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"We don't need therapy - We have Jesus": An exploration of the impact of culture on perceptions of mental health and help-seeking behaviours.

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Abstract— **Previous studies have suggested that Black Caribbean (BC) and Black African (BA) individuals attach stigma to mental health (MH) (Shefer et al., 2012) and medical help-seeking behaviours (Campbell & Long, 2014). Additionally, Shefer et al. (2012) hinted that there may be differences between these two groups. This research thus set out to explore whether BC and BA individuals differ in their perceptions of MH and the type of help seeking behaviours they would utilise, if required. N=67 participants completed a questionnaire concerning their perceptions of MH, their preferred help-seeking behaviours, and whether their cultural and/or religious beliefs had an influence on these factors. A series of correlations and t-tests found that no significant differences existed between these two groups in these areas. However, interesting trends in participants' responses emerged, providing support for the impact of factors such as background beliefs on how individuals interact with healthcare professionals, in accordance with the postulations of Horne (2006).**

Keywords— Black African, Black Caribbean, Black Minority Ethnic (BME), Culture, Help-seeking, Mental Health, Perception.

INTRODUCTION

According to the World Health Organisation (WHO; 2018b), mental health (MH) is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity. The WHO (2018a) further highlights that MH is not as prevalent as one would hope. For example, within the United Kingdom (UK), MH problems persist, with these issues representing the largest single cause of disability (MIND, 2017). For instance, according to MIND (2017), 1 in 4 people within the UK will experience a MH problem each year. However, research within the UK also suggests that some populations are more prone to experience MH issues than others. Specifically, the Black Minority Ethnic (BME) community has been highlighted as the most likely to be diagnosed with MH problems, to experience a poor outcome from MH treatment and to disengage from mainstream MH services (Mental Health Foundation, 2018). Furthermore, within the BME community it has been found that people from African and Afro-Caribbean (AC) communities are more likely to be admitted to hospitals for mental illness (NHS, 2017).

Researchers have addressed the growing need to understand why this may be. For instance, according to Keating and Robertson (2004), and Conner et al. (2010), black individuals tend to disengage from mainstream MH services because they lack trust in healthcare professionals. In similar trend, Mclean et al. (2003) have linked this to members of the Black community having previous bad experiences within healthcare services, and believing that they are most likely to be forced into medication or face racial mistreatment. In line with this, Rabiee and Smith (2014) have identified the belief that MH services and healthcare professionals lack cultural sensitivity and an understanding of cultural perceptions of MH. Additional studies also highlight the negative perception of medical help-seeking and a lack of MH understanding within the black community (Shefer et al., 2012; Campbell & Long, 2014). These researchers found that individuals prefer to seek the most culturally accepted help-seeking method of prayer and/or developing a relationship with God (Conner et al., 2010). Engagement with MH services has thus emerged as a complex issue with a range of internal and external barriers being implicated.

Literature review

The literature review will begin by presenting the theoretical framework within which the study's analysis and findings will be interpreted. Previous studies will then be presented which support the theoretical framework, and suggest ways in which this framework can be extended. Following this, the study's research question and hypotheses will be presented which highlight how the proposed extension to the theoretical framework will be investigated.

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Theoretical framework

Horne's (2006) expansion of Leventhal et al.'s (1980) common sense model of self-regulation can give insight into the processes that impact perceptions of MH and help-seeking behaviours among the BC and BA populations. While this model has been used to understand adherence to medication among multiple populations (Horne, 2006), it is yet to be applied to understanding health inequalities and health behaviours within the Black community. Horne (2006) links the likelihood of engagement with medical services to three main factors: (1) individuals' concerns about the impact of the medication, (2) individuals' perceived need for the medication, and (3) individual differences (e.g. cultural beliefs).

Among these factors, concern and the perceived need have been highlighted as the most influential (Horne, 2006). Concern is influenced by background beliefs about medication, and need is influenced by perceptions of the illness (Horne, 2006). In line with Horne's arguments, therefore, these two factors may cause the lack of interaction with MH services among BC and BA individuals as follows: 1) low levels of concern may be present due to background beliefs about medication expressed as fear of medication (Campbell & Long, 2014) and previous bad experiences within healthcare services (Mclean et al., 2003); and, 2) low levels of treatment need may be present as a result of perceptions of illness such as its need to be handled by spiritual counsel (Conner et al., 2010; Islam et al., 2015) and emphases on the stigma associated with MH (Shefer et al., 2012).

Horne (2006) also implicates individual differences such as cultural beliefs. The impact of culture on interaction with MH services within these populations has been highlighted in the literature, supporting his arguments (Shefer et al., 2012; Campbell and Long, 2014). For instance, after accessing these services, research suggests that black individuals may feel that the MH services are not suited to their needs and disengage from treatment (Mental Health Foundation, 2018). Therefore, cultural beliefs also may be primordial. The implications of this are multifaceted. For instance, should culture have an impact, then any mental health approach must be cognizant of the role of culture in order to increase engagement within Black communities. However, within the literature, studies have mainly focused on African-American (AA), Afro-Caribbean (AC), Black Caribbean (BC), Black African (BA) and South Asian (SA) individuals, with little work comparing the impact of differences in culture between any of these groups. Such research is primordial in underlining the role culture plays in this pertinent area.

The literature review will explore this impact of culture. It will present studies which have examined perceptions of MH and MH services among these populations, specifically looking at evidence supporting: 1) interactions between culture and levels of concern (e.g. through previous bad experiences and fear of medication); 2) interactions between culture and levels of treatment need (e.g. perceptions of mental illness and stigma); as well as 3) the presence of cultural differences between BC and BA individuals. This will be done in an attempt to provide evidence of the effect of culture, as well as to highlight gaps in this research. Hence, the review will support the current study which argues that culture plays a more important role on perceptions of MH, and access to MH services, than has previously been identified.

Culture and previous bad experiences within healthcare services

Research has highlighted the impact of previous bad experiences within healthcare services as influencing interactions with MH services among black communities; here the role of culture has emerged. For instance, Mclean et al. (2003) carried out research using semi-structured interviews and focus groups to investigate AC's perspectives on MH treatment in the UK. They recruited 30 participants, who were either service users (SUs), lay individuals, members of voluntary organisations or professionals who worked within mainstream or community-based MH services. The researchers found that their AC participants reported that healthcare professionals were unable to understand their culture. They cited negative experiences within MH services, and had the expectation of racist mistreatment, and the over-prescription of drugs instead of being offered talking therapies. This highlights the role of various factors related to treatment concern (specifically beliefs about the type of service one will receive and a preference for talk therapy) on willingness to engage with healthcare services. However, further research suggests that these treatment concerns may be influenced by culture.

This emerged in research by Memon et al. (2016) who investigated the perceived barriers to accessing MH services among people from BME backgrounds. They used two focus groups, which consisted of 13 men and 13 women, living in Southeast England. Thematic analysis was performed and identified two broad themes about perceived barriers to accessing MH services. One of the main themes identified was cultural naivety and discrimination which affected the relationship between the SU and the health provider, suggesting a link between culture and treatment concern. The findings were shared across the male and female participants which emphasises the idea that these views were more culturally- than gender-determined. Therefore, the literature suggests that treatment concerns may interact with culture to exert its impact on perceptions of MH services, and help-seeking behaviours.

Culture and fear of medication

Studies highlight the impact of a fear of medication on the likelihood of accessing MH services among BC and BA individuals; however, here the role of culture has been largely ignored. For example, Keating and Robertson (2004) explored whether there was a 'circle of fear' which led to poorer access to treatment by BC and BA adults. The researchers conducted focus groups of professionals (n=45), relatives or carers (n=19), and SUs (n=29) from African, AC, BC and BA backgrounds in London. Relatives, carers and SUs were asked to discuss their experiences receiving care and treatment and their interactions with MH services. Professionals were asked about their experiences of working with Afro-Caribbean communities, their perceptions of the concern for these communities and levels of support they received to work with them.

Although not all the professional participants were Black, similar themes emerged across all groups: (1) the sources and content of fear (e.g. attitudes towards MH and MH diagnoses, perceptions of MH services and the use of professional power), and (2) the impact/consequences of fear (e.g. limited trust, delayed help-seeking and 'hiding' the illness). Researchers concluded that fear interrupts the interaction of BC and BA individuals with MH services, essentially stopping help-seeking behaviour. These results suggest that fear may be a particular factor within SUs from these communities, thus again highlighting the role played by treatment concern. However, the impact of culture on such treatment concern was not specifically explored. For instance, no details were obtained concerning the impact of cultural differences between these two groups. Therefore, research is needed to shed insight into the impact of culture in relation to treatment concerns such as fear of medication.

Culture and the belief that MH needs to be handled by spiritual counsel

Culturally-motivated beliefs concerning MH have also emerged as influencing the likelihood of accessing MH services among these populations. For instance, Conner et al. (2010) collected data from 42 African-Americans aged 55 and older, who self-identified as having a recent depressive episode. These researchers identified two main beliefs influencing help-seeking behaviours within this group: (1) that MH 'was a weakness' and (2) that MH professionals cannot be trusted. Among Black men there was an unwillingness to accept that they were depressed and this unwillingness influenced their avoidance of medical advice. Similarly, among the AA women, there was the idea of being a strong Black woman and the belief that seeking help for MH issues meant that one was weak and lacked faith in God. Despite this difference in reasoning, the findings highlighted that both genders tended to seek the most culturally accepted method, which consisted of prayer and developing a relationship with God, as a way of coping with their MH issues. However, it can be argued that confidence in these findings may be limited by the inclusion of individuals who self-identified as having a recent depressive episode. Depression negatively influences one's perceptions of their experiences (Beck, 1976), and thus may have biased participants' responses.

In line with this proposed interaction between culture and treatment need, though, similar findings also emerged in Mantavoni et al.'s (2016) study. Through semi-structured interviews, the researchers investigated help-seeking for mental illness in communities of African-descent in South London. Participants highlighted that the Church tended to be the 'first port of call' when someone experienced psychological distress; these church leaders lacked an understanding of MH issues, and thus would adopt a spiritual approach rather than referring the individual to MH professionals. Like Connor et al. (2010), these researchers identify the preference for culturally appropriate treatments for MH, thus implicating the interaction between culture and treatment need. However, they extend these findings to show the active involvement of multiple individuals in maintaining the selection of this culturally appropriate choice, from family members to spiritual leaders.

The prevalence of this impact of culture has also emerged in quantitative studies. For instance, Ward (2003) conducted an exploratory, cross-sectional survey design in USA where 272 AAs (aged 25 – 72) answered questions on their beliefs about mental illness, attitudes toward seeking MH services, and preferred coping behaviours. Like the two previous studies, Ward also found that individuals preferred culturally-motivated religious coping methods. Quantitative research allowed more information to be garnered concerning the similarities among the genders, and the complexities of their feelings concerning the use of MH services, thus extending previous findings. However, Ward and the previous studies cited failed to explore the differences between BC and BA individuals, limiting the insight given into the role of culture; therefore, future research is needed.

Cultural differences between BC and BA individuals

As shown above, within both these cultures, research highlights that treatment concern (e.g. bad previous experiences, fear of medication) and treatment need (e.g. preference for spiritual counsel) may influence engagement with MH services. However, differences have also emerged between these two groups, hinting that culture's influence may be even more pervasive. For instance, Shefer et al. (2012) found that BC participants in London, UK, were more critical of psychiatric services, suggesting that the quality of service received was more influential on their lack of help-seeking compared to BA participants. Within this study, a substantial proportion of BC SUs perceived their mental illness to be a 'disability', whereas none of the BA participants had this perception. The capacity of these BC individuals to acknowledge their mental illness may suggest that the pressure and stigma to hide or not identify as a person with mental illness and subsequent avoidance of psychiatric help-seeking, is a greater issue within the BA community than the BC community.

This is supported by the findings of Rabiee and Smith (2014). Among AC and BA SU's and carers in Birmingham (UK), they found that the BA participants in particular held the belief that psychiatric staff had limited knowledge or understanding of the supernatural causes that their cultures attached to certain mental illnesses. For instance, they stated that in some cases, their cultures held that MH issues were related to witchcraft, and so the necessary cure would be spiritual, not medical; however, staff were ignorant and dismissive of this reasoning. They identified this lack of knowledge and cultural sensitivity among healthcare staff as potentially socially excluding such BME individuals as themselves from MH services. The researchers also highlighted that recruiting AC participants was easier than recruiting BA participants, with the most frequent reason given from the latter group for not participating being ''There is no mental health problem in our community'' (p.127). These findings thus largely align with those of Shefer et al. (2012) who, as discussed above, also identified the presence of similar differences among BC and BA individuals concerning their openness to MH issues. Therefore, these studies hint that culture's influence is significant, and requires further investigation.

The current study

Findings have largely supported the framework of Horne (2006) which emphasises the importance of treatment concern and treatment need on an individual's adherence. For instance, research has shown the impact of factors such as negative past experiences (Mclean et al., 2003; Rabiee and Smith, 2014), fear of being over-prescribed with drugs (Mclean et al., 2003), and perceiving faith-based help-seeking as the culturally accepted method (Connor et al., 2010). This suggests that Horne's (2006) concepts can be used to understand the avoidance and/or disengagement with MH services among BC and BA individuals. However, further research suggests that Horne's framework underestimates the role played by culture. For example, studies have suggested that the role of the aforementioned factors may be the effect of culture. In addition, studies exploring BC and BA individuals separately have shown that cultural differences exist between these two groups, thus further emphasising the core role played by culture.

Furthermore, studies in this area have largely utilised qualitative methods such as focus groups and semi-structured interviews. By adopting these methods, in-depth information was elicited. Focus groups also increased the dependability of these findings, as when a solid foundation of trust is built, participants may then share and elaborate on their honest opinions (Denscombe, 2010). Similarly, semi-structured interviews decreased the possibility of social desirability, as participants may have felt able to discuss truthful experiences or opinions with the researcher (Denscombe, 2010). However, the emphasis on these methods suggest that the need may exist to apply the strengths of quantitative analysis, to more fully explore the impact of culture on perceptions of MH and help-seeking behaviours within these two communities.

These two gaps will therefore be addressed by the current research which aims to explore the question "How do Black Caribbean and Black African individuals perceive mental health and what type of help seeking behaviour would they utilise, if required" using a quantitative method. The study has the following hypotheses:

1) There will be significant differences between BC and BA individuals in terms of their help-seeking behaviour

2) There will be significant differences between BC and BA individuals in terms of their perceptions of MH

METHODOLOGY

Participants

The study consisted of 67 participants including 51% (n=34) BC and 49% (n=33) BA individuals. All participants were aged 18 or over. All participants were students. Participants were not asked to specify their gender, as in previous studies BC and BA individuals' perceptions of MH and help-seeking methods were consistent across genders (Memon et al., 2016). However, as the research aimed to explore the differences between BC and BA individuals, participants were required to select their ethnicity.

Materials

Question one required participants to state whether they identified as BC or BA. Question two of the measure was taken from the General Help-Seeking Questionnaire (GHSQ; Rickwood et al., 2005). This increases the internal reliability of the findings as the GHSQ is a flexible and sensitive measure of help-seeking intentions that can be applied to a range of contexts (Rickwood et al., 2005; Smith et al., 2008). The GHSQ was found to have good reliability, its Cronbach's alpha was 0.85 and the test–retest reliability assessed over a 3-week period was 0.92 (Takaoka, 2017). Therefore, to investigate possible help-seeking behaviours, participants were provided with several options for example: intimate partner, friend, family member, MH professionals, religious leader and an "I would not seek help from anyone" option. There was also an option to select other and provide an alternative response. Participants were asked to indicate how likely or unlikely using a 5-point Likert scale ranging from very unlikely (1) to very likely (5) they would be to seek help from these options if they were facing a personal or emotional problem.

Similarly, the remaining questions were influenced by existing knowledge on the topic area and the views presented by the Black community in previous research (e.g. Shefer et al., 2012; Memon et al., 2016). For example, participants were asked to select a reason from the five provided options to suggest why the BME community may not seek help from the General Practitioner (GP), such as being afraid of what they might find out. Here, the option of 'other' was also provided for participants to suggest an alternative reason if necessary. Additionally, to investigate perceptions of MH, participants were required to indicate how strongly they agreed or disagreed with five statements provided using a 5-point Likert scale ranging from strongly disagree (1) to strongly agree (5). For example, whether there is a stigma attached to MH within their culture, and if they considered MH to be a weakness. Deriving questions from previous findings enabled the questions asked to measure what the research was intended to measure (Denscombe, 2014). Objectivity was achieved as the researcher was neutral in the approach to the research, the process of data collection was fair (Denscombe, 2014) and the analysis of findings was carried out on SPSS, which is a reliable software. The findings were also checked by the dissertation supervisor to reduce human errors.

The research may not have high external validity due to having only 67 participants. However, although the findings of this research may not be generalisable to all BC and BA individuals, the questions asked participants about their real-life experiences, thus producing ecological validity. In addition, the internal validity was increased as participants were free to complete the measure privately and in their own time (outside of the researcher's presence), reducing social desirability bias. Overall, this meant that the findings could provide an insight into: 1) the perceptions of MH and help-seeking that these participants have and, 2) whether true differences exist between the BC and BA groups in these two areas.

Procedure

Participants were recruited using non-probability sampling techniques. Specifically, posters, and emails were

circulated around the De Montfort University campus, targeting student groups where BC and BA participants were most likely to be found. This included, for instance, the De Montfort University African Caribbean Society (ACS); and a student networking website called Campus Society. Individuals who met the criteria (of BC or BA origin and over 18-years of age), were invited to take part, and to encourage others within their social circles who also met the criteria to take part as well.

Data analytic plan. To analyse the results, independent t-tests were run to compare the means between BC and BA participants across how likely they were to seek help from the different individuals. Independent t-test were also conducted to see: (1) how likely or unlikely participants would be to use MH services if required and (2) whether participants agreed or disagreed with statements concerning their perception of MH and help-seeking behaviours and, the influence that their culture and/or religion may be having on these perceptions. A Chi Square test was conducted to explore the differences and/or similarities between BC and BA participants in terms of why they believe members of the BME community were less likely to seek help from a GP regarding any MH concerns.

RESULTS

As shown in Table 1, overall, both BC (M =4.13, SD = 1.01) and BA (M = 3.97, SD = 1.26) individuals were most likely to consult an intimate partner to discuss any emotional or personal problems. However, BC and BA participants differed in terms of who they would be least likely to discuss any personal or emotional problems with. BC participants (M=1.72, SD = 1.25) considered religious leaders to be their least likely choice, whereas BA participants (M= 2.00, SD = 1.11) considered their least likely choice to be MH professionals.

Table 1. *Table showing Means and Standard Deviations for options of who to seek help from.*

Option of who to seek help from*	Black Caribbean	Black African
Intimate partner*	M =4.13 SD = 1.01	M = 3.97 SD = 1.26
Friend*	M = 3.03 SD = 1.26	M = 3.34 SD = 1.13
Family member*	M = 3.00 SD = 1.34	M = 3.25 SD = 1.32
Mental health professional*	M = 2.41 SD = 1.27	M = 2.00 SD = 1.11
Religious leaders*	M = 1.72 SD = 1.25	M = 2.13 SD = 1.29
I would not seek help from anyone*	M = 2.72 SD = 1.37	M = 2.56 SD = 1.34

** Item taken from Question 1 of the General help-seeking questionnaire (GHSQ;* Rickwood et al., *2005)*

As shown in Table 2, overall, 38% (n=13) of BC participants and 24% (n=8) BA participants believed the BME community was less likely to seek help from the GP regarding any MH concerns as they may be afraid of being forced into medication. The second most selected reason chosen by BC participants was having a lack of trust in healthcare professionals (chosen by 18% of BC participants) whereas BA participants second most selected reason was being afraid of what they might find out (chosen by 21% of BA participants). However, "do not want others to find out" was selected the least by BC individuals as only 17% (n=4) selected this choice and "lack of trust in health professionals" was selected least by BA individuals with only 12% (n=4) selecting this option.

Table 2. *Table showing which options were selected the most across the ethnicities.*

Reason to not seek help from GP	Black Caribbean	Black African
Afraid of what they may find out*	5	7
Do not want to be forced into medication**	13	8
Do not want others to find out*	4	6
Lack of trust in health professionals***	6	4
Other	4	5

** Item adapted from Schefer et al. (2012)*

*** Item adapted from Mclean et al. (2003)*

****Item adapted from Connor et al.(2010)*

In terms of accessing MH services if they were recommended to them, both BC (M = 3.24, SD = 1.10) and BA (M = 3.12, SD = 1.17) participants were neither more nor less likely to use these services. Considering participants' perceptions of MH, both BC (M = 3.97, SD = 1.03), and BA (M = 3.82, SD = 1.21) participants agreed most with the statement: "There is a stigma attached to mental health within my culture". The statement with the least amount of agreement for both BC (M =1.74, SD= 0.93) and BA (M= 2.12, SD= 1.29) participants was: "Mental health is a sign of weakness''.

Help-seeking behaviour

Independent samples t-tests revealed no significant differences between BC and BA individuals on any of the options concerning places for seeking help: intimate partner ($t(64) = 0.54$, $p = .59$, $d = 0.15$), friend ($t(64) = -0.92$, $p = .36$, $d = 0.06$), family member ($t(64) = -0.49$, $p = .63$, $d = 0.15$), Mental Health professional ($t(64) = 0.14$, $p = .22$, $d = 0.35$), religious leaders ($t(64) = -0.44$, $p = .11$, $d = 0.12$) and not seeking help from anyone ($t(64) = 0.36$, $p = .72$, $d = 0.05$). Participants were also given the option to select 'other', and were required to state who this would be in the space provided. However, this option was removed from the analysis as although 10 participants selected 'other', participants did not state who this would be. Only one participant stated, 'work colleague' in the space provided.

A Chi Square test was performed to explore the difference between the responses of BC and BA participants concerning why they thought members of the BME community were less likely to seek help from their GP regarding any MH concerns. The findings were non-significant, X^2 (5, 67) = 2.62, $p = .76$, $V = 0.20$. In addition to these options, participants could select 'other', and provide an alternative reason. Four BC and five BA participants provided responses in the space provided (See Appendix). Both BC and BA provided similar responses: they were both able to deal with MH issues themselves or with family support; one BA participant also linked this to not wanting to waste professionals' time and another BA participant suggested not being patient enough to wait for an appointment.

However, differences also existed in these responses. A BA participant provided a response that considered the

influence of religion, faith and praying on improving MH. Similarly, another BA participant stated "Mental health is not perceived as a medical issue" (See Appendix). However, unlike the comments left by BA participants, BC participants highlighted the effect of previous negative experiences with professionals (See Appendix). A BC participant also indicated that MH was a 'white people issue' which indicates race as being a potential barrier to accessing MH services. Additionally, a BC participant discussed the idea of not being 'strong enough in the mind' to deal with or admit to having a MH issue, offering another potential explanation for avoidance of help-seeking behaviours (See Appendix). Five participants selected more than one option; these were removed from the analysis.

In terms of the likelihood of utilising MH services if they had been recommended, an independent samples t-test found that there were no significant differences between reported likelihood in BC (M = 3.24, SD = 1.10) and BA (M = 3.12, SD = 1.17) participants, t(65) = 0.412, p = .67, d = 0.07. Therefore, although both BC and BA participants would rather seek help from an intimate partner (Table 1) and do not want to be forced into medication (Table 2), most participants were neither more nor less likely to access MH services if they had been recommended.

Perceptions of the relationship between culture and MH issues

A series of independent samples t-tests were used to evaluate participants' scores on each of the statements regarding their perceptions of MH. None of these t-tests emerged with significant results (Table 3).

Table 3. *Table showing Means, Standard Deviations, t, p* and *d values for Question 5.*

Item	Items adapted from	BC	BA	T	P	*D*
"My view on mental health issues are influenced by my cultural and/or religious beliefs"	(Campbell and Long, 2014)	M = 3.09, SD = 1.24	M =3.06, SD= 1.44	0.08	.92	0.05
"Mental health is a sign of weakness"	(Conner et al., 2010)	M = 1.74, SD =0.93	M =2.12, SD = 1.29	-1.40	.167	0.28
"Mental health issues require the assistance of healthcare professionals"	(Anglin, 2006; Campbell et al., 2014; Rabiee and Smith, 2014)	M=3.62, SD=0.92	M=3.76, SD= 0.97	0.56	.580	0.09
"There is a stigma attached to mental health within my culture"	(Campbell et al., 2014; Mantavoni et al., 2016)	M=3.97, SD=1.03	M=3.82, SD =1.21	-0.61	.547	0.09
"Psychotic symptoms are a spiritual problem and require help from a religious leader"	(Conner et al., 2010)	M=2.00, SD=1.13	M=2.55, SD=1.35	-1.79	.078	0.43

DISCUSSION

This research project sought to extend Horne's framework by evaluating its application to perceptions of MH and help-seeking behaviour among BC and BA individuals. It specifically focused on exploring the extent to which cultural beliefs affect perceptions of MH, and help-seeking behaviours, comparing their effect to other factors put forth by Horne such as treatment concerns, and perceived need.

Culture, treatment concerns, and perceived need

The results suggested that BC and BA individuals were most likely to discuss concerns with an intimate partner, friend or family member. However, for BC participants a religious leader was their least likely option. Whereas BA participants were least likely to approach an MH professional, and a religious leader was their penultimate choice. This contradicts previous research as a reluctance to approach a religious leader emerged in both groups, whereas Mantavoni et al. (2016) found that communities of African-descent considered the Church to be the 'first port of call' when experiencing MH concerns. Notably, some of the participants in Mantanovi et al.'s study stated that pastors lacked an understanding of MH issues. In these cases, research (Cinnirella & Loewenthal, 1999; Campbell and Long, 2014) has shown that individuals may resort to prayer or aim to develop a relationship with God, therefore, the reliance on faith-based treatment nonetheless persists. This suggests that although there was a reluctance to seek out religious leaders within this sample, the reliance on spiritual counsel may still prevail, with for instance a focus on prayer. Evidence of this emerged in this study. Here, BA participants' free responses highlighted that they believed having faith and praying were effective in improving MH. This mirrors the key theme identified by Campbell and Long (2014) which stated: "you don't need a doctor it'll go away just pray". It therefore suggests a link between culture and the belief that MH needs to be handled by spiritual counsel, that may span across all BME communities as highlighted in previous research (Connor et al., 2010; Manatovi et al., 2016; Ward, 2003). This thus contradicts Horne to some degree as it suggests a link between culture and treatment concerns, however, this is limited as differences were not found between the two groups.

However, while these results thus seem to refute the hypotheses, further analysis in fact provides supporting evidence. As aforementioned, BA participants considered MH professionals to be their least likely option when discussing any personal or emotional problems. When this is considered alongside additional findings, interesting trends emerge. For instance, BA participants also believed that a "lack of trust in health professionals" had the least effect on BME individuals accessing MH services (Table 2). Collectively, this suggests that, for them, a lack of preference for MH professionals may

not be linked to a lack of trust in MH professionals. Instead, this lack of preference may be related to the finding that they may associate seeking MH services with being forced into medication and other factors such as not wanting others to find out, which was selected by 18% of BA participants – one of their most popular choices. Similarly, BC participants considered being forced into medication as one of the main deterring factors for accessing MH services. This perception that MH services will lead to the individual "being forced into medication" was consistently found by previous studies (Mclean et al., 2003; Conner et al., 2010). Not wanting others to find out was not a frequent choice among BC participants, thus suggesting the presence of differences based on culture.

Additional differences also emerged for the two groups on this measure, providing further support for the hypotheses. Unlike BA participants, among BC participants, a "lack of trust in health professionals" was the second most chosen option (chosen by 18% of BC participants). As such for these participants, this lack of trust may be a significant factor influencing their greater likelihood to discuss personal or emotional problems with an intimate partner. This thus suggests that the impact of culture on help-seeking behaviour may be far more pervasive than previously suggested in the literature. Here, interactions are hinted to exist between culture and treatment concerns but this link varies to some degree. For instance, it hints that this reasoning may be stronger among BC participants (e.g. lack of trust in health professionals) while among BA participants, perceived need (e.g. fear of not wanting others to find out) may be exerting a stronger impact.

This difference was further emphasised by participants' free responses. A BC participant suggested that mistrust existed frequently because of negative experiences with professionals. Whereas BA participants suggested that, due to the impact of fear stemming from the possibility that an illness may be diagnosed, they may not be brave enough to handle it. These findings support the hypotheses and mirror the results of Shefer et al. (2012). Specifically, although both BC and BA participants were reluctant to seek medical advice, their motivations for this behaviour differed. Like our current findings, within Shefer et al.'s study BC participants were more critical of psychiatric services, while BA participants highlighted a lack of understanding within their community.

Given these results, it was interesting to find that participants largely selected neutral in terms of their likelihood of accessing MH services. This could reflect the idea that participants may be open to utilising MH services as found by Ward (2013). However, they may feel reluctant to access these services due to the fear of racist mistreatment (Mclean et al., 2003) and the lack of cultural sensitivity within MH services (Rabiee & Smith, 2014). The reasons that emerged in this study include, as aforementioned, fear of being forced into medication, lack of trust in MH professionals, and a fear of what they may discover about themselves. These factors tie in with the contextual issues and background beliefs discussed by Horne (2006), who argued that quite often previous experiences, cultural beliefs and negative perceptions of prescribed medicines can influence the coping methods adopted in handling health issues. However, again it further extends Horne's arguments as cultural differences in these reasonings emerged.

Perceptions of the impact of culture on MH issues

When participants were directly asked about their beliefs concerning the impact of culture on MH issues, interesting trends again emerged. For instance, the mean scores for the statement "mental health is a sign of weakness" were similar between both BC and BA participants, and in both cases, the findings suggested that they were in disagreement with this claim. Contrary to this, Conner et al. (2010) found that participants often associated MH with being a sign of weakness which can suggest that an individual may lack faith in God. Therefore, unlike the current study, the literature seemed to suggest that MH was negatively perceived among black individuals. However, further analysis of the present data again revealed different trends: within the free responses, a BA participant emphasised the importance of having faith in God as "the Bible says that we should not worry about anything". This hints that participants may be aware of the biological causes of MH, and so do not believe that it is a sign of weakness, but this knowledge has been ineffective in overcoming their culturally-informed help-seeking behaviour.

This is further seen when considering the result that BC and BA participants both largely disagreed with the idea that psychotic symptoms were a spiritual problem and required the assistance of a religious leader. This again contradicts previous research which suggested that both BC and BA individuals often relate MH issues with witchcraft which requires a spiritual cure (Rabiee & Smith, 2014). In line with this, Campbell and Long (2014) also demonstrated that the Black community believed medication was not necessary, compared to the need for religion/religious practices. However, in another free response given by a BA participant, there is again a hint of understanding the biological nature of MH. For instance, this participant stated that they recognised MH as a medical issue. However, they did not engage with services solely because there were others more in need. In spite of this knowledge though evidence emerged of a reluctance to engage due to spiritual preferences. Therefore, this similarly suggests that culture still may be exerting an influence on help-seeking behaviours within these populations in spite of increased awareness.

While these similarities suggest that culture is exerting an influence, differences emerged between the two groups. This further highlighted this impact of culture, and also provided support for the hypotheses. Specifically, BC and BA participants agreed that MH issues require the assistance of healthcare professionals, however, higher levels of agreement emerged among BA participants, suggesting some cultural differences. These results mirror the findings of Shefer et al. (2012) and Campbell and Long (2014) where BC participants were found to be more critical of MH services and healthcare professionals. Therefore, they may place slightly less importance on their role in curing MH issues. However, this in no way meant that BA participants were less defined by cultural opinions. The prevalence of cultural views still emerged within this group: a higher proportion of BA participants also believed that the assistance of a religious leader was required. This suggests that

BA participants viewed seeking help from both as necessary and that their preferences may depend on the situation itself. Such arguments emerged in Rabiee and Smith's (2014) study where many participants considered the cure for MH issues to be spiritual in some cases, but in other cases it was deemed necessary to access professional services for medical treatment. However, as both BC and BA participants also agreed most strongly with the statement "There is a stigma attached to MH within my culture", the impact of cultural stigma, rather than cultural preferences, on informing these views requires further exploration. Considering that BC individuals are mostly affected by having a lack of trust in healthcare professionals, it may be particularly important for this community that a culturally competent workforce is created so that these services are more suited to their cultural needs.

Limitations

This research project has answered the research questions and the hypotheses of the study. However, as this was an undergraduate research project, there were limitations to the amount of detail that could be garnered to enable the deepest analysis of the research question. For instance, it may have been beneficial to ask participants to state if they or a person close to them have accessed MH services, as a difference may have emerged between participants who have accessed these services in comparison to those who have not and do not know of anyone who has.

Although the questionnaire was a useful data collection tool, the qualitative responses left by participants for question three, indicated that there may have been multiple opinions. Also, five participants selected multiple choices for question three despite being instructed to select one. This demonstrates a misunderstanding of instructions, which resulted in limited data as those responses could not be used. Therefore, in the future, participants could be asked to rank the suggested options in order of importance and have the choice to provide an alternative reason to maximise the information collected. However, the sample size in this project was larger than those in previous qualitative studies, which increases the generalisability of these findings.

Additionally, this could have been expanded upon if another method of data collection was used alongside this, such as a semi-structured interview. This would have allowed participants to complete this questionnaire, and thus collate quantitative data, alongside a semi-structed interview based on the same topic. Participants would have thus had the opportunity to develop the answers given on the questionnaire and elaborate on various points of interest (Denscombe, 2014).

Conclusions and Recommendations

Horne's (2006) model was applied to the BC and BA communities as these communities continue to be over-represented in mainstream MH services and have been identified as the most likely to disengage from these services (Mental Health Foundation, 2018). By understanding the applicability of this model within these two populations, healthcare providers would be able to identify the influence of possible contextual issues (e.g. cultural influences), background beliefs (e.g. negative perceptions of medication), and illness perceptions (e.g. considering MH to be something you do not discuss) on BC and BA individuals' perceptions of MH and medical help-seeking. What emerged, however, was the overarching influence of culture.

The results from this project therefore reinforce the importance of cultural competency within healthcare. Cultural competency refers to a system which understands the importance of social and cultural influences on health beliefs and behaviours, and is thus capable of providing care to patients with diverse values (Betancourt et al., 2002). This study has shown that both BC and BA participants to have a lack of trust in healthcare professionals, but this was most influential among BC participants. This has also been found in previous research, where this was linked to psychiatric staff having limited knowledge or understanding of the supernatural causes their culture attaches to certain mental illnesses (Rabiee & Smith, 2004). Considering that BC individuals are mostly affected by having a lack of trust in healthcare professionals. It may be particularly important to create a culturally competent workforce so that these services are suited to various cultural needs.

Lastly, previous research has suggested the Black community is less likely to be offered talking therapies (Conner et al., 2010). It could be argued that BC and BA individuals have therefore begun to associate MH services with being forced into medication (Mclean et al., 2003). This idea was demonstrated by this study, whereby both BC and BA participants highlighted a fear of being forced into medication as the most influential factor for not accessing MH services; however, for BA participants there was no parallel focus on a lack of trust in MH professionals, suggesting that for them this alignment of MH services with medication may be particularly influential. Therefore, future research could explore this, and adjustments can be made to ensure minorities are more frequently offered talking therapies as an option of treatment as opposed to just medication.

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APPENDIX

Question Three ''other'' responses.

Black Caribbean Participants

1. The black community has always been taught that mental health issues are only "white people issues." So they are looked on for wanting to get help and often have to suffer in silence.

2. Would probably try and deal with the issue myself and with support from family/friends.

3. I think the majority of black people that have grown up here often have had negative experiences with the professionals they encounter from school onwards. So there is a mistrust in any profession offering assistance/advice.

4. Personally, I think it's all of the above, some people don't want to admit to themselves that they have a problem/issue. And are not strong enough in the mind to approach it, so when people actually offer them help they get aggressive as it's all to much for them.

Black African Participants

1. We believe and have faith in God and rely on Him, having faith is free and does not require prescription. Evidence shows that having Faith and Praying improves mental health. As Bible says that we should not worry about anything, but in everything by prayer we need to let our request known to God… Phillipians 4:6-8. So, because of this we rather don't want to be told we have any form of illness. And the Bible which is our guide and plan on this earth contains so many helpful quotations regarding stress and faith.

2: Most of the times I feel as though it is an issue that is not worth wasting professional time on when there are people in more need , or it is something that I know I am capable of dealing with (granted my family and close ones are present).

3: Misinterpretation, lack of understanding.

4: Not being brave enough and feeling like I can handle things myself. Also getting an appointment from the GP takes time and I'm not a patient person.

5: Mental health is not perceived as a medical issue.