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Conceptualising mental illness among University students of African, Caribbean and similar ethnic heritage in the United Kingdom

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ABSTRACT

Objective: Students of African, Caribbean and similar ethnicity (ACE) encounter unique mental health challenges within the Western higher education system, such as feeling constrained in social spaces and perceiving greater stigma about mental health. Students of ACE are also resilient to mental health problems, such as depression, when enduring social inequality. This study aimed to conceptualise mental illness and help-seeking behaviours among university students in the United Kingdom (UK) in the context of their identity as ACE.

Design: Six university students of ACE in the UK were interviewed about the meaning of mental illness, the influence of ACE culture on mental health and help-seeking by ACE students. Thematic analysis was applied from a socio-constructionist theoretical lens to interpret the interview transcripts.

Results: Five main themes emerged, namely 'Perceived meanings and attitudes toward mental health problems', 'Beliefs about the non-existence of mental health problem and its spiritual attributions', 'Family dynamics and the 'silencing' of mental health problems', 'Help-seeking for mental health among people of ACE' and 'Stigma and discriminatory responses to mental health issues'. Participants expressed that mental health is an imported concept that people from ACE communities tend to shy away from. A reluctance to discuss mental health problems arose over fear of rejection from families and fear of not being understood by a mental health professional from a different cultural background.

Conclusion: University students of ACE and their families struggle to adopt the Western conceptualisation of mental health. Consequently, there is poor awareness of mental health issues and stigma of mental illness among university students of ACE which pose a barrier to help-seeking for mental health. The limited sample size constrains the ability to draw sound conclusions. Nonetheless, a culturally sensitive conceptualisation of mental health is needed to address poor help-seeking for mental health among people of ACE.

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Mental health is intricately interwoven with social functioning (Vontress, Woodland, and Epp 2007, 130–141). Social inequality and racial prejudices have had a lasting impact on the attitudes of people of African, Caribbean or similar Ethnicity (ACE) towards mental health and help-seeking (Jidong, Dung Ezekiel, Husain et al. 2021, 1–14; Mantovani, Pizzolati, and Edge 2017, 373–384; Nickerson, Helms, and Terrell 1994, 378–385; Utsey et al. 2015, 195–220). This social inequality is likely to have come from the hegemony of the European colonial rule (Jidong, Dung Ezekiel, Husain et al. 2021, 1–14; Bhui, Ascoli, and Nuamh 2012, 185–205; Bain 2018, 4–21). Racism can be defined as 'an organised system, rooted in an ideology of inferiority that categorises, ranks and differentially allocates societal resources to human population groups' (Williams and Rucker 2000, 75–90). Racism is also defined as 'a global hierarchy of superiority and inferiority along the line of the human that have been politically, culturally and economically produced and reproduced for centuries by the institutions of the capitalist/patriarchal western-centric/Christian-centric modern/colonial world-system' (Grosfoguel 2016, 9–15). This historical persecution of people of ACE has created a legacy of oppression, as evidenced by the unlawful and merciless killing of people of ACE, most notably Stephen Lawrence, Trayvon Martin and George Floyd. The Black Lives Matter movement arose from these persecutions (Rogers et al. 2021, 87–101). The Western domination over former colonies appears to continue through the use of the labour force of former colonies in low-paid jobs (Limki 2018, 327–342; Utsey et al. 2015, 195–220; David and Okazaki 2010, 850–887). Furthermore, former colonies follow an education system that imbibes Eurocentric norms and this perpetuates Western domination (Seth 2011, 263–282). Mental illness prevails in such a climate of mistreatment and oppression and when people of ACE experience inferiority (Doyle, Joe, and Caldwell 2012, S222–S231; Mills and Edwards 2002, 273–304; Vontress, Woodland, and Epp 2007, 130–141). Therefore, models of mental illness must address social adversity arising from such historical oppression due to the European colonial legacy.

University students of ACE in the United Kingdom (UK) encounter such inequalities through a distorted learning experience, such as their lack of relatedness to the majority of academic staff and students who are of European descent and learning material being Eurocentric, being ignored and avoided in learning and social environments and being stereotyped as criminal (Stoll et al. 2022, e050720). They must constrain themselves in academic spaces to be seen as acceptable by students of European descent (Stoll et al. 2022, e050720). The persistent racism towards ACE students increases their poor mental health and mental illness (Stoll et al. 2022, e050720). Nonetheless, there is conflicting evidence concerning the relative rate of mental disorder in ACE students. On the one hand, a higher rate of depression has been reported in ACE students than European-descent students (Eisenberg, Hunt, and Speer 2013, 60–67). On the other hand, a lower rate of depression is seen in ACE students compared to European-descent students (Dzierzewski et al. 2020, 1972–1983; Keyes 2009, 1677–1706). People of ACE may even report better mental health than people of European descent (Keyes 2009, 1677–1706). It is suggested that people of ACE are resilient to poor mental health in the face of social inequality by having good coping strategies, such as religiosity, a sense of community among ACE people and cultural socialisation (Keyes 2009, 1677–1706; Smith et al. 2014, 316–327).

The experience of ACE students may reflect the wider ACE population. Older African-Americans are likely to experience poor mental health arising from the historical legacy of slavery and perceived trauma, but this relationship remains undocumented (Mills and Edwards 2002, 273–304). In Britain, people of ACE are more likely to be diagnosed with a severe mental illness when compared to people of European descent (Bhui, Halvorsrud, and Nazroo 2018, 574–578; Kirkbride et al. 2008, 18–24). They are four times more likely to be detained under the Mental Health Act than other ethnic groups (Care Quality Commission 2018). This disproportionate suffering of people of ACE continues along the healthcare pathway (Jidong, Dung Ezekiel, Husain et al. 2021, 1–14). Once diagnosed, patients of ACE are more likely to experience negative outcomes from mainstream mental health services and are less likely to receive psychological therapies than patients of European descent (Das-Munshi, Bhugra, and Crawford 2018). People of ACE who are diagnosed with schizophrenia receive depot antipsychotic medication more often than patients of European descent, and experience poorer treatment that leads to disengagement from services, social exclusion and a deterioration in mental health (Das-Munshi, Bhugra, and Crawford 2018; Fitzpatrick et al. 2014). With regards to physical illness, the incidence of the Coronavirus disease (COVID-19) is higher among people of ACE than people of European descent (Poteat et al. 2020, 1–3; Raifman and Raifman 2020, 137–139). A higher incidence of COVID among people of ACE suggests that social inequality, neglect and poor mental health are linked to poor physical health. Eurocentric models of mental disorder, such as the Diagnostic and Statistical Manual of Mental Disorder (American Psychiatric Association 2013) and the International Classification of Disease (Khoury, Kogan, and Daouk 2017, 1–6), may be obsolete among people of ACE if the models of mental disorder ignore the mental distress arising from historical persecution due to European colonialism, e.g. slavery (Jidong, Dung Ezekiel, Husain et al. 2021, 1–14; Mills and Edwards 2002, 273–304). The diagnosis of mental disorder must be culturally sensitive so that it recognises the cultural dysthymia that arises from racism, demoralisation, depression, social anxiety and anti-social behaviour (Vontress, Woodland, and Epp 2007, 130–141).

A further failing of Western biomedical explanations of mental health is its presumed superiority over traditional beliefs (Cooper 2016, 696–718). Western biomedical explanations of mental health are tied to the colonial mentality. Colonial mentality is the assumption of colonial values (David and Okazaki 2006, 241–252; Jidong, Dung Ezekiel et al. 2021). The colonial mentality consists of apathy towards sub-cultures within one's own culture, and it includes a dislike of the physical attributes associated with one's culture (e.g. skin colour and facial features) and feeling indebted to the colonial legacy (David and Okazaki 2006, 241–252). The colonial mentality relates to lower self-esteem, more depression and more anxiety among Ghanaian people (Utsey et al. 2015, 195–220). International ACE university students still feel estranged in the UK and relatedly, experience depression, loneliness, stress and insomnia (Stoll et al. 2022, e050720). The superiority of Western explanations and experiences of poor mental health of people of ACE could be addressed if the mental health framework adopted decolonisation (Vontress, Woodland, and Epp 2007, 130–141).

The stigma of mental illness also maintains mental illness (Mantovani, Pizzolati, and Edge 2017, 373–384). Stigma is the process whereby labelling, stereotyping, separation, status loss and discrimination co-occur in the context of power (Link and Phelan

2001, 363). Public or social stigma is where the wider community holds negative beliefs about mental illness and considers particular traits to be contrary to community norms (Mantovani, Pizzolati, and Edge 2017, 373–384; Lally et al. 2016, 49). University students are susceptible to stigma from mental illnesses, such as schizophrenia, and hence are less likely to seek help (Lally et al. 2016, 49; Benov et al. 2013). ACE students report higher perceived public stigma about receiving treatment for mental health than European-descent students, based on a large ($n = 153{,}635$) survey of college students in the United States of America (Goodwill and Zhou 2020, 1–7). Here, perceived public stigma about mental health treatment referred to how people would react to someone seeking mental health treatment. Thus, higher perceived public stigma in ACE students than European-descent students suggests that ACE students might fear the consequences, such as rejection and exclusion, of revealing their help-seeking for mental health problems and it highlights the problems with underrepresentation of ACE students on University campuses (Goodwill and Zhou 2020). For instance, a participant expressed in their own words that being diagnosed with a mental disorder meant that 'You are rejected by your own community, by your own environment. They will say that you're not useful any more' (Mantovani, Pizzolati, and Edge 2017, 373–384). The attitudes of the community towards a person with a diagnosis of mental disorder constitute social stigma. Internalised stigma occurs when the person internalises these negative social conceptions (Lally et al. 2016, 49). Social stigma of mental illness is high among people of ACE and it can deepen the internalised stigma and discrimination that students of ACE experience and hinder them from seeking help (Mantovani, Pizzolati, and Edge 2017, 373–384; Stacie et al. 2018). Such perceived public and social stigma may constitute the conceptualisation of mental health among university students of ACE.

Help-seeking for mental health among people of ACE

Notwithstanding the limitations of the Westernised conceptualisation and treatment of mental illness in serving people of ACE, help-seeking from mental health professionals and education about symptoms of mental illness is necessary beyond the realms of traditional spiritual healing (Yorke et al. 2016, 174–194). There is knowledge exchange and overlap between the Westernised view of mental illness and African culture (Cooper 2016, 696–718). People of ACE may not seek mental health support because African-descended faith communities regard mental illness as a moral failing and a spiritual weakness, and mental illness is thought to occur from not having enough faith in God (Mantovani, Pizzolati, and Edge 2017, 373–384). The spiritual beliefs about mental illness are that mental illness denotes being 'possessed by the devil' and is 'a curse' (Mantovani, Pizzolati, and Edge 2017, 373–384; Cooper 2016, 696–718). Spiritual beliefs and stigma about mental illness are barriers to help-seeking among African-Americans (Neely-Fairbanks et al. 2018, 162–174). The Sub-Saharan African culture believes in spiritual healers and considers that 'if illness is thought to be a punishment requiring spiritual expiation then medical intervention is less likely to be considered' (Cooper 2016, 696–718; Leavey, Loewenthal, and King 2016, 1607–1622; Tuffour, Simpson, and Reynolds 2019, 104–118). Equally, having a religious faith is a powerful deterrent of mental illness (Mushonga and Henneberger 2020, 147–160; Shahina and Parveen 2020, 392–397). Mental health services need to embrace spiritual beliefs and address

cultural stigma since these beliefs shape help-seeking (Cooper 2016, 696–718; Loewenthal et al. 2012, 43–66). Indeed, spiritual healers are 'highly respected members of the community and provide great stability' and 'are believed to understand the cultural signs, symptoms, or distress experiences' (Yorke et al. 2016, 174–194; Crawford and Lipsedge 2004, 131–148).

The family environment is another route to experiencing mental distress and recovery (Tuffour, Simpson, and Reynolds 2019, 104–118). University students of ACE in the UK have limited support from families and it increases their barrier to seeking mental health support (Stoll et al. 2022, e050720). African-American families are stricken by the malaise of racism since they are unable to provide the emotional and financial support towards a family member with mental illness (Vontress, Woodland, and Epp 2007, 130–141). African-American families blame each other for their frustrations (Breggin 2000). In particular, African-American fathers experience more social adversity from their own mental illness than fathers of other races (Doyle, Joe, and Caldwell 2012, S222–S231). Social rejection from the family is a mark of such social adversity, e.g. 'If somebody within their family has gone mentally ill, it's a shame, and they rather push that person out of the way and don't talk' (Mantovani, Pizzolati, and Edge 2017, 373–384). University students of ACE are more suicidal when experiencing difficulties arising from their family and encountering difficulties with academic performance than students of European descent (Luca et al. 2017). Lack of family support can delay access to mental health services. African-American families have more difficulty engaging with their ill relative in mental health services and are more burdened by caring for their ill relative than European-Americans families (Smith et al. 2014, 316–327). Nonetheless, African-American families are better at engaging the community in helping their mentally-ill relative than their European-Americans counterparts (Smith et al. 2014). African-American families use more positive-reframing and religious styles of coping; yet, they are in more denial than European-Americans families (Smith et al. 2014). Spirituality and religion are seen as the trusted sources of treatment (Tuffour, Simpson, and Reynolds 2019, 104–118). People of ACE have the same desired outcomes for recovery as people of European descent, namely being resourceful and supporting others with mental illness, growing spiritually, having a family and being able to work (Tuffour, Simpson, and Reynolds 2019).

Cultural congruity is another factor that influences help-seeking. 'Ethnic matching is important in enhancing care pathways' for ACE in the UK since the cultural congruity between mental health professionals and their patients can improve mental health outcomes (Smith et al. 2014, 316–327; Loewenthal et al. 2012, 43–66; Yorke et al. 2016, 174–194). Greater cultural mistrust of European-Americans by ACE University students is related to a lower likelihood of seeking psychological help from a counsellor of European descent (Nickerson, Helms, and Terrell 1994, 378–385). Likewise, ACE university students in the UK are reluctant to seek help from European-descent majority mental health practitioners because of their lack of trust and the racial stereotypes that the practitioner might hold (Stoll et al. 2022). Values can be shared between the researcher and the participant or between the clinician and the patient if they share their cultural heritage, e.g. both the researcher and the participant being a first-generation immigrant. Acknowledging such shared values can demystify the participant's mental health problems from a cultural perspective (Tuffour, Simpson, and Reynolds 2019, 104–118).

Hence, cultural congruity between the researcher and the participants is an important step towards reconfiguring the Eurocentric conceptualisation of mental distress.

In summary, the mental distress among people of ACE is entrenched in the socio-historical legacy of colonial oppression and the psychological trauma of slavery. Whilst resilient to poor mental health (Dzierzewski et al. 2020, 1972–1983; Keyes 2009, 1677–1706), ACE University students are vulnerable to the stigma of mental illness (Benov et al. 2013; Lally et al. 2016, 49). They may fear sharing their seeking of mental health treatment with others due to their perceived public stigma (Goodwill and Zhou 2020, 1–7). People of ACE, including University students, may fail to acknowledge mental illness and fail to seek help because of being racially stereotyped as well as their spiritual beliefs, social stigma, burden of care from the family and/or lack of cultural congruity between patients of ACE and mental health professionals (Goodwill and Zhou 2020, 1–7; Mantovani, Pizzolati, and Edge 2017, 373–384). However, there is a dearth of literature on how university students of ACE conceptualised mental health. The overarching research question posed was, '*How do University students of ACE conceptualise mental illness and help-seeking behaviours?*' Such an insight into their understanding of mental illness could help ACE students to acknowledge any anguish and mental illness over their social discrimination. Thematic analysis was adopted for the present study with the aim to explore participants' defined meanings, especially in terms of what constitutes mental illness, how stigma of mental illness is experienced, coping with poor mental health using religion and other means and attitudes towards seeking help for mental health problems in the context of what it means to be a person of ACE in the Western world.

Methods

Participants

Six participants of ACE were interviewed. All were of Black African descent; three were female and three were male (Table 1). Participants were aged between 22 and 55 years. Three participants had lived in the UK from birth and three participants had moved from their country of origin to make the UK their permanent residence. All participants expressed themselves as having a religious faith, three of whom explicitly stated their

Table 1. Socio-cultural characteristics of the participants and their acquaintance with mental health.

Participant name	Gender	Cultural heritage	Religious beliefs	Acquaintance with mental health
Tia	Female	Nigerian	Is religious and follows the Pentecostal Christian faith	Has lived experience of depression and anxiety
Yanna	Female	African	Religious, although the type of religion is not explicitly stated	Has lived experience of panic attack
Tonie	Female	Not known	Religion is expressed as being extremely important in their life, but type of religion is not specified	Received therapy briefly for poor mental health
Ian	Male	Nigerian	His faith in Jesus alludes to his Christian faith	Psychotherapist
Oliver	Male	Not known	Regards himself as a religious and spiritual person, although the type of religion is not explicitly stated	Does not have a history of mental illness
Tommy	Male	Nigerian	Christian; religion is expressed as being extremely important in their life	Does not have a history of mental illness

Christian faith. Three participants had lived experiences of mental health problems, one was a psychotherapist and two participants did not have lived experiences of mental health problems. Others had knowledge on the subject through research or knowing someone in their ethnic community that had suffered, a friend or family member. All participants were recruited through student adverts and pamphlets handed out at an African-Caribbean Society Meeting at the University where the research was being conducted.

Design

A qualitative method was followed wherein a thematic analysis from a socio-constructionist theoretical framework was used to explore participants' 'defined meanings' in the verbatim data. Such data give an understanding about opinions, motives and thoughts surrounding experiences of mental health issues among students of ACE. The socio-constructionist theoretical framework was adopted in the present study as it assumes that participants' narrative in the dataset may not be a direct reflection of their realities, but in part influenced by their shared history, language and socio-cultural space in which their mental health perceptions, beliefs, experience and opinions are socially construed (Jidong et al. 2020, 40–51).

Procedure

Ethical approval was obtained from the School Research Ethics committee of the participating university. Each participant was informed about the nature of the research and given an opportunity to ask all their questions. The interview began once the participant clearly understood what was being asked of them and provided informed consent. The interview lasted for about an hour. The interviewer asked the participant about the meaning of mental health, specifically 'Black mental health' and the stigma of mental health. The interviewer also enquired about why people of ACE do not seek treatment for mental illness and how the participant would respond if a person told them about their mental health problems. The interviewer went on to ask about the experience of being Black in the Western world and the Black stereotype, especially in the UK, and how ethnic inequalities are experienced in the mental health system. Finally, the interviewer asked about the positive and negative influences of Black culture on Black mental health. When all six interviews were complete, OD (the first author) transcribed the interviews by including nuances, like pauses and stutters.

More illustratively, after a comprehensive coding of participants' ($n = 6$) transcripts, approximately 160 (27 themes per transcript) preliminary themes emerged across the datasets. Preliminary findings were harmonised and thematically synthesised into a qualitative narrative addressing the overarching research question. For example, an 'index card-like method' was employed to identify and organise the key ideas and thematic elements from each transcript into categories of meanings.

Methodological approach: inductive and deductive thematic analysis

The study explored participants' conceptualisation of mental illness. The thematic analysis involved searching for themes that emerged as important in describing the study's phenomena (Braun and Clarke 2013). The rigour of doing coding and the development of the themes were further strengthened using inductive and deductive analysis of the interview transcripts (Fereday and Muir-Cochrane 2006, 80–92). Thus, inductive data analysis was primarily data-driven based on participants' defined meanings devoid of existing theoretical frameworks (Smith 2015). The preliminary stages of the study, such as literature review and research question, potentially influenced deductive findings.

Furthermore, the methodological approach to data analysis was conducted using an iterative process that scrutinised every step and process of the practical data analysis (Bryman 2012) as recommended in the six steps of thematic data analysis defined by Braun and Clarke (2006, 77–101):

Step 1: the process of identifying themes began with a careful 'reading and re-reading of the data, noting down initial ideas' (Braun and Clarke 2006, 87). This involved the repeated reading of interview transcripts to get an initial understanding of participants' defined meanings.

Step 2: This stage entailed the production of initial codes. Codes are shorter phrases that summarised plausible or nuance meanings in a few lines of text in relation to the research aim or questions.

Step 3: This staged involved searching for themes. Thus, codes were grouped to form preliminary meaningful themes.

Step 4: The themes were reviewed and refined. This step involved collapsing, discarding, re-naming and splitting some of the themes into more meaningful units.

Step 5: This stage concluded the naming of the themes' titles in the most informative way. The titles of the themes were further explored in the quest to answer the research question. At this stage, the analysis produced five main themes that were relevant to conceptualising mental illness.

Step 6: The final phase of the thematic analysis was to write up. This involved combining the analysis and harnessing the data extracts into a meaningful discussion (Braun and Clarke 2013).

Each set of organised ideas from each transcript was rearranged into a logical flow of thematic information. Each set of organised ideas was compared and contrasted with that of the other transcripts to eliminate or collapse repetitive themes/ideas. Refined themes were critiqued or evaluated against the entire datasets and finally developed into five overarching themes that have been presented in the results section.

The research strategies for establishing rigour and trustworthiness in data analysis were that researcher-one (OD) conducted an initial coding and theming of the interview transcripts. This was followed by researcher-two (DEJ) iteratively reviewing each transcript and corresponding codes and themes for their appropriateness as a means of ensuring procedural fidelity, before adding an analytical commentary of data extracts that best supported the study's final themes as reported in the results section. Researcher-three (PP) further reviewed, scrutinised and finalised the manuscript for journal submission as the corresponding author. In summary, two researchers (OD

and DEJ) conducted the data analysis and the third researcher (PP) further reviewed and securitised the process.

Results

The following themes were identified, namely 'Perceived meanings and attitudes toward mental health problems', 'Beliefs about the non-existence of mental health problem and its spiritual attributions', 'Family dynamics and the 'silencing' of mental health problems', 'Help-seeking for mental health among people of ACE' and 'Stigma and discriminatory responses to mental health issues'. Participants were pseudonymised in the following extracts to protect their anonymity.

Perceived meanings and attitudes toward mental health problems

The dataset highlights the impact of historical events and culture on how mental health is perceived and understood. These historical events and culture impact the implicit meaning participants ascribed to mental health. As one participant noted:

> *I think it just means like no matter what you're going through just sort of get over it and brush it under the rug and carry on with your day. I think Black people tend to have this mentality so yeah, I think this is very relatable […] I think just because of our heritage I think a lot of Black cultures like African and Caribbean cultures tend to look down on mental health, tend to see it as something negative, a lot of our cultures are influenced by slavery and religion. I think some of those religions and some of the doctrines in the past have given the Black community the impression that mental health is an indication that something is evil or something to be stayed away from. So, I think that's why we don't really talk about it. (Tonie)*

Tonie's view draws on a construct that positions mental health as a product of the historical processes that inform a particular culture. For example, 'Black culture' was construed from a less positive perspective when drawing on issues of religion. One possible explanation for such a perception might be the role of slavery, which appears to represent a sense of exported culture likely to impact indigenous local African and Caribbean culture. The implications of slavery and colonialism appear to inform a negative perception of mental health. Such a negative perception of mental health arises especially when drawing from the imported western religion where mental health issues are perceived poorly, hence explaining why the Black communities appear to shy away from the issues or talk about it less. In its extreme, some participants perceive it as an avenue for exploitation. For example, another participant (Tommy) felt that:

> *Mental health is just something people love to throw out there as an excuse for everything, like I can't go to work because I'm depressed that's probably another reason; I don't believe in it and why it doesn't mean a whole lot to me. It's something people will make noise about for now, and when the hype has died down no one will hear about it again until there's another craze over it. (Tommy)*

Tommy's understanding denotes a sense of exploitation where people are perceived to misuse mental health as a basis for their private gain or the continuing tendency to disregard the phenomenon of mental health as suggested by Tommy's remark, '*I don't believe in it and why it doesn't mean a whole lot to me*. The notable implication for

such a construct is that it risks undermining the negative consequences of mental health issues if left unaddressed. In addition, such a construct appears to downplay mental health as a serious societal problem by trivialising its impact through a sense of blaming and denying of its existence. It also takes a 'sweeping under the carpet approach' which appears risky given the enormous negative impact on persons suffering from mental health problems. Despite the negative views some participants expressed positive attributes towards mental health. For example, a participant viewed '*[mental health as] important to me because it encompasses all things that people can't see it's easy to hide your mental well-being*' (Ian). The extracts highlight the significance accorded to mental health depending on the participants.

Beliefs about the non-existence of mental health problem and its spiritual attributions

Datasets showed some consistency in the attribution of the cultural beliefs about potential non-existence of mental health problems and/or the spiritual cause of mental health problems among the people of ACE. For example, one participant said:

> *Ooo my country of origin, ooo erm well ooo that's that's pretty bad it's very bad in the sense that again that lack of awareness that lack of not wanting to simply acknowledge that mental health exists. It's not the devil trying to overtake a person, mental health illnesses are real very real they are real diagnoses there are real mental issues. These illnesses need to be addressed and that lack of awareness that lack of not wanting to address things from a medical point of view has stopped a lot of people from receiving good sound medical help. (Ian).*

Mental health problems are construed as not real and are further demonised as the works of the devil in the spiritual realm. This socio-cultural construction of mental health problems is attributed to the lack of awareness among people of ACE and is perceived as significant barriers to help-seeking behaviours and access to care. There may also be generational differences in awareness of mental health and a potential shift from the current perspectives among the older generation as Yanna said:

> *By educating the parents and the families, it's more of the older generation Black people the ones that are brought up back in Africa they have the mentality of oh you'll be okay just pray I think if they're educated more on the topic then that can also make things easier*

The above extract showed that the older generation of immigrants with strong African or Caribbean roots dissociate themselves from mental health problems. Furthermore, the extract referred to the role of religious activities, such as prayers, in healing or reducing the effects of mental health problems.

Family dynamics and the 'silencing' of mental health problems

Cultural values and belief systems shape all facets of human existence, including family life. Consequently, cultural attributions about mental health influence one's upbringing through verbal expressions of what to say or not and general discourses about mental health. For example, Yanna said:

> *but because of their upbringing and the African culture and stuff they'll brush it off like you're crazy kind of thing and that doesn't help especially if the person is struggling within themselves*

and they want to talk but they can't talk because they know the reaction, they'll get … it's a bit sad.

Yanna's extract suggests that African family settings and cultural expectations do not seem to produce a conducive avenue to express or talk about mental health challenges. Therefore, according to this extract, it is particularly disheartening to be unable to talk about mental health when there is potential rejection associated with the expression of mental health challenges with family members. Yanna suggests that young people cannot talk openly about their personal distress. Families are sometimes not capable of knowing how to understand struggles with mental health as they may have other responsibilities to cope with and instead of being of help they can criticise and even get annoyed by their behaviour (Premkumar et al. 2019). Such fear of rejection and criticism from the family can discourage the person with mental health challenges discussing about their mental health with their family. Yanna fears the rejection she would experience by opening up to her parents. Likewise, Tia narrated her similar lived experience in the following extract:

For me I feel like I suffered for so long with depression without a diagnosis and without talking to anyone about it because I was scared of what they [family members] would say – I knew that if I told my parents they'd talk me out of that way of thinking and probably tell me I need to pray more about it … I think that's what even made me feel even more depressed because I knew that I needed my parents in this time, but they just wouldn't understand at all what I was going through.

Tia's prolonged experience with depression echoes the initial narratives from Yanna, which showed a tendency to conceal the experience of mental health challenges. She also hints at the intergenerational gap in understanding mental illness as suggested by her parents' ignorance of her suffering from depression and their resorting to spiritual solutions. This also suggest that the younger generation of African and Caribbean communities seems to have better access to mental health awareness in comparison to the older generation.

Help-seeking for mental health among people of ACE

Ethnic and cultural identities play essential roles in help-seeking behaviours within the mental healthcare system and service provision (Jidong et al. 2020, 40–51). These behaviours may include decision-making about whether to seek help or not. Positive help-seeking behaviours also involve building service-users' confidence and rapport with the potential service providers. See the following comments from interviewees:

Tonnie: 'I think it's very important to have someone that you feel safe around someone that you feel understands you I think it can be hard especially as a black person to go out and get help from someone that comes from a completely different socio-economic background to you and a different religious background and a different erm racial background because what tends to happen is you feel like they don't kind of understand where they are coming from or understand things that you've been through so I think when you are from an ethnic minority finding help is really really hard just cos it's not advertised just as much'.

Tia: 'I feel like firstly there aren't enough minority ethnic people within the mental health system; this could be because it's been seen as an unappealing job, or actually, do you know what, I feel like Black people get turned off by jobs like this because a white patient will

100% rather be treated by a white psychiatrist so it's like they [ACE] have a fear of white people looking down on them in a way so in order to avoid this they just don't get into that kind of work in the first place.'

The above extracts gave a cultural identity perspective to help-seeking for mental illness by suggesting the current service provisions are Eurocentric. Tonnie expressed a sense of safety in seeking help from someone who understands her culture. She also expressed the challenges Black people can face because of their mental health issues not being understood when seeking help from a professional who is from a different cultural background. This notion highlights the vital role of cultural identity, values and beliefs in mental health issues and services. This reluctance of ACE people to seek jobs in the mental health system highlights the cultural stigma that is associated with the mental health profession and the framing of mental health illness and services. Therefore, the underrepresentation of ACE cultural values and practices in the current mental healthcare system creates significant fears and strong avoidance tendencies to seek mental healthcare or become service-providers in a system that is not trustworthy. Other interviewees said:

Ian: 'counselling and therapy is very Eurocentric in the sense that – the way it practiced its almost for it to just fit the white Anglo-Saxon population'.

Oliver: 'even if you speak English fluently the fact that you don't have an English accent makes you … could make it difficult for you to communicate with err err the people that are outside of your ethnic group erm finding a job it makes it that that … a little difficult finding a job err being a member of the immigrant community because as I said you speak with an accent that's not English you're Black erm and you're not educated in the ways of the western world … '

Ian's extract critiqued the mental health services as purely Eurocentric with little or no elements of equality, inclusion, and diversity to accommodate ACE communities. Similarly, Oliver expressed that not having an English accent or not having a Western education can be a point of discrimination that can affect help-seeking. Oliver's extract did not specify job seeking challenges to the mental health professions. However, it is apparent that the ACE people can encounter disadvantage when finding work within the mental healthcare sector because of not having the same educational background as European-descent people. This disadvantage of having a minority cultural identity can carry across to other fields of human endeavour and it amounts to systemic discrimination.

Stigma and discriminatory responses to mental health issues

The analysis highlights a pattern of 'silencing' the illness and believing it to be 'non-existent', and such a pattern indicates stigma and vulnerability to stereotyping or discrimination. These were apparent in extracts from the participants below:

I think a big thing [stigma suffered from mental health problems] is the embarrassment, they're just kind of ashamed, they don't want the shame. They don't want to sort of be seen in a certain way and sometimes people can- I guess be a bit proud and a bit conscious about how they're going to be viewed they don't want to bring embarrassment to the family they don't want to disappoint people […] I just think we need to speak about it [mental health issues] more often, I think when people become comfortable with speaking about mental health challenges it becomes normalised and once it becomes normalised then we can become more educated about it. (Tonie).

> *There's a stigma attached to it [mental health issues] because the people you know have a detached perspective to it [due to stigma and discrimination] you know they look at someone with a mental health issue and they look at it like ok this cannot be me there's something wrong with that person or that person must have done something wrong you know, that is not the case well I believe it's the case to a certain extent mental health can affect anybody you know it just depends on what is causing it so if more people are educated about the causes of mental health then ultimately the stigma will be removed. (Olivia)*

Olivia's and Tonie's extracts reflect how societal beliefs could impact the perception of mental health. 'Stigma' is ascribed to the society where being identified as having a mental health condition could draw negative connotations. The participant extract also appears to highlight the importance of relationships. In essence, retaining one's relationship becomes more important than disclosing issues with mental health. Consequently, it is believed that disclosing challenges of mental health problems leads to stigma and the risk of losing friends and associates. The adverse impact that may arise from such perspectives is that suffering in silence appears to become the order of the day to avoid the stigma attached to those having mental health issues.

Discussion

The present study explored the conceptualisation of mental health and attitudes to help-seeking for mental health among the university students of ACE in the UK. Data were collected from immigrant and first-generation ACE students and analysed, and the data revealed three overarching themes. Our findings provide fresh insight into ACE mental health among University students of ACE in the UK and build on previous research. The first theme on perceived meanings and attitudes toward mental health problems highlights the influence of slavery and suggests how western religion has adulterated the African and Caribbean cultural values and practices. The connotation of slavery and western religion in Black culture brought on by western colonialism may cause university students of ACE in the UK to have a negative perception of mental health, not acknowledge it and, instead, to adopt a resilient stance in the face of mental health problems. Such a negative perception and rejection of mental health suggests the toll that racism takes on university students of ACE. This finding was supported by Sanni (2021, 71–86) (2021) who examined how colonialism and slavery used religion to silence and extort African and Caribbean values and heritage. However, this finding is slightly contrary to the mixed methods study by Jidong et al. (2022) when examining Berom cultural beliefs and attitudes towards mental health problems in Nigeria. The study found Berom indigenous preference for Christian religious and traditional healing for dealing with mental health problems in their communities. Similarly, Tuffour *et al.*'s (2019, 104–118) also showed spirituality and religion as the trusted sources of treatment for people of African and Caribbean heritage. Thus, even though it seems that Christianity was imposed on African and Caribbean communities by Western colonisation and colonisers, studies (Jidong et al. 2022; Tuffour, Simpson, and Reynolds 2019) show that people appear to have adopted and found recourse in these Westernised Christian beliefs.

Another conceptualisation of mental health by our sample of university students of ACE in the UK was the non-existence of mental health problems and the use of spiritual

explanations for both the causes and healing of mental health problems which is consistent with the wider literature (Cooper 2016, 696–718; Mantovani, Pizzolati, and Edge 2017, 373–384). Such beliefs among ACE students in the UK could amount to the lack of acknowledgement of mild to moderate levels of certain mental health problems, such as anxiety and depression, and for people of ACE to regard these problems as not requiring intervention. Severe mental illnesses, such as psychosis or suicidal tendencies, are believed by people of ACE to be caused by external forces such as devil or spirits, and therefore, are believed to require spiritual intervention, such as religious prayers or healing (Jidong, Dung Ezekiel et al. 2021). Mantovani, Pizzolati and Edge (2017, 373–384) explored the relationship between help-seeking behaviours and mental health stigma among people of ACE in faith-based communities in the UK. Their findings revealed a Christian-oriented belief system that people of ACE hold which is that mental health problems are primarily caused by moral failure, evil spirits, devil and demon possessions. In a similar study, Leavey, Loewenthal and King (2016, 1607–1622) examined how clerics from various ethnic and faith groups conceptualised mental health problems. They found that a trajectory of help-seeking behaviours relate beliefs about spiritual causes of mental health problems to spiritual intervention and an avoidance of the biomedical model of intervention. Both Mantovani and colleagues (2017, 373–384) and Leavey and colleagues (2016, 1607–1622) revealed similar findings to the present study; however, both those studies were conducted with Christian faith-based organisations that may not necessarily reflect the beliefs of other non-Christian faith-based populations among University student. The present study examined mental health beliefs in a small sample of the student population of ACE. These findings may be interpreted tentatively because of the small sample size. Nonetheless, they support the literature on applying spiritual explanations to the causes of mental health problems and the occasional evidence of students of ACE having greater positive mental health than students of European descent by taking religion as a coping strategy (Dzierzewski et al. 2020, 1972–1983; Keyes 2009, 1677–1706).

The present study revealed the complex family dynamics among people of ACE and the impact they can have on the tendency to 'silence' mental health problems. This finding gave further insight into how university students of ACE in the UK conceptualise mental health. Family attitudes towards mental health help-seeking play an important role in the intention to seek help for mental health among African-American college students (Barksdale and Molock 2009, 285–299; Stoll et al. 2022, e050720). Family stigma and spirituality are potential barriers to mental-health help-seeking among African-American youth (Planey et al. 2019, 190–200). This finding concurs with the findings of other pieces of research that University students of ACE in the UK find it difficult to seek mental health support and they experience isolation and alienation when they encounter family stigma and lack of family support (Stoll et al. 2022, e050720). The findings of the present study also tentatively suggest how some family members could hinder the expression of mental health challenges and help-seeking behaviours due to fear of stigma, misunderstanding, repercussion and lack of adequate support, and consequent experience of deterioration in mental health. This finding partly reflects that of Smith and colleagues (2014, 316–327) who examined the race-related differences in the mental health problems of a loved one in a family-oriented mental health intervention programme in America. African-American families reported less knowledge of

mental health problems and higher levels of negative experiences of caregiving or support to a family member with mental health problems than their European-American counterparts (Smith et al. 2014, 316–327). Furthermore, Mantovani and colleagues (2017, 373–384) found the likelihood of avoidant behaviours and silencing of mental health problems among families of ACE. Therefore, mental health problems are concealed as a secret with no eagerness to seeking help which results in mental health problems becoming severe at the point of contact with the mainstream service-providers. As in the present study, Mantovani and colleagues (2017, 373–384) and Barksdale and Molock (2009, 285–299) recommend the involvement of families, relations and community members to be active co-creators of mental health intervention as possible ways of eliminating stigma and barriers to help-seeking behaviours.

A potential barrier to help-seeking behaviours is the perceived underrepresentation of ACE among mental health service providers (Jidong, Dung Ezekiel et al. 2021; Yorke et al. 2016, 174–194). Participants in the present study conveyed that being a person of ACE and having a non-Caucasian English accent was construed as posing abarrier in the general job search and when seeking jobs in mental health sector, as well as posing a barrier whencommunicating with mental health professionals. Such a view is consistent with previous research (Madut 2019, 61–78). The third theme about help-seeking for mental health issues among people of ACE more concerned the cultural barriers that people of ACE encounter when seeking help from a mental health professional who is from a different cultural background. Thus, the theme alluded to a limited access to mental health professionals of ACE and a perceived underrepresentation of service-providers from ACE. This suggests a lack of trust and incompatibility of a European-descent-dominated care system and a poor socio-cultural construction of mental health aetiology, conceptualisation, diagnosis and treatment (Nickerson, Helms, and Terrell 1994, 378–385). Cultural and ethnic congruity between service-users and service-providers is found to be essential for the potential service-users. Similar findings were reported by Grey and colleagues (2013, 146–157) who examined 53 articles in the UK policy initiatives published between 1991 and 2012 with detailed explanations of mental health inequalities. They found that the Black and Minority Ethnic groups continue to experience mental health inequalities despite numerous major government policy initiatives to close this gap. This explains the massive under-representation of service-providers of ACE in the mental healthcare system. A similar argument was made by Cooper (2016, 696–718) who critically evaluated the many questionable modernist/colonialist Eurocentric assumptions about mental health diagnosis and treatment and how it is being imposed on people of ACE. A colonial mentality and internalised oppression are barriers to mental health help-seeking among Filipino Americans (Tuazon et al. 2019, 352–363). Thus, the Eurocentric conceptualisation of mental health as biomedical and the subsequent discreditation of African traditional and cultural beliefs about mental health problems are key barriers to help-seeking behaviours. Decolonising mental health and developing a culturally sensitive primary mental health care system can overcome cultural and language barriers (Loewenthal et al. 2012, 43–66; Jidong et al. 2020, 40–51). Equally, recognising the need for psychotherapeutic help, stigma tolerance and interpersonal openness relate to greater confidence in the mental health profession among ACE college students (So, Gilbert, and Romero 2005,

806–816). Thus, educating students of ACE about the nature of mental health may improve the relationship between mental health and help-seeking by ACE students.

A final theme emerged in response to the aim to understand how stigma of mental illness is experienced by university students of ACE. The theme identified discriminatory responses to mental health issues. This finding concurs with the findings of a large (n = 153,635) survey of college students in the United States of America where ACE students reported greater perceived public stigma than European-descent students (Goodwill and Zhou 2020, 1–7). As shown in previous themes, the findings highlight a pattern of 'silencing' of mental health problems and believing them to be 'non-existent'. Such attitudes indicate stigma and discrimination. These challenges could be addressed from spiritual and cultural standpoints since these beliefs shape lived experiences of MHPs and help-seeking behaviours as exemplified in numerous previous studies (e.g. Mantovani, Pizzolati, and Edge 2017, 373–384; Neely-Fairbanks et al. 2018, 162–174; Loewenthal et al. 2012, 43–66).

Limitations and implications

The following limitations are noteworthy. Whilst the issues raised concerned ACE, only six participants of ACE were interviewed. Further research is needed in a larger and more diverse group of people of ACE to make the findings more generalisable. The above extracts may not reflect the generality of an African/Caribbean parent's position on mental health discourse. Still, these extracts offer valuable insight into the impact of culture on mental health experience. Furthermore, at the time of study, some participants had resettled in the UK. It was not known how long they had lived in the UK prior to the study which knowledge would have given more insight into their acculturation. We recommend that these pieces of information be sought in future research. Whilst cultural congruity between the researcher and participant brought out the cultural nuances of the participants' experiences (Tuffour, Simpson, and Reynolds 2019, 104–118), it also narrows the breadth of experiences in the exchange. It is possible that participants may have expressed their views in a biased way due to social desirability and felt reluctant to speak openly about their experiences of being a person of ACE. Participants who move to the UK to study and make UK their permanent residence may deny any feelings of racial insubordination out of a feeling of gratitude for the Western lifestyle and colonial mentality (David and Okazaki 2006, 241–252), even though they may feel disorientated and isolated by the lack of family and social support (Yorke et al. 2016, 174–194). The implications of the findings are to integrate the legacy of colonialism and religious beliefs into the social construction of mental illness. Families could be educated about the stigma of mental health that University students experience and people of ACE alike (Yorke et al. 2016, 174–194). Creating awareness and re-awakening interest in mental health education through campaigns and drama about the realities and lived experiences of mental health problems may be beneficial for the African communities.

Conclusion

People of ACE in Western societies experience a disproportionate amount of mental distress than people of European descent (Kirkbride et al. 2008, 18–24; Bhui, Halvorsrud,

and Nazroo 2018, 574–578; Jidong, Dung Ezekiel, Husain et al. 2021, 1–14). A tendency to dismiss the existence of mental health problems was found among University students of ACE in the UK in the present study and it may partly stem from the historical legacy of slavery, Westernised religious and traditional spiritual beliefs of people of ACE, poor family support, stigma of mental illness and under-representation of mental health professionals of ACE. The beliefs about mental health issues as expressed by the UK University students of ACE in this study are largely potentially transferrable to those of people of ACE communities. The tendency of families of people of ACE with mental health problems to silence such problems may further hinder help-seeking for mental health problems. The small sample size warrants caution in drawing conclusions. Still, the involvement of families in mental health intervention, decolonising mental health by moving away from Eurocentric models of mental disorder and consulting with mental health professionals of ACE could remedy the failings of the Western models of mental disorder.

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