

smoking. That's why I think it's in school, if they do it from the beginning it will have, yeah they will get more messages when they have more education I think (339-443).

Some went further to say that it is often those people who have not had an education who drink to excess.

Nur (professional): Yes I totally agree, definitely more education in school now it's the younger generation they will be bringing up children in the future so it's them now. The older generation of course they need support and help but because of the language barriers, but if it's open to them the school's education is the most important because these people who are drinking, most of them have no education (344-350).

Helping individuals to recognise “how much they drink instead of how often” (Gizem, line 295) was discussed. Hasan added that information about units and percentages of alcohol is just as important in helping to educate people about drinking within the recommended levels.

Hasan (professional): when people are drinking what you call 70cl Raki, which is about 45% of alcohol, they wouldn't think drinking like that on one or the other day, they think oh I'll just take a few shots of whiskey or these 2 or 3 types this is not an alcohol it is not an alcohol problem. That is what I think the measurement is different is, in their world than what is in reality. (290-295)

The importance of the media providing accurate and educational messages about alcohol was raised by a few participants. This particularly applied to the messages related to drinking being good for one's health, a prevalent discourse within the Turkish-Kurdish community.

Ceren (professional): maybe giving education idea of why the media is wrong I don't know err, I think the media has an impact, saying it's good for health and drink wine for the blood (302-304).

Nur (professional): Yeah, I think for the majority. I think the media is the biggest impact because I mean just look at the commercials. The best looking men and girls are always presenting, presented with a nice alcohol in a glamorous life and everything. This is becoming the chosen social environment (351-355).

In terms of NHS alcohol services, a few participants spoke about the shortfalls in helping the community understand what services are available and providing information in Turkish.

Hasan (professional): I think one of the, I don't find much of the help from NHS I don't see. Even if it is, people are not aware like it is err there is nothing, there are no posters or anything in their prescription to say in their own language to understand what is going on like if you're using certain medication and it was written then it would maybe have warned them but there is nothing like that I don't see. I find there is a bit of some shortage in that area to be aware to warn the people about what is happening and also what services are available (405-

Nur highlighted the need for professionals to approach their work differently when it comes to people who drink alcohol:

Nur (professional): I think the NHS it is coming from a medical tradition, they expect if people are suffering from certain things they come and seek for help. For alcohol err I believe there should be more outreach workers to do community work (413-416).

Most participants agreed that consistency and “continuity of services” (Hasan, line 495) were essential for the future of alcohol prevention and treatment work. Whilst there was much positive talk about the existing NHS services, the importance of maintaining job roles that formed crucial links from the community to NHS services was raised by many.

Gizem (professional): There is a very good service called err drug and alcohol action team or something, it is run by the council. Erm here they employee Turkish-speaking person, in mostly part-time and this person starts their work and comes to our door and says let's work together and we just start to work together and that post disappears in three months or six months (420-425).

In the following extract Gizem likens the alcohol services to alcoholics, suggesting that both are invisible.

Gizem (professional): There is only one organisation isn't it err it started as AdAction and then become DAAT and now it's Lifeline. In the last five years three times their name changed err nobody can make a familiarity with these services when they need advice to each other or go and access. They are like alcoholics they are visible and invisible you know these services....bizarre (440-445).

Hasan agreed with the importance of services maintaining one identity, in particular so that GPs know how and to whom they can refer their patients to.

Hasan (professional): I think that it is the continuity, if the NHS starts something I think about long-term rather than rather six months in a year in one organisation but when there was continuity in one organisation, in one place then everyone will know so even the GP they are mixed up where they are to send

to and who is responsible for this one and who can do better care for the other one (432-438).

Gizem, like many other participants expressed concern about the future of services within the NHS.

Gizem (professional): So err everything was err there was no genuine services in this area for many years and I'm not hopeful for the near future that NHS will provide sufficient service for alcohol (428-430).

According to many of the participants, one of the primary barriers in seeking help was language, not only with regard to many members of the community and professionals lacking a shared language but also in terms of a shortage in interpreting services within NHS organisations.

Hasan (professional): But two of them they were really desperately looking for help which we referred them to the alcohol and drug, but because of that, the interpreting, the lack of interpreting in that service as well so but I don't know what happened (89-92).

Many of the participants also spoke about the importance of having "culturally competent services" (Esra, line 480). Simply having a shared language was seen as not enough to provide a good service for the Turkish-Kurdish community.

Deniz (community): the clients with err alcohol problems come from the specialist teams and the person from the team tells us well actually I know we are specialist in alcohol but this person is not benefiting from the service, he needs to talk to someone from the same culture (475-479).

Esra (professional): Even in here, in Derman when people are employed they are asked how much they know about this culture, this community and the burning issues. Language is important but language is not enough for these people to get access to the services (482-486).

Gizem spoke about the importance of training local and national organisations about the culture and the needs of minority groups.

Gizem (professional): And also I think the NHS and the local government needs err training for themselves to understand the community's different needs in some certain areas like alcohol (418-420).

The following extract gives an example of a popular treatment resource in London and how, in Nur's opinion, it is only appropriate for speakers of English.

Nur (professional): Erm, then I never attempted it again to take any client to AA groups. If someone speaks English you can advise them to go. How isolated we are, that's why I gave this example. There is a good tradition here, people come together to support each other to get rid of something that they don't want to erm but we can't use that (469-474).

Some of the participants spoke about prevention work in terms of looking at the source of the problem. Unemployment was spoken about as a cause for drinking to excess and a few participants raised the idea that by tackling wider societal problems, the problem of drinking may be reduced.

Kadir (community): I am saying that if people were not jobless this could be prevention, if someone has a routine work style, then they can stay away from that thing. This is my opinion. If I am jobless then I would be stressful.

Interpreter: So you think that there should be a preventative situation to guide people away from it.

Enes (community): I think most of it stems from being jobless (470-476).

Many of the participants discussed the importance of psychological support for people who drink. This was often framed within the idea that the person's family should be the first to help, but if more support were needed, psychology can be helpful.

Elif (community): I think they should go to get psychological support.

Selin (community): I think initially the persons' family should persuade them, and support them but if the situation continues and the person doesn't accept what's going on, then there is a need to ask for professional help from a doctor or a psychologist (150-154).

In the following extract Zeynep gives the example of a relative who was a torture survivor and who had benefitted from therapy.

Zeynep (community): One day I caught him in the park with it in his hand, alcohol, I said to him you are an ill person, you cannot uphold yourself you are still in treatment....he was having psychological therapy, because he was given electric shocks there, there was a medical centre (...) thing (...) err there was <name> there he helped him into the therapy (60-65).

The above extract highlights the severity of the circumstances that many people from the Turkish-Kurdish community have come from or now find themselves in. Yusuf also described the importance of helping people who are in distress and who may otherwise end their lives.

Yusuf (community): So it's quite different getting support from your family, if he is not getting the support from them he can't get it by looking around, because the doctor's help is different and psychotherapy is different, so if he doesn't get this support he may attempt suicide (410-414).

CHAPTER FOUR: DISCUSSION

4.1 Summary of the findings

This study sought to explore perceptions of alcohol use and related help-seeking behaviour in the Turkish-Kurdish community in Hackney, East London, with particular regard to how cultural context and gender roles impact on drinking and seeking help.

4.1.1 Theme One: Explanations for drinking

The first study aim referred to recognition of the cultural context of the Turkish-Kurdish community with regard to the problems they face and how this may contribute to the problem of alcohol use. The first theme 'explanations of drinking' goes a long way to addressing this aim by detailing the personal, social and political context of the community. The distress caused by the problems of poor housing, unemployment (often related to immigration), seeking asylum and having refugee status, according to these participants, may contribute to why an individual looks for solace in alcohol.

This first theme summarises participant's experiences and understanding of how and why people in their community drink alcohol. Participants discussed three topics within this theme, and the three sub-themes that emerged from their accounts were: personality type, stress, and culture. For example, many participants believed that those who drink lack willpower or have a weakness in their ability to cope without drinking alcohol. Others thought drinking excessively was caused by the stress that individuals faced and this was often related to issues around immigration and loss of roles and financial independence.

Factors related to an individual's personality included descriptions of a lack of strength and willpower, as well as a weak character. Many participants described the community members that use alcohol to excess as having different levels of resilience to others and ultimately a different type of

personality. Some participants described coping styles relating to personality type and how alcohol is sometimes used as a coping strategy. Whilst using alcohol to cope was linked with personality type, it was also discussed in relation to coping with stress, the second sub-theme.

Stress was cited by some participants as an excuse why an individual drinks but almost all participants agreed that stress was also a legitimate precursor to alcohol use. Stress was regarded as part of a more complex picture of mental health which included feelings of sadness and loneliness for example. The idea that one can lose oneself by drinking and therefore eradicate stress, at least for a short period of time, was debated with disparate opinions. However, most participants agreed that stress from family, in particular within a marital relationship, can cause an individual to drink. Marital stress was discussed as often occurring when husbands felt shame about their family being compared by their wives with other families. Shame itself was also discussed as a direct contributor in causing an individual to drink.

The third and final sub-theme of 'explanations of drinking' was culture. This was discussed in all focus groups in terms of the impact of living in a different culture and often the resulting lack of financial independence felt most strongly by the men in the community who were described as being under pressure to provide for their family. Participants spoke about members of their community feeling stuck between Turkish culture and British culture and the limitations caused by not speaking English. Many participants described the desire to fit in and adapt to British culture and way of living. They felt that drinking was very much part of daily life in the UK, and that alcohol was not something to be concealed, but is socially acceptable, unlike in Turkey. Related to this was the idea that alcohol is much more readily available in the UK compared with Turkey with many social activities involving alcohol or being located in public places where alcohol is sold.

A loss of identity within a 'new' culture was an important factor explaining why members of their community drink. Many members of the Turkish-Kurdish community have refugee status and have been through numerous distressing

events, causing loss of roles, family, country and culture. Some argued that a new identity and a sense of belonging within the drinking community could be found more readily and serve to reduce distress. However, participants were also eager to point out that this is not unique to their community, and problems with alcohol are seen across the population with individuals from diverse backgrounds. It was important in all three focus group conversations that stigma concerning alcohol abuse should be reduced and that the correct messages about the community and alcohol should be told, by giving context to their story and recognising the widespread nature of alcohol problems.

However, not all participants spoke about personality type as a reason for using drinking as a coping strategy. There was very little discussion relating to this sub-theme within the professional focus group. Furthermore, the women-only focus group spoke very little about stress as the reason for drinking. They did discuss the importance of family support in helping an individual to feel better but did not cite stress and lack of support as a cause.

4.1.2 Theme Two: Impact of drinking

This theme relates to the second aim of this study: factors influencing members of the community to drink and the effects of alcohol on the community.

Participants spoke about the impact of drinking alcohol in terms of harm to the self (sub-theme one), harm to others (sub-theme two), but also the positive associations with drinking (sub-theme three). Related to how alcohol affects the individual, all focus groups talked about how alcohol can cause or heighten mental health problems including suicide, and how it affects the body and can cause physical harm. A vicious circle was described where individuals feel low so they drink to help their mood but this effect is short-lived and ultimately leads to feeling low again and in turn serves to heighten psychological distress. The existence of Turkish gangs and drinking amongst the younger generation was of concern to most participants. They spoke about the high number of suicide amongst the youth in the Turkish-Kurdish community and their fear about the involvement of alcohol and mental health difficulties.

Harm to others was discussed in relation to causing problems within families such as domestic violence and distress amongst children of those who drink. Participants also spoke about harm caused to the physical environment by those under the influence of alcohol. Many participants voiced their concern about the link between drinking and divorce. Discussion highlighted the severity of the impact on the marital relationship in particular, but also the wider family network. Reference was also made to the poor choices that people under the influence of alcohol make, such as drink driving, and how this impacts the wider community.

Positive accounts of drinking included stories about alcohol being important at weddings as a part of celebrations and dancing. The positive connotations between alcohol and good health in the media were also discussed particularly in relation to the harm of smoking and how drinking is the lesser of the two evils. Many participants also identified how drinking is part of being a man within Turkish culture: part of his identity. Participants also referred to the important role of alcohol sales in helping businesses thrive. There was also discussion about how the Turkish media had presented positive messages concerning the physical health benefits of drinking alcohol. Stories about alcohol improving circulation, blood and kidney function were identified and the idea that alcohol works better than antidepressants for lifting mood.

4.1.3 Theme Three: Help-seeking

This final theme addresses the third aim of this study by exploring how men and women seek help and how gender roles impact on help-seeking behaviour. Participants identified the role of men and the role of women as being fundamental to patterns of help-seeking in the Turkish-Kurdish community. It was felt by most participants that drinking was more acceptable for men than women and furthermore, drinking was a rite of passage into manhood. Participants spoke about the importance of men demonstrating their suitability when approached by a potential wife and her family, and this included him taking part in activities men are expected to do, including drinking alcohol.

The responsibility for men to look after the household, particularly in relation to finances, was raised by many. The need to provide sufficiently for the family in order to avoid being compared with others who have more was viewed as a burden that men must carry. Particularly the male participants made reference to the responsibility that goes with being the head of the house and having to provide for the family, an obligation that continues even when their children are grown up.

Also discussed was the idea of men being concerned about the stigma of seeking professional help for alcohol dependence and the potential labelling that this may involve, for example as an alcoholic. This, many participants felt, contributed to men's reluctance to seek help and was coupled with barriers of language and having enough information about possible sources of help, and with the idea that women of the family will provide the support needed.

Despite not being associated with the role of head of house, women in the community were discussed as having the role of keeping the family together during difficult times, being the first source of support for a husband that drinks, and for helping men to seek help when appropriate. Participants spoke about the premise that a wife should not only support her husband if he is drinking, but should be the sole provider of that support. Whilst it was recognised in the groups that this is not always the case and that professional services have an important supportive role, the belief that women should be sufficient in providing help prevailed.

Many participants also spoke about the role women play in advocating for the men in the community during health-related appointments. The example of wives speaking for their husbands during GP appointments was cited as commonplace. So, for women, the onus is on them not only to seek the help needed for the men, persuade the men to attend, but also then to communicate with the professionals. Some participants explored the notion that a young girl's dignity would even be questioned if she started to drink and how it is culturally unacceptable for a woman of any age to be seen drinking.

All participants also spoke about service development for those who are dependent on alcohol and those who drink to excess. It was generally agreed that individuals needed to find themselves in dire circumstances before considering seeking help from professional services. However, service provision was discussed as very important despite participants' views that the family was the first place of support for anyone who drinks. Many participants spoke about the importance of providing psychological therapy for those that drink, particularly where distress or more formal diagnoses such as PTSD are present.

Participants spoke about the need for improved advertising of NHS services available for people who drink and the importance of these services remaining consistently available and visible to the community. Participants drew a parallel between the invisibility of people who are dependent on alcohol in their community and the invisibility of services that can help them.

Education was seen as essential by nearly all participants in the prevention of future generations having problems with drinking alcohol. Awareness-raising about the dangers of drinking above recommended guidelines was seen as essential by most participants as was the need for education about units of alcohol or rather a focus on quantity and its relationship with harm caused. There was also much discussion about services needing to understand and help reduce the stigma of drinking and the shame associated with accessing professional help.

Accessibility in terms of location and shared language was also seen as vital by many participants who also spoke about the necessity of having a shared cultural understanding with health-care professionals. Participants discussed the difficulties of accessing popular alcohol treatment resources, such as Alcoholics Anonymous, because of the language barrier and religious affiliation.

The three themes that emerged during the process of analysis will now be discussed in relation to the existing literature and how they add to or differ from what has already been studied in previous research.

4.2 Unique Findings

This study supports the idea that experiences and needs are specific to particular populations and whilst the Turkish-Kurdish community share similarities with other immigrant groups in London, this study has helped demonstrate how they are also unique in their historical context, language and culture. For example, knowledge of the historical context of migration to London, including the potential exposure to torture and war, and what has been lost (for example job, money) in the process, is important to understand in order to provide the most appropriate treatment.

The findings of this study are unique with regard to how a change in culture and how differences between the 'old' and 'new' cultures (in terms of availability, drinking culture etc.) impact directly on drinking levels within the Turkish-Kurdish community. This study also highlights how harm caused to a family by one member of the family who drinks can be vast. Participants identified spouse violence, marital problems and breakdown of relationships with children, as the most prevalent types of harm caused within their community. Similar to previous research which highlighted the fear of being labelled 'alcoholic' (Thom, 1986) this study found that stigma of even being associated with alcohol impacted on help-seeking behaviour. Furthermore, the impact that gender roles have on help-seeking behaviour has not previously been identified within this community.

4.3 Contribution to the Literature

The findings of this research add to previous literature with regards to reasons why people drink. Whilst preceding studies do not specify the notion of a 'weak personality', personality type has been linked to drinking and coping styles. Kuntsche et al. (2006) argue that drinking is more likely amongst women who are anxious and men who are "sensation-seeking". Sensation-seeking and cognitive motivation are personality constructs that have been historically associated with personality type and drinking (Stacy et al., 1991). Whilst previous research has labelled constructs or domains of personality, this thesis is unique with regard to the complexity described by participants for why people drink in terms of the various factors that contribute (personality, stress and

culture shift) to alcohol abuse. This study backs up the findings from other research about stress being an important factor in excessive drinking (Colder, 2001; Williams & Clark, 1998).

The impact of immigration on the use of alcohol has been found to be influential by previous researchers. The findings of this study are consistent with others which also report drinking amongst women is far lower than among men in minority groups who have left their countries of origin (Schiff et al., 2010). These findings also corroborate evidence of discrimination amongst immigrant groups and how this correlates with heavy drinking (Kim & Spencer, 2011). These findings are also consistent with studies that explored the impact of drinking on physical health, mental health and family relationships. The London Ambulance Service reported that the borough of Hackney has the third largest number of incidents associated with alcohol. This study found that suicide was a concern for the Turkish-Kurdish community and this is consistent with data from the Office for National Statistics (ONS, 2011), which found that two-thirds of suicides are related to alcohol, and that suicide rates are more prevalent, and rising, amongst young men.

Whilst the literature evidences a relationship between divorce and alcohol, which is supported by the accounts given in this study, some authors suggest that causation is not linear and it may in fact be marital breakdown that causes alcohol consumption (Caces et al., 1999). There is also a large body of work suggesting a correlation between alcohol and domestic violence, which was also found in this study along with the need for violence to be tackled at a policy level, not just within services. This supports the suggestion of Leonard (2001) who called for changes in policy-making to address stages of aggression and to help reduce conflict.

The positive accounts of drinking given in this study are consistent with previous research which highlights a reduction of inhibition caused by drinking alcohol (Fillmore & Vogel-Sprott, 2000) and suggests how perceived benefits of drinking can influence choice to drink, particularly amongst adolescents (Goldberg et al., 2002). There is also literature that confirms the findings in this thesis regarding

positive messages about alcohol and physical health. Peele and Brodsky (2000) found moderate drinking to be beneficial to the cardiovascular system and overall modality, as well as psychological benefits including stress reduction, sociability and mood enhancement.

This study found that men are less likely than women to seek help and therefore adds to the literature regarding help-seeking patterns in men. Both previous and this current research suggest that women are more likely to seek help for mental health and alcohol problems than men (McKay et al., 1996). Similarly, comparable with other studies, this study found that the severity of impact on individual health and social relationships predicted help-seeking behaviour more than level of intoxication (Hajema et al., 1991). The differing gender roles amongst the Turkish-Kurdish community identified in this study draw parallels with concepts identified by other authors who describe gender differences in relation to patriarchal structure in Turkish culture (Manço, 2004).

This study found that many service provision changes are needed to meet the needs of the community, specifically regarding language and cultural competence and the need for services to be more visible to the community. These findings support the recommendations made by Tas et al. (2008) to provide services that understand the contextual concerns and distress within the Turkish-Kurdish population in Hackney and for the community to play a more active role in the development of services and policy. Whilst much previous research has attempted to define the term 'cultural competence', at present it is now considered unhelpful to do so unless the definition is specific to a single ethnic minority group (Kim et al., 2006).

4.4 Limitations of the Research

4.4.1 Data collection and analysis

The nature of the research meant that a specific sample of participants was required from a particular minority community and group of professionals, and thus the homogeneity of the participants in terms of ethnic background and area of residence was not problematic. Within this sample, however, there was a range in age and faith backgrounds (within the Islamic faith). The youngest participant however was aged 29 and therefore none of the participants represented the generation that was discussed in the groups as having growing problems with alcohol abuse. There were fewer participants in the male focus group (n=3) compared to the other two groups (n=5) and although this was because two men could not make the group on the day for personal reasons, it may also represent a reluctance of men to talk about this subject. The interpreter acknowledged that the male focus group was harder to recruit than the female group. Furthermore, the group of professionals were all from Derman and whilst they are likely to have the most accurate knowledge about, and experience with, the community, it may also be useful to hear experiences of health-care professionals that see Turkish-Kurdish individuals in different settings.

Participants in the community focus groups were recruited from GP surgeries by the interpreter and thus may be considered a group who are pro-active help-seekers at least in terms of their physical health. This was not felt to impact on this research because participants' views were being elicited about their community, and their personal relationship with seeking help was not relevant, although it is acknowledged that this may inform their opinion and expectation about others. The sample of community participants was recruited by the interpreter and knew of his role as health advocate. Therefore there is a question about whether the participants felt they needed to agree to take part in the research in case they needed his help for future health concerns.

Whilst opposing beliefs were elucidated during each of the focus groups, it can also be assumed that, like normal conversations that take place outside of research, the focus group was also a social setting and thus dominant discourses may still have precluded some opinions. It is perhaps naïve to assume that ‘natural’ conversations can take place in research and the prevailing ideas of society or within a community will not also be apparent in a research setting (Macphail & Campbell, 2001).

The critical realist epistemology of this research enabled participants’ descriptions to be understood in terms of their reality shaped within their social context. It would have been possible to conduct this research with a social constructionist framework, considering that thematic analysis is not tied down to any one epistemology. This approach may have elucidated descriptions that had been socially constructed with shared meaning, and therefore helped explain the problems the community faced in the context of understanding.

4.4.2 Language and culture

The difference in language between myself and two of the focus groups meant that there was not only a difference in cultural understanding but also that the data needed to be translated and this process will have added to the loss of context and meaning. Whilst every care was taken to ensure the participants’ words were used accurately, by using an interpreter and translator from the Turkish-Kurdish community, unavoidably the words were filtered by them and myself in the process of analysis. Patel (2003) highlights the inevitability of this shift in meaning when she writes about research with refugees. She describes the interpreter as someone who is:

“empowered to speak on behalf of the refugee person, to create their own meaning and to convey that meaning...in their own words” (p. 225).

Working in collaboration with the interpreter did allow for a richer understanding about the cultural context of the discussions during the groups. This co-working also meant that Turkish words that have no English translation could be explained and Turkish phrases and idioms could be translated into the equivalent English saying whilst the history of the phrase was clarified.

4.5 Reviewing the quality of the research

4.5.1 Representativeness

Qualitative research is often criticised for its limited generalisability (Mays & Pope, 1995). However, this study did not aim to represent the views of individuals who drink, or even those who have personal experience of drinking alcohol. Instead, it aimed to explore perceptions of a minority group who live in the area in question and who share cultural knowledge of their own context. Within the critical realist framework of this study, all participants were considered 'expert' about themselves and their culture (Anderson & Goolishian, 2005) and thus their accounts were sufficient. Yet, as noted above, it is quite possible that this study does provide a somewhat distorted picture by not having recruited the "hidden" destitute (Crawley et al., 2011), only those who were already in services, albeit GP surgeries.

Some of the participants had previous contact with Derman for various reasons, such as counselling and interpreting for health appointments, and may have viewed my role as being affiliated to Derman. This may have inhibited what the participants felt they could discuss so as not to jeopardise their relationship with Derman. Furthermore, the group of Derman staff who participated may have felt conscious about disclosing information that they felt may reflect negatively on the organisation of their individual work.

4.5.2 Sensitivity to context

Usual standards of validity and reliability used in assessing the quality of quantitative research are not always appropriate in evaluating qualitative work. This section will employ the assessment criteria as suggested by Yardley (2000) who proposed that doing justice to the context of the research is within the data itself. She argues that by looking for data that contradicts emerging themes and ensuring that these themes are soundly based within the theoretical framework of the study, sensitivity can be achieved. When analysing the data I was careful to assess contradicting extracts and consider how they differed

from the emerging themes. During the focus groups I was eager to ascertain if my understanding matched that of the participants' through respondent validity (Henwood & Pidgeon, 1992) by summarising what I had heard and asking for clarification if needed. I also hope to present my findings at Derman's annual conference. Sensitivity to cultural context was of paramount importance during the research process and thus collaboration with the interpreter and transcriber, who were able to explain cultural and religious concepts, was essential for the accuracy of this research to be trustworthy.

The impact of my own values on this research must be acknowledged as they are "often so deeply ingrained and cultural in nature" (Corbin & Strauss, 2008, p.85) that it was difficult to be aware of them at all times. However, the epistemological stance of this study allowed for an analysis of the cultural context of the narratives given by participants and close working with the interpreter enabled my assumptions to be questioned and explored before, during, and after the focus groups. The reflective diary was also useful in helping my thinking about power differences and how my values influenced the research.

4.5.3 Commitment and rigour

Yardley suggested that evaluation of commitment to the research topic and rigour in data collection and analysis, are essential components in assessing qualitative research. My research aims helped guide my questions during the focus groups and I strove to give adequate time to each participant and each line of questioning and discussion. For this reason and as a result of all participants having much to say about the topic, it was with regret that I had to end the focus groups because of time limitations in terms of room use, but mainly because I had proposed an allocated time for the group and did not want to run over by too much and break our agreement.

My analysis was thorough and I took months to read and compare the data. I was fortunate to have a break in my studies (maternity leave) after the data collection, as it enabled a long process of discussion about the data with the interpreter and reflecting on the words of the participants. I spent time in looking

for what seemed like 'important moments' (Boyatzis, 1998) before encoding and creating themes. The thoroughness of the data analysis was also guided by my supervisors and peers to aid my analytic skills rather than to ensure complete data reliability while I acknowledge that different researchers may construe differing results (Fereday & Muir-Cochrane, 2006).

The analysis of this study used a critical realist approach and therefore inter-rater reliability was not assessed as no-one else analysed the data. However, my understanding of the accounts given by participants was checked with the interpreter and my supervisors reviewed a draft copy of the analysis chapter and thematic maps.

4.5.4 Transparency and coherence

The intentions for conducting this research and the research process itself have been made clear at every stage possible. The Appendices evidence the process of analysis, including worked extracts of data, offering an audit trail of how the research was conducted. This thesis has justified why thematic analysis was chosen and how it best works with the aims of this study.

Transparency about why I chose this topic to research and how the research has been conducted has been essential to my successful collaboration with Derman and the Turkish-Kurdish community. My thoughts about the research have been documented in my reflective diary which has helped me to remain clear about my anxieties, assumptions and desires, and in turn enabled me to share these where appropriate with the interpreter, supervisors and participants.

4.5.5 Impact and importance

It is essential to evaluate the usefulness of research, and arguably the most significant measure to ascertain this is its quality (Yardley, 2000). This research hopes to help inform non-statutory and NHS alcohol and mental health services about their Turkish-Kurdish clients and the cultural context from which they come. Furthermore, it may be relevant to clinical psychologists working with this community, particularly those who are looking to provide outreach services and help engage minority groups with mainstream NHS services. The findings will of

course be available to Derman and I hope to write up this research for an appropriate academic journal with their permission.

4.6 Reflexivity

Yardley (2000) also proposes that the researcher reflects on how their assumptions and motivations shape the research process. As Brewer (2000) states, it is not possible for a researcher to be value-free as they share the values of their society as any other individual does. The following sections will outline my motivations and assumptions in the hope to explore the impact my values on this research.

4.6.1 Researcher values

Using a reflective diary (see extracts in Appendix U) helped me to think about my expectations for the research. My observations about the focus groups helped me challenge the assumptions I brought to the research. I wrote about my concerns relating to the difference between myself and in particular the male participants who were all Turkish speakers, of a different generation, different religious and cultural background and who had dealt with difficult circumstances that I can only imagine (such as torture and fleeing one's home). However, the inclusion of stories about these very topics within each focus group made me hopeful that participants felt at ease with me. Alternatively, perhaps not having a shared language helped distance their narratives from my direct hearing and comprehension and thus helped conversations to be more honest.

I was constantly mindful of whether my questions contained assumptions about culture, religion or so on, or if they made it obvious to participants that my beliefs arise from my position as a heterosexual, white, middle-class woman with an agnostic religious understanding. I would also consider myself a Feminist and was acutely aware of how this may impact the research with regard to hearing about the differing roles of men and women. This viewpoint has likely influenced the interpretation of the 'service development' theme, despite my paying attention to reporting the words of the participants accurately and attempting to keep hidden my personal values during the research process.

4.6.2 Experience of the topic

My interest in alcohol use stems from my work as a Psychologist, during and prior to training. Previous work in inner London with people who are alcohol dependent and from various cultural and ethnic backgrounds sparked my interest in the contextual difficulties that lead to drinking as a coping mechanism and how I, as a Psychologist, can work best with different groups. I have found it challenging to harness the opinions of under-represented communities in alcohol services I have worked for, particularly where English was not spoken and I had no easy access to interpreting services. I felt a mismatch in what NHS services could provide and what community members required so have been keen to explore this in a research capacity.

Work in other settings such as with inpatients on psychiatric wards has also served to heighten my interest in working with minority groups and to consider the cultural, family and religious context of a presenting problem. I strongly believe that all mental health services can benefit from learning more about the communities they serve.

During this research I was aware of my relative power as Trainee Psychologist and speaker of English and wanted to 'come alongside' (Miller, 2010) the participants by sharing their concerns and being open about my interest in this research. Amongst the focus group with health-care professionals from Derman, I wanted to again make clear my interest and offer a naïve stance in order not to create the assumption that I was the all-knowing expert from the NHS there to help them. My experience as a clinician influenced my response to many of the participants' distressing stories and I was aware of having to remain neutral but empathic to see the research through rather than to respond as I would in a therapy setting.

4.7 Implications and Recommendations

4.7.1 Service-level implications

In terms of what this study found, consistency of service provision was deemed crucial in ensuring potential clients and health-professionals alike can adequately identify the appropriate services over time. Changes in NHS provision nationally have affected provision of health and psychological care in Hackney and participants felt it important that despite any changes, service names should remain constant and visible. Services should also advertise more widely what they have to offer potential clients, such as in local cafes and other public places frequented by the Turkish-Kurdish community: but also that any information should be available in Turkish. Participants felt that providing alcohol services with Turkish speakers or interpreters was essential. However, many suggested that a shared language was not enough and that cultural understanding was also needed, specifically with regard to immigration and its consequences, Turkish culture norms and values, and the role of the family in providing support. Derman and its service-users might be best situated to offer this sharing of knowledge and training. Similarly, this study found that the process of acculturation, moving from one culture to another, has an impact on drinking levels and the way in which alcohol is viewed by the community. As a result, services need to be aware of this process and provide support accordingly, for example, early intervention targeting individuals who have recently moved to the UK.

Participants explained the reluctance of the community to seek professional help unless they could not find support elsewhere, so given the reluctance and stigma associated with disclosure of an alcohol problem, awareness about confidentiality within services seems crucial. Given that members of the Turkish-Kurdish community felt so passionate about talking about this topic in this research it seems neglectful to not utilise the expertise of the community in service provision but also to offer space for these concerns to be discussed, informally via 'stop and chat' public spaces, for example, or by offering volunteering opportunities to enhance community connection (Friedli, 2009). Particularly with regard to the finding of this study that women seek help on

behalf of the men, it is essential that service information is provided in locations that women attend. This research supports the British Psychological Society (Whiteley et al., 2012) guidelines for clinical psychologists working in alcohol centres which advocate building greater links to community resources to help strengthen NHS services and ultimately help reduce the number of people dependent on alcohol and the associated social problems.

4.7.2 Clinical implications

Any intervention which ignores the social context of the client is likely to be unsuccessful, particularly amongst those who have already faced injustice (Summerfield, 2001) and with regard to the role of the family in supporting recovery. This study found that women engage with service more readily than men and therefore clinical intervention should incorporate women and the family, rather than for example be provided on a one-to-one basis for the man. Clinically, it may be useful to provide systemic therapy to help bridge the family and professional roles and to make sure the whole family is supported and involved. Systemic approaches may also help to inform psychologists about who is making the referral and why and how the problem is co-constructed within the family, social and political system (Fredman, 2006). The findings of this research suggest a holistic approach to drinking is needed which incorporates the social, familial and cultural context of the individual.

This study was successful in generating lively debate amongst groups of people from the Turkish-Kurdish community. It may therefore be useful to facilitate peer support groups for men and separately for women who drink alcohol and who would benefit from exploring their shared experiences. Atkinson et al. (2001) proposed that service-user involvement is essential in order to address issues specific to minority groups such as:

“the definition and impact of racism; differences and similarities in cultures; culturally determined beliefs on health and help-seeking and religious belief systems” (p.34).

Psychologists could also offer consultation to teams working with the Turkish-Kurdish community and provide specialist formulation, intervention and

therapeutic skills information. It is essential for clinicians to think carefully about the language they use in their service material and within clinical therapy sessions. Shame of being labelled 'an alcoholic' was viewed by the participants of this study as a contributory factor in preventing help-seeking. Psychiatric diagnoses may not therefore be helpful and should be used with caution. This study also found that drinking was associated with 'weakness' in men and used as a coping method for dealing with stress. It may therefore be useful in clinical work to incorporate these ideas into formulation and to help families think about how this might add to the stigma that accompanies drinking.

4.7.3 Policy-level implications

This study found that women seek help on behalf of the men and therefore it is important for the women in the community to be provided with information about services. With the accurate information, women can help shape service development in line with their needs and those of the wider community. In the same way, education was deemed essential by participants in combatting future problems associated with drinking alcohol. I advocate using the expertise of the community in helping to inform education providers about the cultural context of information provided in schools regarding alcohol. The findings of this study suggest that the problem of alcohol use stems from wider political and social concerns such as immigration, unemployment and financial difficulties. Participants of this research wanted to see action being taken by government bodies and policy makers to help eradicate these political and social concerns which they felt contributed to distress. Bauman (2007) summarises the current political framework of an individualistic society:

"Although the risks and contradictions of life go on being as socially produced as ever, the duty and necessity of coping with them has been delegated to our individual selves" (p.14).

The mental health system is clearly not exempt from this criticism, particularly with the growing popularity of CBT and the Improving Access to Psychological Therapies (IAPT) model. However, clinical psychologists are unique in their training and ability to formulate problems taking account of wider influences and

thinking about distress in context. This should be used to help inform policy makers and shape service planning and provision.

Promotion of strength-based narratives about the Turkish-Kurdish community may help to create an understanding of the resilience of the community and the problems they have historically faced and currently face. This would potentially reduce the stigma around seeking help and spread understanding about why some people turn to alcohol as a way of coping. Whilst all efforts should be made to provide support for those dependent on alcohol, adequate provision is also needed for those who are affected by associated domestic violence, particularly as this is often a hidden problem due to the sensitivity of disclosure about alcohol use and abuse.

4.7.4 Research implications

Further research would help to explore the findings from this research. For instance, more research is needed with non-English speaking minority groups who are under-represented in psychology services to help identify how psychology can better help these populations. These already disempowered groups risk being further marginalised if research does not include them (Patel, 2003).

This study highlighted the gender-based help seeking patterns within the community and there are a number of avenues to explore using research. Firstly, it might be useful to compare age groups to further investigate the idea that was raised by participants about the cultural role of women to seek help on behalf of the men and to identify if the younger population, perhaps those born in the UK, adhere to such values. The age range of participants in this study was 29-58 years old. This research highlighted the concern for the younger Turkish-Kurdish generation so it may be valuable to interview them about their understanding of the problems faced by the community and to explore whether they see value in seeking professional help. It may also be beneficial for the Turkish-Kurdish community and health professionals alike if research is conducted with those not accessing any services as well as those who have, and who can talk about their personal experiences particularly in relation to

help-seeking. This would also give a voice to those who drink, or have done, and who may find it difficult to talk about their experiences due to the concerns outlined in this study, such as stigma.

All three focus groups highlighted the fact that they would be able to talk for longer than the time allocated about drinking alcohol within the community and the associated problems. It seems therefore that this is a fruitful subject area and further research could not only help provide health services with insightful information about the cultural context of the difficulties but also give a voice to, and bear witness to, the community. It is difficult to fully appreciate the experiences of the community from a set of one-off focus groups.

In summary, this study found that personality, stress and culture are relevant factors in reasons why people drink alcohol. The impact of drinking was discussed not only in relation to the harm it causes the individual that drinks, their family and the wider community, but also how alcohol is part of more positive experiences, traditions and roles. The different roles of men and women in relation to help-seeking behaviour were highlighted, as was how services might consider this in their policies and provision of treatment.

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APPENDICES

Appendix A: Literature Review Terms

The literature was obtained from a variety of sources, in part because the subject matter was scarce in the 'psychological' literature and a wider scope was thus needed. With this in mind, a Google alert was set up from summer 2011 with the terms 'Turkish' and 'alcohol'. A journal review was conducted using the EBSCOhost search engine to search PsychInfo, Science Direct, Cinahl and Web of Knowledge. Pubmed was also searched independently once successful search terms had been established from EBSCO. Where there were few results, the search criteria were changed from results from the last 15 years to results since 1970 to the present day. Search terms included: 'alcohol'/'drinking alc*'/ 'alcohol dependency' AND 'UK'; AND 'ethnic minorit*'/ 'BME'. 'Turkish speaking'/'Kurdish' AND 'help-seeking'; AND 'motivation' AND 'focus group'. 'Immigrant*'/ 'asylum seek*' AND 'alcohol'. 'Focus group' AND 'interpret*' AND 'ethnic minorit*'. 'Interpreter' AND 'thematic analysis' AND 'BME'.

Literature was also obtained from voluntary organisations working with the community in question, relevant websites listing publications on alcohol use e.g. www.alcoholconcern.org.uk, and articles sourced from pertinent lectures and reading lists.

Appendix B: Participant Information Sheet

University of East London

Stratford Campus

Water Lane

London

E15 4LZ

Private & Confidential

Alcohol use and the Turkish-Kurdish community

I am writing to invite you to take part in the above study. The aim of this study is to collect more information about the experiences of the Turkish-Kurdish community with regards to alcohol problems and what motivates or discourages members of the community to seek help from local services.

(Professionals Group Insert:) You are invited to take part if you are interested in discussing the issues around alcohol, motivation and help-seeking in the Turkish-Kurdish community and your experiences of engaging or working with them. I am interested in finding out more about your work with this community, the social context of alcohol use in this population and what barriers/difficulties may be present in accessing help from services.

(Community Group Insert:) You do not need to have experience of drinking alcohol; you are invited to take part if you feel you have something to say about these issues and would like to share your experiences of being a member of the community.

This study hopes to help local NHS services and non-statutory organisations to think about how we can meet the needs of the Turkish-Kurdish community effectively and how we structure our services to address their concerns. It will also help us with training for other staff around alcohol and psychological issues.

Taking part is voluntary

- You do not have to take part
- If you decide to take part you can withdraw from the study at any time without giving a reason.

All information collected from the groups is kept confidential and made anonymous

- No one, other than the researcher (and Interpreter), will listen to your contributions in the group
- No identifying information will be used, and participants are identified only by a code number
- Recordings of the group will be kept locked away until the study is finished, at which point they will be destroyed.

What does taking part involve?

- Taking part involves attending a group with approximately 2-5 other participants. The group will last for approximately one hour.
- After attending the group you will not be asked to complete any more tasks in relation to this study.

University Research Ethics Committee

If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact the Secretary of the University Research Ethics Committee, Ms Debbie Dada, Admissions and Ethics Officer, Graduate School, University of East London, Docklands Campus, London E16 2RD (Tel 020 8223 2976, Email: d.dada@uel.ac.uk)

Many thanks and best wishes,

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Appendix C: Participant Information Sheet – Turkish

Katılımcı Bilgilendirme Formu

East London Üniversitesi
Stratford Campus
Water Lane
London
E15 4LZ

Doğu Londra'daki Türkçe konuşan toplumda alkol problemi ile ilgili yardım istemelerine motive eden etkenleri araştıran çalışma

Size yukarıda adı geçen araştırmaya katılmaya davet ediyorum. Bu araştırmanın amacı Türkçe ve Kürtçe konuşan toplumların alkolla ilgili yaşadıkları tecrübeler ve alkolle ilgili yerel hizmetlerden yardım isteme konusunda kendilerini teşvik eden ya da tam tersine cesaretlerini kıran şeylerle ilgili dah fazla bilgi toplamaktır.

Bu araştırmada yer almak için kişisel olarak alkol probleminiz olmak zorunda değil. Eğer bu toplumdan birisi olarak bu konuyla ilgili paylaşmak istediğiniz görüş ve tecrübeleriniz varsa bu araştırmada yer alabilirsiniz.

Bu çalışma bu konuyla ilgili ihtiyaçlarınızı etkili bir şekilde karşılayabilmek ve ilgili servisleri endişelerinize cevap verebilecek şekilde nasıl yapılandıracaklarını düşünebilmek için NHS'e (İngiltere Sağlık Sigorta Kurumu) ve Derman gibi sivil toplum kurumlarına yardımcı olacaktır.

Katılım sadece gönüllülük esasına dayalıdır.

- Katılmak zorunda değilsiniz.
- Katılmaya karar verirsiniz araştırmanın herhangi bir aşamasında hiçbir neden göstermeden katılımınıza son verebilirsiniz
- Bu araştırmaya katılmazsanız bu kararınız ileride yardım veya tedavi talep edebileceğiniz servisleri etkilemeyecektir.

Araştırma dahilinde toplanacak bilgilerin hepsi gizli ve anonim (isim belirtilmeden) tutulacaktır.

- Araştırma kapsamında gerek grup söyleşilerinde gerekse birebir görüşmelerde söylediklerinizi araştırmacının dışında hiçkimse dinlemeyecektir.
- Katılımcıların kim olduklarını belli edecek hiçbir bilgi kullanılmayacak, katılımcılar sadece kod numaralarıyla bilinecektir.
- Katılımcılar ile ilgili kayıtlar araştırma sonuna kadar saklanacak ve araştırma bittiğinde de yok edilecektir.

Bu araştırmaya katılmak ne içerir?

Bu araştırmaya katıldığınızda sizden bire bir görüşme ya da aynı bölgede yaşayan yaklaşık üç kişinin daha katılacağı bir gruba görüşmelere katılmanız istenecektir. Bayların sadece erkeklerin katıldığı gruba, bayanların da sadece bayanların katıldığı gruba katılması istenecektir.

- Gruba ya da bire bir görüşmelere katıldıktan sonra bu araştırmayla ilgili başka herhangi birşey yapmanız istenmeyecektir.
- Bu araştırmaya katıldıktan sonra herhangi bir psikoloji seansına katılmanız istenmeyecektir.
- Bu araştırmaya katılmanın yaratabileceği herhangi birdurumda lütfen araştırmacı ile ya da Derman çalışanlarıyla konuşunuz.

Üniversite Etik Değerler Komitesi

Katılmanız istenen bu araştırmanın yürütülmesiyle ilgili sormak istediğiniz herhangi

birşey olursa lütfen Üniversite Araştırma Etik Değerler Komitesi Sekreterliğinden

Debbie Dada ile aşağıdaki adres telefon veya e-mailden kontak kurunuz.

Ms Debbie Dada

Secretary of the University Research Ethics Committee, Admissions and Ethics Officer, Graduate School, University of East London, Docklands Campus, London E16 2RD. Tel 020 8223 2976 Email: d.dada@uel.ac.uk

Appendix D: Consent Form – English Version

Alcohol use and the Turkish-Kurdish Community

- ✓ I have read the information sheet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.
- ✓ I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the experimental programme has been completed.
- ✓ I hereby freely and fully consent to participate in the study which has been fully explained to me.
- ✓ Having given this consent I understand that I have the right to withdraw from the programme at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date:

Appendix E: Consent Form – Turkish Version

Katılımcı İzin Belgesi

Doğu Londra'daki Türkçe konuşan toplumda alkol problemi ile ilgili) yardım istemelerine motive eden etkenleri araştıran çalışma

- Yukarıdaki araştırmanın programıyla ilgili bilgileri okudum ve bu bilgilerin yazılı bir kopyası bana verildi. Bu araştırmanın içeriği ve amacı bana açıklandı ve bunların detaylarıyla ilgili soru sorma ve konuşma fırsatım oldu. Bu araştırmayla benden istenenleri ve bu araştırmanın prosedürünü (izleyeceği yöntemi) anlıyorum.
- Bu çalışmaya katılımımın, özellikle de bu araştırmayla toplanacak verilerin kesinlikle gizlilik ilkesi içerisinde saklanacağı, bu verilere bu araştırmaya katılan araştırmacıların dışında kimsenin eline ulaşmayacağını Bu deneme programı tamamlandığında ne olacağı bana anlatıldı.
- Bu sebeple şahsıma tamamıyla açıklanmış olan bu araştırmaya yer almaya özgür irademle rıza gösteriyorum.
- Bu araştırma dahilinde konuşmaların kayıt edileceğini bu kayıtların sadece araştırmayı yapan kişi tarafından dinleneceğini ve sonradan imha edileceğini anlıyorum.
- Bu araştırmaya katılmaya rıza göstermekle birlikte, araştırmanın herhangi bir aşamasında herhangi bir neden göstermek zorunda kalmadan araştırmadan çekilebileceğimi, bunun sonucunda hiçbir şekilde olumsuz etkilenmiyeceğimi anlıyorum.

(Lütfen büyük harflerle doldurunuz)

Katılımcının Adı Soyadı:.....

Katılımcının İmzası:.....

Araştırmacının Adı Soyadı:.....

Araştırmacının İmzası:.....

Tarih:

Appendix F: Focus Group Interview Schedule

Aim 1: Explore the cultural context of this community with regard to the problems they face and how this may contribute to the problem of alcohol use and seeking help

How would you describe your community?

Prompt: Positives/Challenges

Aim 2: Determine what factors influence members of the community to drink and how alcohol affects the community.

Can you tell me how alcohol affects your community?

Prompt: relationships/social/psychological

Aim 3: Examine how identity and gender roles of men and women impact on help-seeking and motivation for treatment of alcohol-related problems.

What motivates members of your community to seek help?

What prevents members of your community from seeking help?

How do you see your role as women/men/professionals in the community with regard to seeking help for alcohol related problems?

How do you see your community in the future in terms of alcohol-related problems?

Can you tell me what changes, if any, you would like to see that would help with access to treatment for alcohol problems?

Service providers:

Have you changed the ways you have approached the community with regards to alcohol treatment (in light of your clinical experience)?

What are your experiences of how members of this community with concerns about how much they are drinking come to be known to services/ their help-seeking behaviour?

Appendix G: Participant Demographics

| <i>Name</i> | <i>Date of Birth</i> | <i>Address</i> | <i>Ethnicity</i> | <i>Details (if applicable – previous/current treatment for alcohol)</i> |
|-------------|----------------------|----------------|------------------|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

[Completed in Turkish with help from the interpreter where appropriate]

NB: Each participant completed a separate (identical to the above) form so personal details are not shared amongst the group. The tables were then compiled by the researcher following each group based on the details given by each participant.

Appendix H: Ethical Approval

UNIVERSITY OF EAST LONDON

APPLICATION FOR THE APPROVAL OF A RESEARCH PROGRAMME INVOLVING HUMAN PARTICIPANTS

Please read the Notes for Guidance before completing this form. If necessary, please continue your answers on a separate sheet of paper: indicate clearly which question the continuation sheet relates to and ensure that it is securely fastened to the report form.

| | |
|----|--|
| 1. | Title of the programme: Concepts of motivation for seeking help with alcohol problems among members of the Turkish- and Kurdish-speaking community in East London Title of research project (if different from above): Name of researcher (s) (including title): Mrs Elizabeth Adeyanju (Trainee Clinical Psychologist) Nature of researcher (delete as appropriate): (b) student If "others" please give full details: Student number: U0933888 Email: libby_adeyanju@hotmail.com |
| 2. | Name of person responsible for the programme (Principal Investigator): Dr Lynne Dawkins Status: Senior Lecturer in Psychology Name of supervisor (if different from above): Dr Christopher Whiteley Status: Consultant Clinical Psychologist |
| 3. | School: Psychology Department/Unit: Clinical Psychology |
| 4. | Level of the programme (delete as Appropriate): Postgraduate (Professional Doctorate) |
| 5. | Number of: (a) researchers (approximately): 1 (b) participants (approximately): 9-12 |
| 6. | Nature of participants (general characteristics, e.g University students, primary school children, etc): Adults (18+) who live in the Borough of Hackney. From the Turkish, Kurdish and Turkish-Cypriot community. NHS workers and non-statutory organisations' employees working in Hackney in alcohol and/or mental health services who work with this community. |

Appendix I: Transcript Conventions

| | |
|-----------------------------|---|
| [Laughs] | Indicates laughter |
| (<i>notes in italics</i>) | Explanation made by translator regarding cultural nuance/explanation of Turkish words |
| (...) | Pause in speech |
| - | Denotes speech ending abruptly |
| (xxx) | Inaudible speech |
| // | Overlapping speech |
| < > | Name is given |

Appendix J: Worked Extract by hand

248 okay we have a problem because they already they would feel it and then
 249 they would say oh you're getting this, they might be **excluded** from their own
 250 **family environment** as well. That's my opinion.

251 GIZEM: I found very **rare** that a man comes and **says I have a problem** with
 252 alcohol. Like erm you know when they drink and get drunk and they claim
 253 that they're not drunk and they say I'm not an alcoholic, **it is not a problem**, I
 254 don't get drunk, I know where I should stop, I hear this a lot. I drink this you
 255 know in control and so, and it's very, very difficult for a man to accept that
 256 it's a problem. We **hear mostly from their partners and families** that they
 257 identify this as a problem and they come and seek help from the GPs,
 258 advocacy team, mental health support team, what to do, so only I saw a few
 259 men in all these years that seeking help-

260 HASAN: Because I think that it's still there, not breaking that ice as I say
 261 because they are worried that they will **be branded** as an alcoholic, like all
 262 you see is he's an alcoholic and he's getting help and he's drunk all the time.

263 NUR: Yeah it's very scary isn't it?

264 ESRA: And also I think regarding the alcohol for someone to go and seek for
 265 help they really need to see that **everything is collapsing** in their life because I
 266 think the description of alcoholism is also changing. I recently have been
 267 checking and had this conversation with one of my clients erm when I asked
 268 him how much he drinks alcohol, he describes it as yeah a few days a week
 269 with a certain amount of alcohol and he doesn't go out that means he
 270 doesn't get any trouble and he goes to sleep so there is no problems around
 271 it. But physically he's damaging himself but as long he **doesn't get any trouble**
 272 with **family** members or anybody, he doesn't call this alcoholism.
 273 Professionals would look and see **all sorts of damages**: physical, social etc.
 274 But the person who's taking alcohol they need to see that **everyone is telling**
 275 **them** something is wrong with them and also they also notice that
 276 **biologically** some part of them, **physically** so they can't do as they used to, I
 277 think that's one of the things, there's something about the **awareness in** the
 278 community.

*Men not coming forward to services
↓
partners + families seek help
↓
Very rare men present*

reluctance to speak truth about problems - particularly family consequences

denial of problem claim knowledge of limits

range of support

concern about been labelled - it hides everything else about the person

recognition of fear/damaging task

*changing definition of alcoholism
↓
quantity + frequency*

possible to cause physical harm at relatively low level

But, if no impact on family - it is not seen as alcoholism

need for greater awareness

*level of harm for help to be sought
↓
collapse*

*Professionals can see wider context of harm
↓
need to hear from others that there's a problem + physical harm*

279 GIZEM: Also if someone gets ill err because of alcoholism, lung cancer or
280 something that encourages people to come and see us.

physical harm
needed to seek
help

281 Libby: So it sounds like it's got to be something quite serious, some knock-on
282 effects with the family, or something serious physically for people to feel able
283 to then come forward.

284 NUR: I think they may not be aware they may think that as long as you
285 mention just an alcoholic person will be abusive or violent until death. I think
286 they are not aware of the serious effect it's putting on their body and the
287 damage it's doing, so maybe awareness, raising more about this issue.

lack of awareness
about effects on
body. idea of
being labelled abusive
violent

288 HASAN: I think like in advertising saying oh this amount or in this sort of area
289 it means you might have a problem like most people in our culture what you
290 call, when people are drinking what you call 70cl Raki, which is about 45% of
291 alcohol, they wouldn't think drinking like that on one or the other day, they
292 think oh I'll just take a few shots of whiskey or these 2 or 3 types this is not
293 an alcohol it is not an alcohol problem. That is what I think the measurement
294 is different is, in their world than what is in reality.

advertising-making
clear how much
alcohol is in a
drink. Different
%s of alcohol

295 GIZEM: How much they drink instead of how often.

concern about frequency
should also be about
quantity.

296 HASAN: Yeah

297 CEREN: I had a client, he was, I mean he is diabetic and he drinks too much
298 and then he you know we warned him and asked him to stop you know
299 taking alcohol and he said he was watching TV, Turkish TV and the doctor
300 said you know it's actually good to have a drink of wine because it's healthy
301 for the circulation and blood and you know he's just trying to find an excuse
302 all the time and also maybe giving education idea of why the media is wrong I
303 don't know err, I think the media has an impact, saying it's good for health
304 and drink wine for the blood.

Influence of
'professionals' in
the media -
alcohol is healthy
? maybe an excuse
impact of the
media on behaviour

305 NUR: And in the newspapers.

306 HASAN: And, sorry they say also beer for the kidney, and that's what they
307 say, look I'm just drinking beer because it's good for my kidneys, it's like
308 water. They do.

specific examples
given of how
alcohol is good
for certain organs

more
awareness
raising is
needed

lack of
awareness
about
strength

positive
messages on
TV
need education
to correct
this

309 CEREN: Yes, for my kidney and why you know help for kidney stones and it's
310 like you know (...)

311 HASAN: Also they say it's like an antidepressant that keeps me a bit calm
312 instead of like some stage but we're not allowed to take cigarettes but now
313 they are telling me to not take alcohol so what do you want me to take some
314 kind of drugs. So they say at least alcohol, is better, they compare it in their
315 minds, it's better than these antidepressants. So if they don't hurt anybody I
316 just drink at home so it's, I'm not doing any harm.

Comparison with
antidepressants -
alcohol acting
in similar way

helping oneself,
not causing harm
to others.

alcohol is
the better
option

messages
about
smoking

317 GIZEM: When I was growing up they were warning us against smoke.
318 Alcoholism is, err not as dangerous as smoking. Smoking is more dangerous
319 than alcohol they used to say to us.

comparison:
alcohol better
than cigarettes.

constant
messages in
news

320 ESRA: Yes I do remember something like that. I think they do things, little
321 things, every day in the news, in the newspapers saying that a glass of wine is
322 good for your blood circulation. I remember my parents actually started to
323 buy wine saying it's good my daughter it's fine and it became the culture in
324 the family after I think when they were in their 60s or something.

changed behaviour
because of positive
messages about
alcohol + health

325 NUR: Somebody actually bought my mum a bottle of wine.

326 All: [Laughs]

327 NUR: Yes, my mum, she is a well-covered woman, a Sunni woman who is
328 praying, but because they had heard that it was good but it's like are you
329 trying to encourage her? Drink one of these you will be fine. She tells, she still
330 tells me about it.

example of
religious woman
encouraged to
drink alcohol.

not told
about potential
harm of
drinking

331 Libby: So there is definitely something about the messages being portrayed in
332 the community and by the media and that makes me wonder if this will
333 change for the younger generation. If they get their messages through British
334 schools for example, whether that will help influence the information they
335 receive about alcohol.

336 HASAN: I think that will do because I have a daughter she is 11 years old and
337 when I do drink, she tells me, because I try to not drink as much as you and
338 me, I am drinking after she goes bed and she was waking and saying daddy
339 why are you drinking? I say it's just once or twice a week. She was telling me

importance of
education -
example of young
girl having had
messages about
drinking and
asking her father
about it.

correct
messages
needed from
a young age

idea that
those who
drink did
not have an
education

alcohol as
part of the
accepted
environment
(socially)

positive
associations

sense of
strength
with drinking

340 no daddy at school they tell us you know it is not good for you; it's as bad as
341 smoking. That's why I think it's in school, if they do it from the beginning it
342 will have, yeah they will get more messages when they have more education.
343 I think.

344 NUR: Yes I totally agree, definitely more education in school now it's the
345 younger generation they will be bringing up children in the future so it's them
346 now. The older generation of course they need support and help but because
347 of the language barriers, but if it's open to them the school's education is the
348 most important because these people who are drinking, most of them have
349 no education.

350 GIZEM: Is that true?

351 NUR: Yeah, I think for the majority. I think the media is the biggest impact
352 because I mean just look at the commercials. The best looking men and girls
353 are always presenting, presented with a nice alcohol in a glamorous life and
354 everything. This is becoming the chosen social environment.

355 GIZEM: Also you know in Hackney there is this gang culture for the
356 youngsters and err these macho young men who drink and take drugs.

357 HASAN: I can do it, you can't do it, yeah.

358 NUR: This is another issue this gang culture also is, there is definitely alcohol
359 in their...

360 ESRA: Oh it's partying and having fun the first thing that comes to mind is
361 actually alcohol.

362 CEREN: When I was a child, when I was about 12 years old my dad actually
363 gave me a Raki and because of the fun you know I used to come home ahead
364 of time just to drink the Raki. And I, you know as a woman you know, I felt
365 I'm a strong one you know in the family, I can deal with everything you know
366 and then I used to drink with him all the time and I just got drunk all the time
367 like this you know. Thank God he wasn't living with us otherwise you know I
368 would have become an alcoholic.

message at
school about
alcohol being
bad - as bad
as smoking

more education
needed.

language barrier
of providing
messages to older
generation

media's influence:
commercials
that associate
glamour + drinking.

association with
gang culture +
'macho men'

alcohol as
part of this
culture

part of
partying / fun
- think of alcohol

remembers fun
of drinking/
being drunk

relief that wasn't
around alcohol
all the time

Appendix K: Worked Extract on computer

| | | |
|----|---|--|
| 35 | Deniz: It happens a lot. For example if someone is drinking alcohol, he | Prejudice towards professional treatment |
| 36 | is ousted by his children, and wife and family, and the community, and | |
| 37 | therefore feels completely isolated and gets more depressed without | |
| 38 | any support from the family. But when he is sober and is taken | A drinker can separate from his family and this leads to further depression |
| 39 | somewhere for support then accepts it. | |
| 40 | Selin: Of course, it's continuing. And this stems from people who have | |
| 41 | not been using it in Turkey but started using it here, why, because they | |
| 42 | are getting a small amount of money from the government, they are | |
| 43 | getting a little money and with that they start by getting a small | Impact of receiving benefits when move to the UK. Small amount of money goes on alcohol. No benefits are given by Turkish government |
| 44 | amount of alcohol and starting like that...but in Turkey because the | |
| 45 | government does not give any money they cannot do this there. | |
| 46 | Elif: For example I have a relative who was a multi-millionaire and | |
| 47 | came here// | |
| 48 | Beyza: No I don't agree with that and the reason is that some people | |
| 49 | who were financially quite well off, came and did not start drinking, | |
| 50 | they had money there in Turkey and have money here too, but still did | |
| 51 | not drink....people come here and get trapped in trying to adapt to two | Drinking stems from trying to adapt to a new culture |
| 52 | cultures and get depressed and find solace and comfort in alcohol. | |
| 53 | Zeynep: I know it from this, my husband he was ill in Turkey....He was | Find comfort in drinking |
| 54 | ill, he was put in jail due to left wing right wing issues so they took him | |
| 55 | inside, and was given electric shocks and became ill as a result of it, I | |
| 56 | know this...they gave electricity to his brain, so he was gone. My father | |
| 57 | in law sold two apartments to save him, he was given treatment and | |
| 58 | saved, during his time in treatment he didn't drink at all, he wouldn't | |
| 59 | even stand near anyone who smoked, he would throw himself out, so | Example of a husband who was tortured and ill as a consequence but did not drink in Turkey. Turned to alcohol when he came here |
| 60 | he came here...not knowing any language or knowing anything, and he | |
| 61 | is also ill, I never even realised, he had been here only 6 months and | (PTSD? Psychological impact) |
| 62 | one day I caught him in the park with it in his hand, alcohol, I said to | |
| 63 | him you are an ill person, you cannot uphold yourself you are still in | |
| 64 | treatment....he was having psychological therapy, because he was | |
| 65 | given electric shocks there, there was a medical centre (...) thing (...) err | |
| 66 | there was <name> there, he helped him into the therapy. Anyway my | Went for psychological treatment for the PTSD |
| 67 | husband then said look I don't know anyone here I don't know | |
| 68 | anything, I can't talk with anyone here... | Unable to talk to anyone here in UK |

| | | |
|-----|---|---------------------------|
| 69 | Beyza: I think this is just an excuse my brother was also tortured but he | Trauma used as an |
| 70 | neither smoked or drank alcohol. | excuse to drink. Similar |
| 71 | Deniz: Not everyone is the same, not everyone can cope with it. | experience which didn't |
| 72 | Elif: Yes excuse, they think they are finding solace in it. | result in drinking. |
| 73 | Selin: No that's not an excuse, that person has been through a lot and | Not an excuse. Way of |
| 74 | suffered at lot. | coping with what a |
| 75 | Beyza: My brother is an example of someone who did not start | person has been |
| 76 | drinking even though he had been through some kind of torture in | through |
| 77 | Turkey. | |
| 78 | Deniz: It wouldn't be! | |
| 79 | Selin: I think it would be, this is also common with English people, | |
| 80 | people work 4 -5 days of the week, so when Friday, Saturday Sunday | Cultural aspect to |
| 81 | comes people end up in the pubs and clubs and consume alcohol, the | drinking in UK, |
| 82 | whole community is like this, it's not about being Turkish, Kurdish or | especially on days not |
| 83 | Turkish Cypriot it includes everyone. They work 5 days and on the 6 th | working, typical to go to |
| 84 | day they give themselves to alcohol, so ours say, why shouldn't we | pubs etc and drink |
| 85 | drink... | T-K men see this |
| 86 | Elif: There is a (wannabe-) desire... | behaviour and think why |
| 87 | Beyza: Because of this desire, they then start to drink as well | not us? |
| 88 | Selin: It's also about personality; if someone is weak or their character | |
| 89 | is weak they will be more inclined to it. | Personality – weak |
| 90 | Elif and Deniz: No no | means they are more |
| 91 | Elif: They are all Muslim (...) even if people practise religion and their | likely to drink |
| 92 | character is weak and if he went to pray he would still drink where no | |
| 93 | one would see him (...)I have witnessed this in Turkey, I was working in | Religion – doesn't |
| 94 | a company, he was a big manager, he was fasting, and he had a private | prevent someone from |
| 95 | office and would then go in and drink his alcohol.. | drinking or being |
| 96 | Beyza: My boss was like that// | dependent on alcohol |
| 97 | Elif: One day I said to him, <name of gentleman> (<name>'s brother): | Managers of companies |
| 98 | you pray and fast, and because you fast you shut down the canteen | are affected by alcohol |
| 99 | and there you are drinking alcohol at the back; you know I am very out | just the same |
| 100 | spoken. He then said my daughter <name> I am 60 years old and I have | |
| 101 | never heard this from anyone, you are very brave to talk to me in this | Brave to stand up to |
| 102 | manner, I said are you going to execute me for my courage, I said this | those in power who |
| | | drink |

103 is what it is. He said you have spoken to me like man, you can access
 104 the canteen. So in three days' time they are going to get money, when
 105 they fast they get more in that month. I can't fast I don't do it, I eat, I
 106 am going to get less money as a result of not fasting, but anyway this is
 107 about having a weak personality, a weak character.

108 Elif: There is religious pressure, there is pressure, otherwise that man
 109 the manager he would have come out and had his drink in front of
 110 other people, but because he is afraid of the religion and the
 111 community he drinks in secrecy//

112 Deniz: They hide behind religion.

113 Selin: It's not about hiding behind the religion; if someone doesn't
 114 have people drinking in his family then he would not drink.....

115 Zeynep: What about that man who hung himself <name>? No one
 116 drinks in his family, but he hung himself due to alcohol problems.

117 Beyza: We are talking about the religious side of things

118 Selin: Sometimes when we attend certain people's weddings there will
 119 be no alcohol on the tables.

120 Elif: That is just for show off purposes, they drink more than you and I
 121 behind the scenes.

122 Selin: Because he is in his own community, but the person who drinks
 123 will drink anyway but not provide it at the wedding.

124 Elif: That's just a show off (...) a show off.

125 Beyza: Well that's the pressure.

126 Deniz: No

127 Elif: Generally the men are in 'men's cafes' and women are usually at
 128 home...women don't really have that desire, like there are weddings, in
 129 'our' (gestured by Elif)community there is no pressure as to, I can drink
 130 and you can't drink..

131 Selin: In our Alevi (group of *Islamic people: commonly associated with*
 132 *singing, dancing*) community, there isn't that pressure on the women
 133 that they cannot drink and men can, like at the weddings there is
 134 Whiskey and beer, the men drink but the women won't drink.

135 Deniz: It's very rare.

136 Elif: Yes it's like this generally.

Related to having a
weak personality or
character

Willpower

Religion as factor for
non-disclosure

Kept secret

Hide behind religion

Influence of family that
drink

Suicide caused by
drinking

No alcohol on show at
some weddings – for
appearances rather than
because they don't drink

Being part of the
community prevents
open drinking – have to
go somewhere else to
do it

Use of cafes

Religion: depends on
sect, in some
communities men
drinking at weddings is
acceptable

137 Selin: In the Sunni community, I do mix in their community as well, the
 138 men won't drink at the table where there are women the men will
 139 group together at another table and sit there to drinkno the women
 140 in the Sunni community won't drink but this doesn't happen in the
 141 Alevi community but it does in the Sunni community. My husband is
 142 Sunni and I am Alevi but because I mix in both of the communities I
 143 know this.

144 Beyza: I think we need to provide support to these people.
 145 Speaking together (xxx)

146 Elif: I think they should go to get psychological support

147 Selin: I think initially the persons' family should persuade them, and
 148 support them but if the situation continues and the person doesn't
 149 accept what's going on, then there is a need to ask for professional
 150 help from a doctor or a psychologist, but one has to find the pathway
 151 to persuade the person. However, if the person is not accepting this
 152 either, though primarily it's the family who should try to persuade the
 153 person.

154 Elif: Generally they don't accept going to those kinds of places.

155 Beyza: There are men who do and men who don't accept going, for
 156 example I am on this route for the last 15 years.

157 Elif: You are on this route, it is rare.

158 Beyza: Sister <name> is also on this route too, her husband drinks too.

159 Beyza: This is not a good thing, my children have been affected by this
 160 very much my older son(...) was a very bright child and student he was
 161 number one in the school, but his father's drinking outside in the
 162 streets, and my sons friends saw this and they approached him about it
 163 and made fun of it, so this has really had a bad effect on him and he
 164 left school as a result, my child hasn't spoken to his father for 16 years
 165 and he only started speaking with him this year.

166 Deniz: Yes it should be the family who tries to sort it out at first, the
 167 family. The husband and wife, and the children and the closest ones to
 168 you. To support in both ways, yes to stop drinking and also to seek
 169 professional help, it needs to be done together so that it has some
 170 benefit.

Religion: men drink
away from women,
share their own table

Need for psychological
support

First port of call should
be the family, then if not
successful, seek
professional help

Family should help
persuade individual to
seek help

Not accepted by all, to
seek professional help

Can take many years to
persuade someone

Impact on family,
particularly children –
getting bullied for a
father that drinks

Having to leave school
because of this bullying

Not spoken to father for
16 years as a result

Family support to stop
drinking and to seek
help

Appendix L: Codebook

| No. | Initial Code | Data extract (line number) |
|-----|---|-------------------------------|
| 1 | Drinking is only negative | |
| 2 | Danger and risk | |
| 3 | Notion of making a choice to drink or not | |
| 4 | Stress is seen as main reason | |
| 5 | Lacking responsibility | |
| 6 | Lacking willpower | |
| 7 | Jealousy as a precursor to drinking | |
| 8 | Lack of control and weakness | |
| 9 | Escapism | |
| 10 | Feeling inadequate, comparison to others and self-worth | |
| 11 | Feeling low | |
| 12 | Positive: celebrations such as weddings | |
| 13 | Availability and money | |
| 14 | Impact on family | |
| 15 | Impact on economy | |
| 16 | Turkish business thriving through sale of alcohol | |
| 17 | Lack of harm to business, located in person | |
| 18 | Impact on environment | |
| 19 | Location and social behaviour | |
| 20 | Impact of alcohol is widespread | |
| 21 | Not viewed as problem until it affects others | |
| 22 | Psychological: Alcohol as a mask | |
| 23 | Concealment: desire to hide drinking | |
| 24 | Concealment: makes situation worse | |
| 25 | Concealment: religion | |
| 26 | Physical: Alcohol stops clarity | |
| 27 | Physical: Feeling unwell on first occasion of drinking | |

| | | |
|----|---|--|
| 28 | Physical: Hides other physical problems/diseases | |
| 29 | Link with domestic violence | |
| 30 | Community spaces and cafes | |
| 31 | Coping with stress | |
| 32 | Alternative being suicide or self-harm | |
| 33 | Death being only other alternative | |
| 34 | Alcohol suppresses negative thoughts / loneliness | |
| 35 | Identity: behaviour is affected, not thoughts | |
| 36 | Identity: missing home | |
| 37 | Importance of not drinking when young | |
| 38 | Influence of elders to prevent drinking | |
| 39 | Punishment of being caught | |
| 40 | Youth have expectations for the future, elders do not | |
| 41 | Unmet expectations lead to drinking | |
| 42 | Providing young people with roles and direction | |
| 43 | Youth should be given alternative means of coping | |
| 44 | Drinking is particularly a problem for the young | |
| 45 | Honour and dignity affected if girl drinks | |
| 46 | Immigration | |
| 47 | Drinking problems not unique to Turkish community | |
| 48 | Impact of migration on men is different | |
| 49 | Reality different from dream | |
| 50 | Feeling lost | |
| 51 | Loss of status | |
| 52 | Unemployment | |
| 53 | Shame | |
| 54 | Fitting in | |
| 55 | UK: Lifestyle is different | |
| 56 | UK: Alcohol more available | |
| 57 | UK: Everyone drinks, part of culture | |
| 58 | New identity as a drinker | |
| 59 | Drinking is part of being a man | |
| 60 | Men: head of house, decision-maker | |

| | | |
|----|--|--|
| 61 | Men being under stress, many problems | |
| 62 | Men: Ways of coping, prone to drinking | |
| 63 | Men: Use alcohol to console themselves | |
| 64 | Men: Expectations to meet needs of others | |
| 65 | Men: Fear of being ashamed and link with stress | |
| 68 | Men: Raising and educating the children | |
| 69 | Men: Lack of support from wife can lead to drinking | |
| 70 | Women: support husbands | |
| 71 | Women: Drinking problem not seen amongst women | |
| 72 | Women: Level of support dictates family coping or not | |
| 73 | Women: Role of help seekers | |
| 74 | Women: Talk on behalf of the men in their family | |
| 75 | Women: More stigma associated with drinking | |
| 76 | Seeking help from others | |
| 77 | Family: immediate or extended can provide support | |
| 78 | Treatment deterrent: shame/stigma | |
| 79 | Treatment deterrent: Fear of being judged and labelled | |
| 80 | Treatment deterrent: Language barrier | |
| 81 | Services not needed if support given from family | |
| 82 | Concept of existence tied up in family | |
| 83 | Lack of family support results in lack of balance | |
| 84 | Sense that outside help will come to them if needed | |
| 85 | Reasons for seeking help: Lack of family support | |
| 86 | Reasons for seeking help: Preventing suicide | |
| 87 | Reasons for seeking help: Importance of psychotherapy | |
| 88 | Future of services: need for improvement | |
| 89 | Future of services: help with unemployment, stress | |
| 90 | Future of services: prevention and education | |
| 91 | Future of services: use of GP surgeries for education | |
| 92 | Future of services: prevention groups | |

| | | |
|-----|---|--|
| 93 | Future of services: understanding why people drink | |
| 94 | Future of services: helping people to create new path | |
| 95 | Future of services: importance of therapy | |
| 96 | Future of services: bringing people back into society | |
| 97 | Future needs: Making alcohol less accessible | |
| 98 | Future needs: a new way of working with the problem | |
| 99 | Future needs: Scientists hold the answers and power | |
| 100 | Powerless: lack of ability to make changes themselves | |
| 101 | Prejudice towards professional help | |

Appendix M: Sample Coded Extract

Professionals group

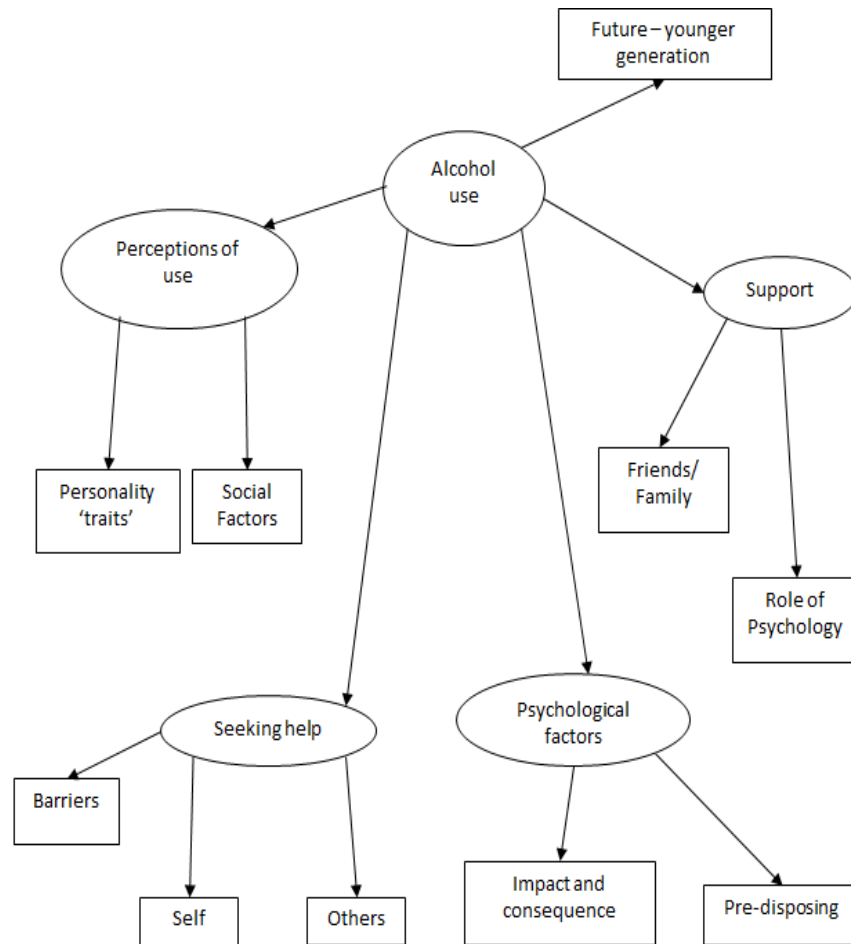
| No | Initial Code | Data extract (line number) |
|----|--|--|
| 44 | Drinking is particularly a problem for the young | <p>Hasan: One of them about the language problem because they can't access it and secondly they cannot access the because even though mostly it's the wives, even when the men's have a problem in our community as far as I see as a health advocate and err for these reasons access is very limited. That's why they try to get or find access in private or try to sort it themselves which is not, and it is their especially in youngster generation, amongst the young generation so yes it is very big (25-32).</p> |
| | | <p>Gizem: Men's drinking is more acceptable and in some cultures it is expected them to be but woman's drinking would not be accept all, it is more hidden therefore we err in the last 16 years I haven't seen any woman coming to seek help for her alcohol problem but I'm hearing lately in the last few years from the parents that their daughters, young daughters, teenagers have a drinking problem and there are more people. If their sons are drinking alcohol it's not a big issue but if it's a girl then it's biggest issue and also other dynamics come with it, their honour and the girl's dignity would be in question (55-63).</p> |
| | | <p>Hasan: I think that will do because I have a daughter she is 11 years old and when I do drink, she tells me, because I try to not drink as much as you and me, I am drinking after she goes bed and she was waking and saying daddy why are you drinking? I say it's just once or twice a week. She</p> |

| | |
|--|--|
| | <p>was telling me no daddy at school they tell us you know it is not good for you; it's as bad as smoking. That's why I think it's in school, if they do it from the beginning it will have, yeah they will get more messages when they have more education I think.</p> <p>Nur: Yes I totally agree, definitely more education in school now it's the younger generation they will be bringing up children in the future so it's them now. The older generation of course they need support and help but because of the language barriers, but if it's open to them the school's education is the most important because these people who are drinking, most of them have no education (336-349).</p> |
| | <p>Hasan: I think that it is a growing problem, it's getting bigger and bigger or it's worse and worse and the solution-wise I think it has to be a continuity of services starting with the surgeries or the NHS or the community organisations and also the awareness like they have done with smoking for a long time which was very effective in our community as well. If they do as much as like smoking and other things I'm sure it will be successful, otherwise it will get worse and worse. But the children it has to be education at school.</p> <p>Gizem: I agree, and err my special worry about the young people, it's a more growing problem for them and you know like from the beginning in schools. But already there are some young people out there who need help for alcohol and drugs (494-505).</p> |

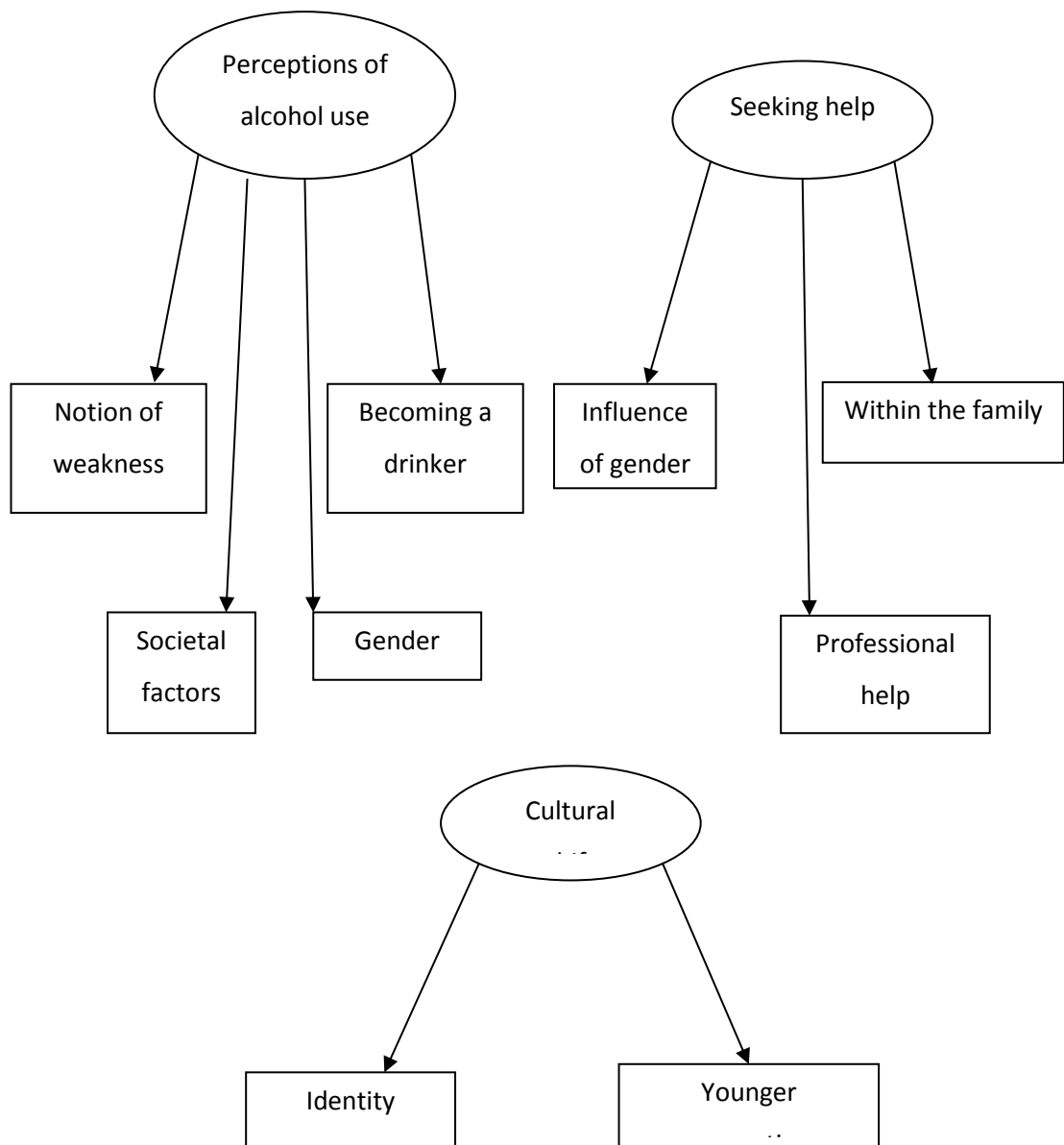
Appendix N: Provisional Themes



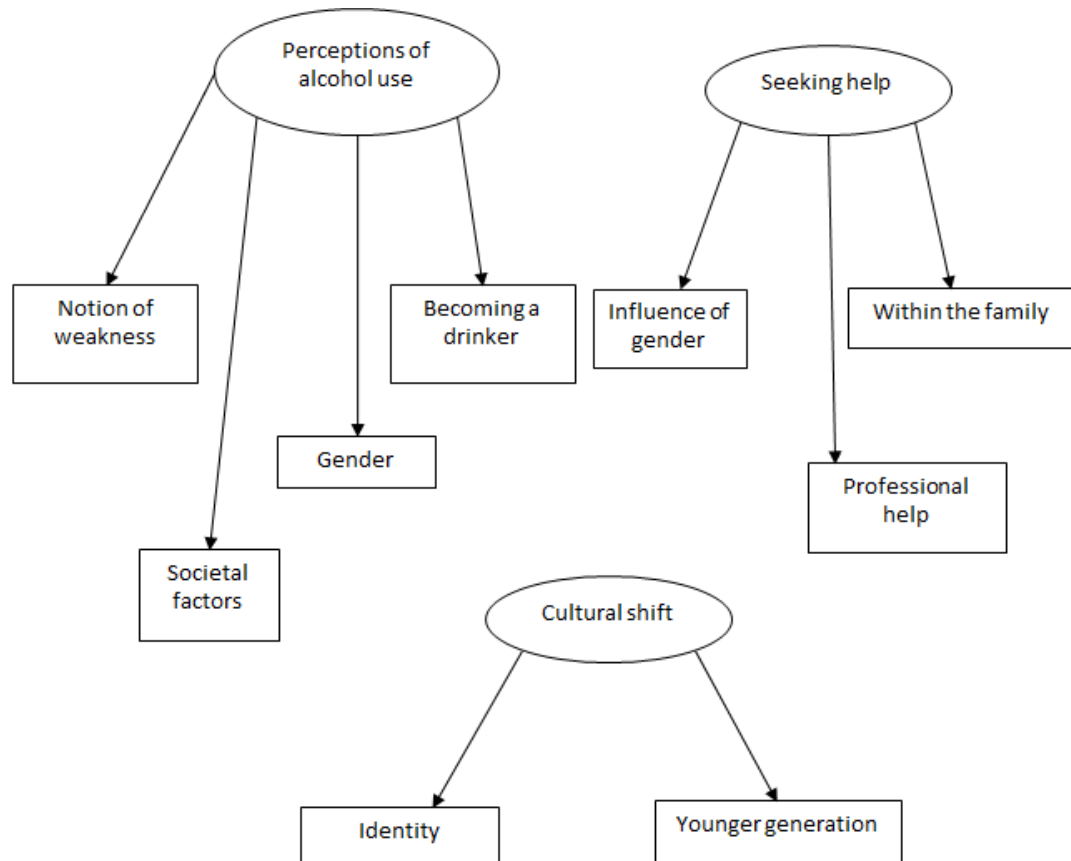
Appendix O: Thematic Map One



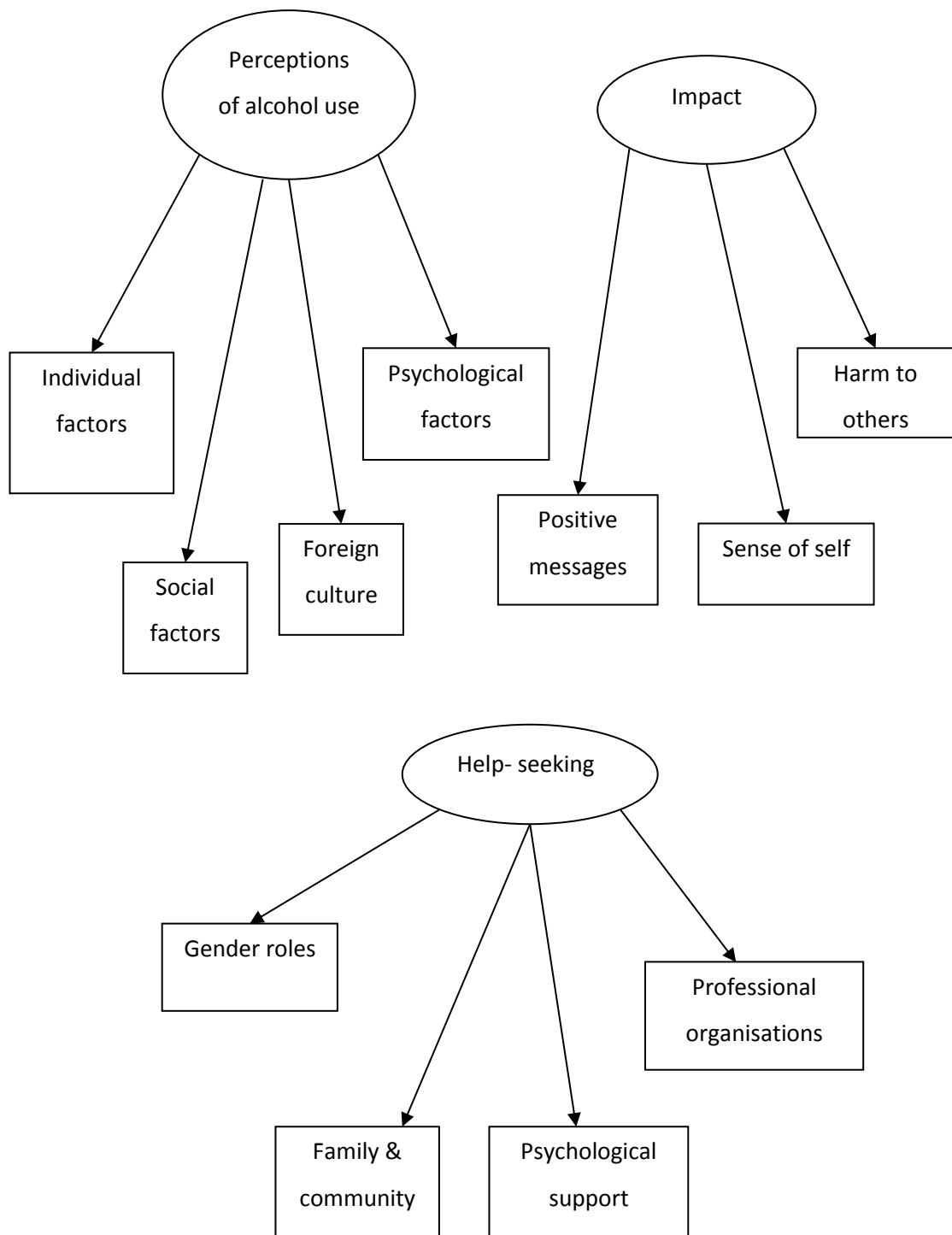
Appendix P: Thematic Map Two



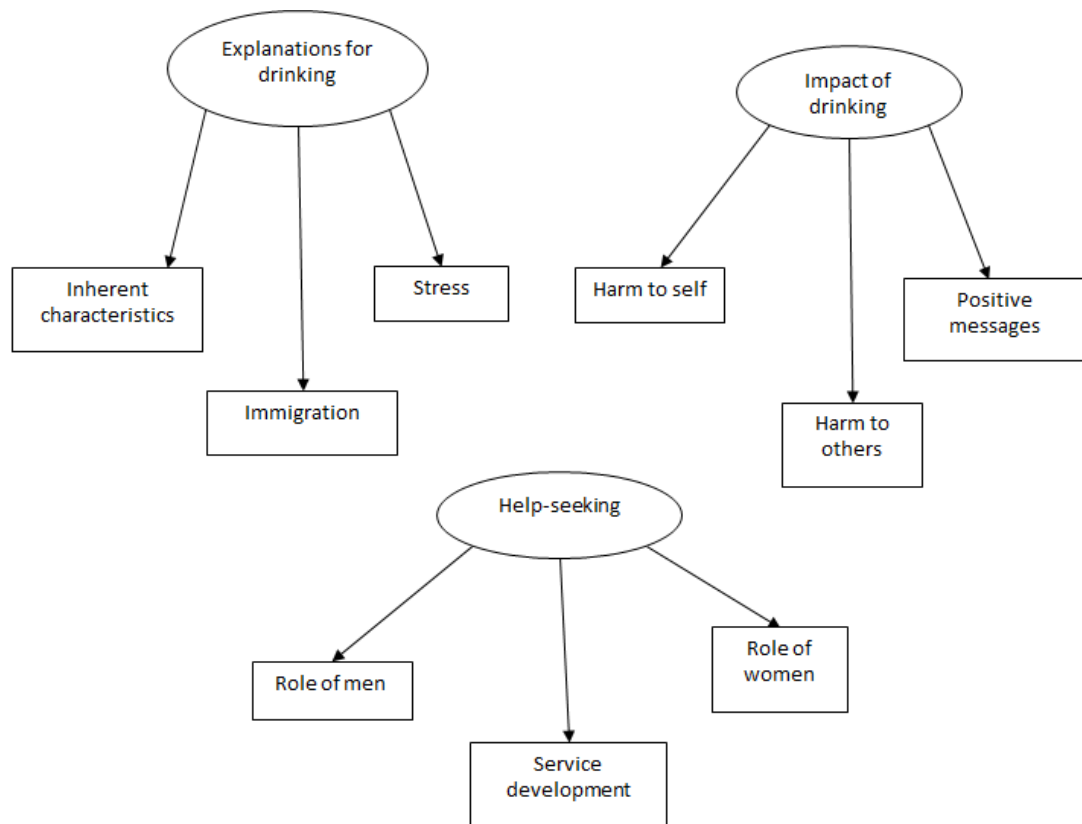
Appendix Q: Thematic Map Three



Appendix R: Thematic Map Four



Appendix S: Thematic Map Five



Appendix T: Defining and Naming Themes

| Name of Theme | Definition | What was of Interest/ Relevance to Research Question |
|---|---|--|
| Theme One: Explanations for drinking | Refers to the perceptions and explanations offered for why people in the T-K community drink | Participants located specific general and cultural reasons |
| Sub-theme: Personality type | Certain personality traits or factors associated with why someone uses alcohol | Notion of weakness amongst a community who demonstrated strength in many ways |
| Sub-theme: Stress | Refers to the experiences of distress and pressure on the community and others who drink | The role of men within the community and family and how stress is dealt with |
| Sub-theme: Culture | Refers to the challenges of living in a new culture and managing the differences between the two | Relevant to cultural understanding of the community's needs |
| Theme Two: Impact of drinking | Refers to the subjective experience of how alcohol affects people. In what ways it has a negative and positive impact | This suggested that there might be differing ways in which alcohol is conceptualised |
| Sub-theme: Harm to Self | Refers to the ways in which alcohol can affect the individual who drinks | Highlights the numerous ways that harm can be defined |
| Sub-theme: Harm to others | How alcohol affects the wider community, family and the environment | Indicates that harm can be caused on a wider level |

| | | |
|----------------------------------|--|---|
| | | |
| Sub-theme: Positive accounts | Refers to contextual accounts about the importance and enjoyment of alcohol | Experiences cannot all be classified as harmful. Levels of consumption is key |
| Theme Three: Help-seeking | Refers to participants' accounts of patterns of seeking help from family and professionals | Cultural influence and gender roles influence over ways in which help is sought |
| Sub-theme: Role of men | Refers to cultural expectations on men to behave in certain ways | Relevant to participants' experiences of how gender roles influence behaviour |
| Sub-theme: Role of women | How women behave given cultural norms | Women's role in help-seeking and the expectations of an active role |
| Sub-theme: Service development | Refers to participants' hopes for future service provision, including the changes that need to be made and how | Relevant to addressing ideas of cultural competency and shaping services to meet need |

Appendix U: Reflective Journal Extracts

Extract 1: Men's focus group

Despite my anxiety about how it would work out – regarding subject matter and using an interpreter – I am pleased and relieved that it went so well. The experience has only reinforced how much I am relying on the interpreter; not only to provide the literal translation but also to help with the cultural nuances that despite our previous conversations I am simply not aware of. Turkish tea was offered immediately as the men arrived – I had brought juice and biscuits – although appreciated, clearly not what was needed! I wondered prior to the group starting about what the men would think about me and why I was asking questions about their community so I made every effort to explain the purpose of the research at the beginning. I needn't have worried so much, they were welcoming in their body language and tried to speak some English and communicate directly with me. I am still left wondering, however, if I can do them justice in the research. I feel a little despondent about my thesis ultimately having little effect on their lives and not being able to put right a lot of the injustices they face/have faced. I hope that my simple interest and time spent listening to their stories is in some way helpful.

Extract 2: Women's focus group

I am somewhat relieved that the women seemed to be genuinely interested in the topics discussed and it was a case of trying to keep to time rather than finding things to discuss. Despite not understanding what was being said at the time of them speaking, the women talked to me as much as the rest of the group, giving me eye contact and the feeling of being very much involved. I feel reassured because one of my biggest fears about doing this research was the community wondering why I was interested in them, possibly judging and analysing them. Indeed, after the group they all wanted to stay and ask me questions about myself and how I became involved with Derman. Being

noticeably eight months pregnant they were also keen to wish me well and ask about the baby. But most striking was the time they took to thank me for my interest in their concerns and their community, each individually thanking me through the interpreter. I left feeling positive that it had been a good experience for the ladies and am now resolute that I will not lose their voices in the process of writing up.