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Research Dossier

Including an investigation of Perceived Ethnic Discrimination, Shame
Related Beliefs and Emotional Well-Being of Black Africans Compared to
White British Adults

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Statement of Anonymity

All names and identifiable information in this portfolio have been changed to pseudonyms or omitted in order to maintain confidentiality and anonymity of the clients and the research participants.
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PREFACE

The Research Dossier consists of a literature review and two empirical studies. The three pieces of work are concerned with emotional well-being in people of African descent. My interest in this area stems from my professional experience, personal experience and passion for cultural psychology. The findings from the literature review highlights a significant gap in the literature on emotional problems in Black people and inspires reflection on the complex interplay between culture and human distress. The first research study involves an exploration of Nigerian peoples’ understanding of the term depression and provides a rich account of the way in which human distress is understood by some Nigerian people. To enhance my psychological understanding, I had a strong urge to investigate risk factors for emotional distress in some African people. This led to the second study in which I adopted a quantitative methodology to examine perceived ethnic discrimination, shame beliefs and emotional problems. By comparing self-report measures of African people to White British participants, I gained knowledge on issues related to cultural differences in shame beliefs towards emotional problems and experiences of ethnic discrimination. Developing knowledge and undertaking research in both quantitative and qualitative approaches has been enriching. I have been challenged to think about my own practice and the ways in which counselling psychologists could be a vehicle for change within the social justice agenda.
INTRODUCTION TO THE RESEARCH DOSSIER

The dossier opens with a literature review exploring depression in Black African and Caribbean adults in the UK and highlights the dearth in the literature on Black people and emotional well-being. Following this review, my first study employing a qualitative methodology uses thematic analysis to explore Nigerian peoples’ understanding of the term depression. The second study addresses issues related to shame, discrimination, and emotional well-being in Black African and employs a quantitative methodology. Implications of the findings for counselling psychologists are discussed and directions for future work are suggested in both studies. The studies are written according to the guidelines of the Journal of Counseling Psychology.
Depression in Black African and Caribbean Adults in the UK: A Literature Review

Abstract

This literature review examined and summarised existing studies on depression and Black African and Caribbean people living in the UK. It addresses prevalence rates and explores the way in which depression is conceptualised, experienced and treated within this population. The review also highlights some of the challenges faced by Black people in accessing mainstream service. Review findings highlight cultural influences and spiritual beliefs in explaining and coping with depression. The implications for counselling psychologists and future research are also discussed.

Key words: Black African, Black Caribbean, culture, depression, perception, help seeking
Depression in Black African and Caribbean Adults in the UK: A Literature Review

Introduction

It is widely recognised that Black\(^1\) people have a long history of inequality and disadvantage as a result of racism and discrimination (Modood et al., 1997). While there is overwhelming literature on schizophrenia and psychosis acknowledging vulnerability factors and its effects on mental well-being (Sproston & Nazroo, 2002) other forms of human distress, such as depression, have been overlooked and little is known. Without this information, Bhugra et al. (1997) highlights the risks of pathologising or under-diagnosing the emotional concerns of Black people. This seems more likely to occur especially if individual phenomenology is not embraced. Depression, in this review is understood as a form of human distress, although it is recognised that the medical model of depression, as delineated by the Diagnostic and Statistical Manual of Mental Disorders (DSM-5, American Psychiatric Association, 2013) sets out a criterion for what constitutes clinical depression (otherwise known as major depressive disorder/episode). In DSM-5, depression is characterised by persistent depressed mood that occurs together with 5 out of 9 physical or psychological indicators, such as, decreased interest or pleasure, feelings of worthlessness, fatigue/ loss of energy, poor sleep, impaired concentration and impairment in day-to-day functioning, for at least two weeks.

The objective of the current paper is to review the literature on depression with Black African and Caribbean people in the UK. A brief summary and evaluation of each of these studies will be outlined. This will be followed by a more thorough critique of various empirical and practical issues in the literature. Finally, implications of the findings for clinical practice and future avenues of research will be discussed.

\(^1\) Consistent with current publications from the Department of Health, the term ‘Black’ is used to include individuals of African, and African-Caribbean descent. However, it is recognised that in using this terminology, the groups become over simplified and homogeneity within groups is implied (Osborne & Feit, 1992).
Literature search strategy

Relevant literature was identified from the following electronic databases: PsychINFO, PsychArticles, Web of Science, MEDLINE, Ovid, and Cochrane Database of Systematic Reviews from 1940 to 2016. Search terms were checked in each database and included: (a) African, Caribbean, Africa-Caribbean, Black, culture, ethnicity and (b) depression or/and anxiety, (c) coping or help seeking and (d) UK/United Kingdom, England, Britain, as either subject heading words or title/abstract words. Literature was also identified from reference lists of relevant articles, the Department of Health and voluntary sector organisation websites. Conceptual papers, book chapters and review papers were also sourced. Two articles were identified through this strategy. Only UK literature were reviewed and included in this review. A total of twenty-three studies were included in the review. Six quantitative studies measuring rates of depression were identified. Seven qualitative studies exploring causal explanations of depression were located and ten studies addressed barriers to seeking help.

Prevalence of depression among Black people

There are presently mixed findings regarding prevalence rates of depression in Black people. Shaw et al. (1999) conducted a survey examining the prevalence of affective disorders (i.e. anxiety and depression) in Black Caribbean’s (71% born abroad) and White Europeans (62% born in Ireland). Based on a sample of 612 people (337 Black Caribbean’s and 275 White Europeans) the 12-item General Health Questionnaire (GHQ; Goldberg, 1992) and a standardised clinical assessment in neuropsychiatry (World Health Organisation, 1992) was used to screen for anxiety, depression and severity of mental health. The authors found that in comparison to anxiety, depression was significantly more common in Black Caribbean women than White Europeans. A similar finding was indicated in another population based study by Nazroo (1997) in which rates of depression for Black Caribbean’s were higher than those for White British participants. In one of the only six studies in this review to examine prevalence rates, Weich et al. (2004) compared rates of depression across prevalence of depression across a range of ethnic groups (i.e. White, Irish, Black Caribbean, Bangladeshi, Indian and Pakistani) living in England. Using the CIS-R, Weich et al. (2004) reported no evidence of high rates of depression among Black Caribbean participants. Williams et al. (2007) and O’Connor and Nazroo (2002) also reported that rates of depression were lower among the older adult Caribbean participants in their study. While prevalence studies have
been useful in determining ethnic variation in depression, a limitation of the cross sectional nature of the studies is that rates of depression are likely to be hampered by confounding factors, such as acculturation, age and social economic status of participants. In particular, Shaw et al. (1999) study failed to accurately define their two samples so it is unclear how representative the Black Caribbean sample is given that the proportion of Caribbean born participants were high. Methodological and sampling bias might also hamper findings on prevalence. For example, all data presented above are cross-sectional in design, and it is not possible to identify causal associations among the factors examined. In addition, the screening instrument used in Nazroo (1997) study was limited by the use of an abbreviated two-stage assessment procedure in which a number of questions were omitted from the CIS-R; therefore, making direct comparisons with other studies difficult. Assessments of depression were based on self-reports and the extent to which cultural factors could affect the willingness of participants to either admit or recall the presence of ‘symptoms’ is unknown. Piccinelli, Homen and Tansella (1997) also note that the lack of specificity in defining depression, variability in criteria and inconsistency in diagnostic procedures may also affect findings on prevalence. Consequently, this means that rates of depression could be under- or over-estimated in such groups by giving insufficient weight to certain items. It is noteworthy to mention that the studies above all focused on Black Caribbean’s and to date, there are no studies indicating prevalence rates in a UK African sample.

Conceptualisation and causal explanation of depression among Black people

Studies investigating cross-cultural research on depression often involve examining whether Western-defined depressive symptoms are recognised in a different cultural context (Jorm et al., 2005) and takes the position that depression is similar to medical conditions and has a clear aetiology, leading to a specific set of symptoms. However, this poses considerable challenge as depression, like other forms of human distress, is distinctly different from physical or medical conditions, especially as cultural factors have been implicated in shaping the presentation, course and outcome (Ryder, Ban & Chentsova-Dutton, 2011; Samaan, 2000). Fernando (1990) argues that the presentation and reporting of human distress is culturally grounded meaning that distress in one culture may not be viewed as such in another. Conversely, culturally sanctioned and acceptable distress within a cultural group may attract pathological explanations from professionals. Moreover, Bhui and Bhugra (2001) point out that the lack of linguistic equivalents for depression may result in conceptual
differences within and between cultures. For example, the word depression has no direct translation in some African and Caribbean languages. Baker et al. (1995), in their study found that ‘sad’ or ‘unhappy’ were rarely used by older Caribbean participants. References to being low-spirited were found to be more common as participants considered depression to be a natural occurrence. Lawrence et al. (2006a) explored differences in the conceptualisation of depression held by Black Caribbean (n=32) South Asian (n=33) and White British (n=45) older adults. Having been presented with a vignette and a semi structured interview they found that Black Caribbean’s and South Asians participants frequently defined depression in terms of worry; emphasising “troubles in the mind”. However, Black Caribbean’s, in particular, increasingly described depression as ‘feeling down’. There were also reports among Black Caribbean’s and south Asians that depression stemmed from a weakness or deficiency in character and has a profound effect on a person’s ability to live their life. In comparison to White British older adults, depression and sadness or grief did not represent distinct conditions of depression among Black Caribbean and South Asians. In a cross sectional survey, Brown et al. (2011) studied perceptions of depression and help seeking among Black women (n=74) and White British (n=72) women with previous experience of depression. The authors compared perceptions of depression through the use of a case vignette, the Brief Illness Perception Questionnaire (BIPQ; Morris-Morris et al., 2002), and the GHQ (Goldberg, 1972). Brown et al. (2011) found that Black women were significantly more distressed on the GHQ and held strong beliefs that depression was socially rather than medically caused. Ethnic differences in perception of depression between the two groups on 5 dimensions on the BIPQ were also found. Black women were more likely to view depression as less serious consequences on their lives, to be associated with fewer symptoms, to be less chronic and less amenable to treatment. This is consistent with previous work by Mallet et al. (1994) and Marwaha and Livingston, 2002). These findings are of significance as it suggests that ‘normality’ is viewed differently depending on the cultural context and that depression is viewed within the realm of normality.

To access beliefs about human distress, Weiss (1997) devised the explanatory model interview where personal and social meaning of distress is acknowledged to be influenced by the individual’s cultural background and personality. The model focuses on five dimensions of beliefs (i.e. identity, consequences, causes, timeline and control, or cure). In an exploratory study by Lavender, Khondoker and Jones (2006) in which case vignettes of depressed individuals and semi-structured interviews were used to elicit explanatory models
of depression among three ethnic groups: Black African’s (n=20), Bangladeshi (n=20) and White British (n=20) aged 18-80, it was found that participants’ understanding of depression varied substantially between the three groups. African people, in particular, did not generally regard depression as an illness. They were more likely to perceive depression to be caused by spiritualism or curses compared to Bangladeshi and White British participants. Disintegration of friendships/partnerships, ensuing isolation and anguish were equally reported by African people as a cause of depression. In a similar study, Bhui, Rudell and Priebe (2006) also found similar results. Bhui et al. (2006) found among their sample of Bangladeshi (n=79) Black Caribbean (85) and White British (n=97) adults, Black Caribbean and Bangladeshi participants were more likely to give spiritual causal explanations for their distress and to prefer complementary treatments. Black Caribbean participants with medical causal explanations were also more likely to seek nonmedical treatments.

Help seeking and Barriers to accessing services

It is well documented that Black people report negative and unequal experiences of care from NHS services (Keating et al., 2001; Wilson, 2003). Goldberg and Huxley (1980) developed a pathway-to-care model suggesting that many people with mental health difficulties in the community do not come into contact with mental health services. They describe a process that determines whether people access specialist care. In this model, help seeking is said to consist of five levels (from the community to the hospital). Goldberg and Huxley (1980; 1992) suggest that access to different levels of mental health services depends not only on the severity of individual’s symptoms but also on responses at a number of filters. They argue that the onset of perceived disturbance is identified initially within the community and it is the responsibility of the individual and their carers to first recognise that the symptoms are distressing. In doing so, potential sources of help are identified. In most cases, the individual is likely to be seen by a GP, whose response may include: not perceiving any real difficulties; detecting a difficulty; and/or offering some form of intervention. Goldberg and Huxley (1980, 1992) highlight the central role of GP’s in mental health care, viewing them as ‘gatekeepers’ through whom patients must pass in order to gain access to mental health services. However, the limitations of this model to Black people has been indicated by several studies, including those which have evidenced that Black people are more likely to enter the coercive end of the mental health system (Watters, 1996). Studies on pathways to, through and out of mental health care have shown that Black people are more likely to be offered medication.
instead of talking therapies if mental health needs were detected (Fernando, 2003; Littlewood, 2000; Tuckwell, 2003). Littlewood (2000) found that this was more likely to occur when professionals hold the beliefs that therapy is not appropriate for minority groups because of a supposed ‘lack of verbal facility’ (p6) or ability to understand and work through their problems. Bhui and Bhugra (2002) argue that cultural appraisal of human distress and preferred interventions by Black people may differ from those of their GPs, which would lead them to non-primary care pathways. This is a great concern as there are substantially disproportionate numbers of Black people who only present to services at times of crisis (The Sainsbury Centre for Mental Health, 2006).

Studies investigating satisfaction in primary care services in ethnic minority groups have found that Black African women consulted their GP less frequently than other women. In addition, the authors found that Black participants were less satisfied with the consultation (Bhugra, Harding & Lippett, 2004; Lloyd & St Louis, 1996). Commander, Dharan and Odell et al. (1997) identified considerable ethnic differences in their study, with Black participant’s having poor level of case recognition of emotional problems in primary care services. Maginn et al. (2004) found that the strongest predictor of detection of depression was a patient’s decision to talk to their GP and that Black people were less likely to say they would discuss psychological problems with their GP and were more likely to find alternative ways of coping with depression. Brown et al (2011) sought to qualitatively examine reasons for Black women’s reluctance to consult their GP when distressed. The study confirmed that Black women were less likely to have sought formal help in the past for their depression. The frequency with which Black women cited anti-depressant beliefs as reasons for non-consultation was marginally greater than that of White participants. They also reported an unwillingness to take anti-depressant medication, which seemed to underpin their decision not to seek formal help from a GP. The authors also reported that some Black female participants identified GP consultation difficulties (i.e. lack of empathy from and poor relationship with their GP) as a deterrent to seeking professional help. In comparison to White female participants, Black women were more likely to seek help and support from religious communities. Marwaha and Livingston (2002) found that the Black Caribbean older adults in their study did not think it appropriate to consult a GP for depression. Many also viewed psychiatric services as inappropriate for depression and believed that they were primarily for psychosis and violence. Black Caribbean’s with no previous history of depression also recognised the importance of spiritual help.
Lazarus and Folkman’s (1984) transactional theory has been used as a framework to understand how individuals react to psychologically stressful situations. The theory focuses on stress (a relationship between the person and environment that is appraised as exceeding available resources), appraisal (one’s perception and assessment of the situation), and coping (effortful or purposeful thoughts and actions to manage or overcome stressful situations). Janoff-Bulman et al. (1983) proposed that individuals with high internal locus of control are more motivated to seek help than those with a low sense of personal control. For these individuals, the belief that they maintain influence over events is instrumental in gaining some control over their lives. In a study conducted by Shaw et al. (1999) on help seeking behaviour in Black Caribbean’s (n=92) and White Europeans (n=62) they identified that Black Caribbean’s were more likely to utilise self-treatment or herbal remedies as a source of non-medical help. Black Caribbean’s were also more likely to seek counsel from the church, in comparison to their White counterparts. Eighty six per cent of Black Caribbean’s sought no medical help specifically for psychological problems, expressing the view that doctors would not be helpful for such problems because: "the doctor can't help with this sort of problem". Similar findings were also found in a qualitative study conducted by Lawrence et al. (2006b). The authors explored older adults’ attitudes and beliefs towards coping with depression and the extent to which beliefs may facilitate or deter older people from accessing treatment. In depth interviews were conducted with all participants and data was analysed using grounded theory (Glaser & Strauss, 1967). Three broad categories (self-help, social support, health care) were identified. Self-help was identified as a category with all groups reporting that the responsibility for combating depression was primarily an internal and personal responsibility (i.e. using cognitive or distraction techniques) with external support considered secondary. Social Support was another broad theme considered by many participants as an important source of help. Great importance was attached to the value of social interaction with friends and those that attended day centres valued the opportunity to meet people. In addition, a large proportion of the Black Caribbean’s reported conversing with God through prayer as an effective means of overcoming depression. Prayer was described as an effective way of communicating with God, in a direct and informal manner, as they would with a friend in the physical world. They reported that they considered religion to be integral to overcoming depression, with some asserting that the absence of a relationship with God, accentuated by a lack of faith, prolonged depression. The final theme related to health care and resulted in differing expectations of the GP’s role within the three
groups. Reservations about seeking help from GPs were similar across the ethnic groups with many stating that doctors were too busy and were overly reliant on medication as a form of treatment. There was a strong belief in the benefits of counselling and psychotherapy for those experiencing depression. Psychiatrists were generally regarded negatively with some participants expressing concerns around stigma related diagnosis. Lawrence et al. (2006) findings are consistent with related studies that have shown that family, friends and religious leaders are identified as important source of help among Black people (Lavender, Khondoker and Jones, 2006). Particular emphasis was placed on the individual to combat depression, yet many still had a desire to discuss psycho-social problems with a counsellor. Cinnirella and Loewenthal (1999) suggest that some African Caribbeans’ greater awareness of stigma associated with seeking help for mental health problems might lead to a preference for private coping strategies such as prayer, and other religious practices which have been identified as important ways of coping among Black people. However, it is plausible that seeking informal or formal help as opposed to relying on one’s faith could equally lead to an increase in stigma as it could suggest that the individual is lacking in faith.

Keating (2007) argues that the ‘circle of fear’ which results from Black people’s perceptions and experience of unfair and unequal treatment in mental health service has generated deeply entrenched mistrust resulting in powerful barriers to accessing care and treatment. Some communities may attach considerable stigma to mental health problems such that members of those communities are reluctant to attend mental health service. While a diagnosis of a mental health problem is likely to have stigmatizing effects, it is equally likely to underpin the decision not to seek help for depression. According to Dow and Woolley (2010) family and cultural scripts related discussing problems outside one’s family can be paradoxical can limit access to services due to shame and stigma and may potentially overburden the family, resulting in potentially higher distress in individuals.

The appropriateness of psychological therapies, developed from predominantly European models of thought (Cochran & Sashidharan, 1996) cannot be assumed for people from other cultural backgrounds, given cultural relativism in the conception, experience and treatment of mental health (Kleinmann, 1997). Research has shown that many western models of depression do not apply particularly well to Black people and do not allow for the culture specific issues that affect this group. However, a critique of psychological models is that little attention is given to the stressors experienced by Black people and does not specifically consider the psychological meaning and significance of race and culture (Harris,
Consequently, Black people are likely to experience a higher proportion of misdiagnosis and inappropriate service, resulting in some people believing that intervention is ineffective and delaying intervention.

Some theorists (e.g. Nobles, 1980) have argued a need for a cultural specific model that takes into consideration the stressors of Black people. They propose an Africentric perspective that takes into consideration “the worldview of people of African descent” and consists of the values, beliefs, and behavior of people of African heritage (Belgrave & Allison, 2006, p. 28). Constantine, Gainor, Ahluwalia and Berkel (2003) identified the following dimensions of an Africentric worldview: communalism (i.e., emphasising the importance of human relationships and the interrelatedness of people), collectivism (i.e., placing priority on group goals instead of individual or personal ones based on family and ethnic group norms) and balance (i.e. balance between one’s mental, physical, and spiritual states). Neblett, Hammond, Seaton and Townsend (2010) propose a protective function of an Africentric worldview in the context of Black people experiencing depression and psychological ill health. Consistent with an Africentric cultural orientation, family members, close friends, and trusted community members are viewed as primary resources of assistance before turning to formal mental health systems to cope with distress (Utsey et al., 2000; Constantine, Myers, Kindaichi, & Moore, 2004). Related to this is the stigma of mental illness, along with feelings of shame and embarrassment associated with having psychological concern (Snowden, 2001).

**Summary**

The studies highlight the importance of examining personal models of depression. Although research suggest that African and Caribbean languages do not have words that are directly equivalent to the English word depression, many participants understood the concept of depression but were not predisposed toward medical models of explanation. This suggests that depression does exist; however it is likely that the subjective experience of depression and its representation may differ between cultures. The personal and spiritual attributions to depression could also explain the rates of stigma reported in these communities (Rack, 1982), although Brown et al., (2011) showed no differences in stigma between ethnic groups.
Limitations

While the study has highlighted important areas about ethnicity and mental health, it is important to recognise some of the limitations of the review. For example, most of the studies described did not use validated measures to assess rates of depression in ethnic groups and no consideration has been given to the impact on depression of multiple demographic factors (i.e. class, education and occupation). In omitting these factors, the studies treat depression as being isolated from the individual’s life experiences (Brown & Harris, 1978). Therefore, the applicability of these findings to other Black groups living in the UK remains uncertain (Wilson, 2001). Additionally, the cross sectional nature of some studies limits interpretation of the results, as causal inferences cannot be made. The studies are also limited through a biased sample. In the majority of cases, there were a disproportionate number of Black Caribbean older adults and as such, results may not generalise beyond this group. Little information still remains on the extent to which men in Black communities experience depression. Place of birth was also deemed relevant in the studies as some participants migrated to the UK from Africa and the Caribbean. It is not known whether, health beliefs, and patterns of health seeking behaviour of Black people born in the United Kingdom are likely to differ from those born outside the UK. Finally, qualitative studies on perceptions of depression and methods of coping have been insightful; however, the use of case vignettes has its limitations as responses to vignettes do not always mirror the reality of people’s experiences, which could increase social desirability in some participants (Hughes & Huby, 2001).

Implications for counselling psychologists

Fundamental to the profession of counselling psychology is the idea that we reside in a social context that gives meaning to experience (Milton, Craven & Coyle, 2010). The studies have shown the complex ways in which depression is conceptualised and treated among Black people. Counselling psychology’s critique of the medical model and the notion of psychopathology means that they are uniquely placed to understand distress as difficulties in living, rather than an illness (Deurzen & Arnold-Baker, 2005). Therefore, working from a pluralistic framework that welcomes client’s epistemologies would be essential when working with this client group. It may be useful to engage in a therapeutic dialogue, eliciting perspectives on depression and perhaps working from a social or Afrocentric perspective.
This would involve a counselling psychologists having greater sensitivity to the behaviours, perceptions, and the language of depression being used by Black African and Caribbean people. The development of a culturally sensitive intervention would be needed. An explanatory model approach could also be helpful to explore the person’s own notions about their illness and may involve some motivational interviewing. Non-specialised settings or accessible community based services might also be helpful in engaging Black people. There is increasing interest among professionals over whether there are more suitable approaches of therapy for patients of particular ethnic or cultural backgrounds (Tseng, 2004). Explorative studies from the review suggest that Black people tend to adopt a social-cultural model as opposed to a medical model of depression.

However, Rack (1982) contends that information gathering in the early stages of therapy with minority groups might be experienced as intrusive, given the perceptions that some Black people might have about White institutions. Hussain and Cochrane (2004) believe that this might lead some professionals to avoid routine questions to avoid causing offence. However, in avoiding such questions, psychologists are at risk of making a number of assumptions about a person and their culture, which restricts any exploration of alternative explanations with the client. Given the importance of faith and spirituality amongst participants it may be important for health professionals and spiritual clergy to engage in a mutual exchange of information to increase access to professional care among Black people. Malik (1998) suggests that one reason for the involvement with religious leaders is that they are part of the ‘community’, with shared belief systems and world view. The use of education about depression could potentially include the destigmatisation of depression as evidence from the review suggests that this is a concern for some people. In doing so, this could potentially increase rates of reporting depression. It is also important that strategies of delivery be suited to local communities. Gray (1999) has argued that the voluntary sector is the most appropriate and least stigmatising source of help for Black people, but the voluntary sector rarely figures in the strategic development of mental health services for Black people in the UK. The inclusion of the voluntary sector, together with health promotion, could be more effective in meeting the needs of Black people. Hussain and Cochrane (2004) highlight the possible divide that might occur amongst processonals. They note that some professionals might adopt a colour blind approach and assume that on a physical and emotional level, all cultures are the same. However, Cochrane and Sahidharan (1996) argue that this approach only dismisses the impact of culture and religious perceptions of mental
health, allowing only for dominant western explanations. The possibility that some professionals would dismiss or marginalise the impact of cultural perspective is very problematic as the above review highlights the importance of understanding cultural perspectives.

**Future Research**

There were no studies that adopted longitudinal or prospective designs. Such designs could potentially be helpful in establishing the relationship between coping strategies and levels of depression over time. Further research that explores culture specific antecedents to help seeking might also be useful in developing a better understanding of the nature of the kind of help that Black people expect to receive from both formal and informal support systems. It would also be helpful to think about interventions based on the coping styles utilised by Black people and about the most effective combinations of treatment strategies.

**Conclusion**

The limited research in this population suggest that there are inconsistent findings on prevalence rates of depression among Black people, although this might be related to a number of factors, such as methodological problems. The review highlights that cultural factors in the construction and management of depression suggest the inappropriateness of western models of diagnosis, management of depression and that alternative methods of coping are more commonly used than professional help seeking. Whilst it is important to consider cultural factors in emotional disorders, Helman (2000) warns of the danger of over-emphasising culture and missing the psychopathology. Findings from the reviewed studies suggests that the way in which people cope with depression may be related to their personal attribute and perceptions of depression and personal preference for informal ways of coping and seeking help. Therefore, the review underlines a need to develop a psychosocial response to depression in order for mental health services to be acceptable to those that would like help.
References


Disparities in health and underutilisation of mental health services among people of African descent have been the subject of numerous debates in the UK and the United States. Several explanations have been proposed for this phenomenon. However, there are increasing concerns about unmet needs among the growing Black African population in the UK. This study aimed to explore how the Nigerian community understand the term depression and what some people do when faced with what is regarded as a mental health problem. Semi-structured interviews were conducted with 7 Nigerian adults living in the UK. The transcribed interviews were analysed using thematic analysis. Several important findings emerged. Firstly, participants were familiar with the concept of depression, and viewed depression to be caused by adverse social conditions. Secondly, participants described three cultural influences (i.e. cultural adaptation, cultural beliefs and religious/spiritual beliefs) that shaped their understanding of depression. Thirdly, participants highlighted methods of seeking help for depression. The implications of these findings are discussed.

Keywords: Nigerian, depression, distress, culture, help seeking
Understanding depression: A qualitative study of Nigerian peoples’ views

Introduction
Much literature exists about depression and progress has been made on researching the general public’s view of depression in the UK. However, there is little empirical evidence detailing views of depression in minority ethnic populations and Black Africans living in the UK. Studies on minority ethnic groups in both western and non-western cultures indicate they have very little knowledge of mental health and do not generally share the same opinions as health professionals or the dominant medical discourse about depression (e.g. Jorm et al., 2005, Lauber et al., 2003; Suhail, 2005, Hillert et al., 1999). While western conceptualisation of depression strongly emphasises an illness framework, a handful of studies focusing primarily on African Americans in the United States (US) and Black Africans in Europe (e.g. Brown, et al., 2010; Kokanovic et al., 2008) suggests that people of African descent are less likely to recognise mood ‘symptoms’ as depression and are more likely to view depression to be situationally orientated, less problematic and not warranting intervention. Moreover, Black African immigrants living in the US are likely to create a language for depression rooted in their personal and cultural experiences (Black et al 2007; Lawerence et al., 2006) and are more likely to use informal services of care, such as spiritual/religious healing (Davis, 1998; Diala et al, 2000).

However, unlike US born African Americans, Black Africans in the UK and Europe have factors which are considerably different; making them more vulnerable to depression and psychological distress (Selten, Cantor-Graae, & Rena, 2007). Factors related to immigration status, cultural adaptation and acculturation (in addition to social and economic difficulties) all have the potential to differentially impact on well-being (Rivera, 2007). Certainly, the evidence suggests that people of African descent in the UK have the highest rate of access to hospital inpatient care and are more likely than their white counterparts to be considered in need of mental health treatment and care (Mind, 2013). The complex relationship between these factors and well-being means vicious circles develop, exacerbating existing health disparities among the growing presence of West Africans (i.e. Nigerians, Ghanaians, Sierra Leone, etc.) in the UK. Sadly, research on Black Africans (in the US and UK) is extremely limited and while Black Africans in the UK and US born
African Americans may share a common racial heritage, the differences stated above could influence the way in which depression is understood because there is a strong affiliation with cultural traditions and a greater orientation to people with the same cultural background among Black Africans (Jeroen, Knipscheer & Kleber, 2007). Moreover, studies based on African-Americans are largely limited to clinical samples and rarely directly examine conceptual understanding of depression (Karasz, 2005). To adequately explore how depression is understood within the ‘Black African’ ethnic category in the UK, this study seeks to use one ethnic minority group (namely, Nigerians) to uncover potential similarities and differences in understanding depression among a large heterogeneous group.

**Nigerians: An understudied group**

Nigeria is situated in the western part of Africa and is the most populous Black African nation (Mbabuike, 1997). Migration from Africa to the UK has been accelerating in the last 20 years, with Black Africans now being the majority group in Britain’s Black community as opposed to those who identify as Black Caribbean. This is significant because migration of Black Africans to the UK started later than that of Caribbean and South Asians. Specifically, Nigerian born British residents represent the largest ‘Black African and Caribbean’ group born outside the UK, with numbers continuously increasing. Contrasting with western cultures, Nigerians have their own traditional patterns of behaviour and cultural values.

Another feature of Nigerian culture is the fundamental importance of religion, culture and the African worldview (Burns & Radford, 2008). Like many countries within West Africa, Nigerian culture emphasise social hierarchies, value communism and cohesive family networks (Constantine, Gainor, Ahluwalia, & Berkel, 2003; Gushue & Constantine, 2003). Great emphasis is placed upon obedience, without questioning or asking for an explanation (Timyan, 1988). However, through cultural adaptation, Nigerian communities have acculturated to the majority culture and are often left balancing two cultures and systems. This distinct context undeniably has an impact on the conceptual representation of psychological distress as beliefs regarding mental health and help seeking are likely to be formed through a person’s experience in both their country of origin and adopted country (Sheikh & Furnham, 2000).

There is widespread stigmatisation of mental illness in the Nigerian community (Awaritefe, 1977; Boroffka & Olatawara, 1977; Cohen et al 2007). Negative attitudes to
mental health may be fuelled by fear and/or culturally specific notions of causation that suggests that individuals are in some way responsible (Gureje et al., 2005). For example, the aetiology of mental health is still largely ascribed to the supernatural, demonic possession and sorcery (Aina, 2004; Adebowale & Ogunlesi, 1999; Landrine & Khlonoff, 1994) which often results in discrimination, rejection, and social distance towards individuals experiencing distress (Adewuya & Makanjuola, 2008; Corrigan et al., 2001). Lavender, Khondoker and Jones (2006) examined beliefs about depression by comparing explanatory models among Nigerian, Bangladeshi and White British people accessing primary care services in the UK. Through case vignettes, the authors found that a religious framework, encompassing spiritualism and magic were dominant themes (in addition to family problems and lack of social support) among Nigerian participants. A diagnosis of depression had an adverse social consequence in all groups, with many Nigerians reporting a sense of shame following a diagnosis of depression. All participants had little identification with case vignettes and many Nigerians did not generally regard depression as an illness, in comparison to White British participants, who were likely to provide a medical model of depression. This was also confirmed in a similar study by Brown et al. (2010) who found that Black African women were more likely to perceive depression as socially caused and less likely to perceive depression as chronic, to have less serious consequences and less amenable to treatment. In the US, Sellers, Ward and Pate (2006) and Ezeobele et al. (2010) studies found that depression was identified as a major problem in the African immigrant community and participants perceived depression as carrying a stigma and leading to social isolation. Intervention strategies emphasised problem solving, herbal remedies and addressing contextual issues. Other studies have also documented the cultural specific methods of coping among Black Africans living in Africa (Abas & Broadhead, 1997; Okello & Ekblad, 2006).

Taken as a whole, a few studies have given the voice of Nigerian people to emerge, although research into Black Africans (in general) and well-being remain under researched. The literature suggests that many Nigerian peoples’ beliefs about depression places emphasis on religious and social causation as opposed to a biological causation. Helpful interventions are likely to be influenced by their understanding of depression. However, the major drawbacks of the available research are that it has tended to cluster different African populations (which include Nigerians), mainly with women and has relied heavily on case vignettes. Although case vignettes are often seen as a convenient way to prompt discussion
and elicit people’s perceptions, beliefs and meanings about issues that maybe sensitive (Neale, 1999) there are some limitations associated with this method. First, the method capitalises on communication between research participants in the generation of data (Kitzingger, 1995) which means stories about individuals, situations and structures do not always mirror the reality of people’s experiences (Hughes & Huby, 2001). Therefore, this study employs semi-structured interviews to understand Nigerian peoples’ frame of reference and to provide insight into important dimensions underlying cultural models of depression.

**Research aims**

The impetus for this study was therefore derived to address the empirical gap and add to an incipient body of knowledge around depression among Nigerian people living in the UK by conducting a qualitative study. It is particularly important to examine the understanding of the public who may never encounter psychology services and who may or may not have been presented with depression. Specifically, Nigerian people form a focus of this study because they have been reported to have higher rates of unmet need. Yet, very limited research on the mental health of this population exists. The question of why the Nigerian community have greater levels of distress within the UK is an issue that is potentially of relevance, but which fall outside of the scope of this research. Therefore, the researcher feels that it is important to gain insight into Nigerian peoples’ understanding of depression as this could potentially contextualise the cultural factors pertinent to this group and thus build on existing findings from this population. This study is particularly relevant to counselling psychology because Counselling psychology traditionally starts from the position that human nature focuses on subjectivity, stressing an understanding and/or a relational view as opposed to the demonstration of truth. With the increase in diverse communities migrating to the UK, ethnicity will remain important for counselling psychologists for the foreseeable future. Another objective of this study is to inform psychologists understanding of culturally appropriate expressions of distress when providing therapy for members of this community and to discover new strategies to reduce barriers for Nigerians seeking support. The research question was framed as:

What is the understanding of the term ‘depression’ among some Nigerian people living in the UK?
This study employed a qualitative research design using semi-structured interviews. The data analysis adopted a critical realism (CR) perspective and used the method of Thematic Analysis (TA; Braun & Clarke, 2006). Qualitative research aims to place participants’ experiences and perceived or identified needs at the centre of knowledge and provide an opportunity to gain rich data of an under researched area (Borum, 2012). This section describes the underlying philosophical position and the methodological approach to the study.

**Epistemological position**

The qualitative framework that guided this investigation was CR (Bhaskar, 1989). CR presupposes an objective reality which exists independently of our thoughts (Sayer, 2001). For Bhaskar (1998) reality is complex and multi-layered. He asserts that our social world operates in a similar way to the natural world where a phenomenon can be explained in part by differentiated and stratified layers/structures. There is constantly an interplay between the social reality and complex filters of language, causal mechanisms and interpretations made by the individual (Houston, 2001). This means, for example, that an individual’s explanation of a phenomenon may be generated in part by inter-related beliefs, which could be shaped by broader social discourses that are likely to emerge from broader political, economic, and/or social structures. The CR position acknowledges the relation between structural and agential approaches, which places emphasis on the social worlds and organisations where individuals are embedded (Blumer, 1969; Snow, 2001). The aim of this study is consistent with a CR philosophy which applies an informed approach in recognising the reality of an individual’s understanding of a phenomenon, whilst acknowledging the historical, social and cultural context. Therefore, a qualitative study of African people grounded in CR is advantageous as it can reveal the relationships between real causative powers (i.e. ethnicity) and real complex social relations. A key feature of CR is the rejection of “epistemic fallacy” Bhaskar, 1978. P36) suggesting that all knowledge is tentative and fallible (Scott, 2005). This reflects the need to accept that there are different valid perspectives on reality and one may need to abandon one’s own evidence in the face of countervailing evidence. Debates around depression have largely been guided by empiricism and social constructionism (Pease, 2010). However, the difference here is that CR allows the exploration of a unidirectional relationship between what an individual articulates and the feelings or experiences of the phenomenon,
Rationale for TA

Although the theoretical underpinnings of TA were driven by CR, TA was chosen as a preferred qualitative methodology because it is descriptive; involving minimal interpretation. In addition, through idiography TA can be used to generate themes of a relatively small homogeneous group with emphasis on detailing the perceptions and understanding of a small group of people rather than making general claims about the larger population, which also fits in with the intention of this study. Therefore, it was felt that TA was a more suitable approach for analysis than other qualitative analysis. For instance, discourse analysis was deemed less appropriate than TA because of its emphasis on the role of language in construing social realities, in contrast to focusing on individuals understanding of a phenomenon. TA was also favoured over IPA because IPA aims to provide a detailed exploration of the individuals lived experience, whilst being rooted in a phenomenological epistemology (Smith et al., 1999; Smith & Osborne, 2003). It was also favoured over grounded theory (Strauss & Corbin, 1990; 1996) which aims to generate theoretical explanations from the data. In contrast to the above methods, a positive of TA is that it is not attached to any pre-existing theoretical framework and can therefore be used within varied frameworks.

Method

Participants and recruitment

Purposeful sampling was conducted to identify 7 Nigerian adults from the general population living in South East England. Recruitment of participants was completed in three steps. Firstly, the researcher contacted libraries, local community centres, and small businesses to advertise the research (Appendix A) which detailed the purpose of the research and inclusion criteria. Eligible participants were English speaking men and women, aged over 18 years, originating from West Africa, without a diagnosis of depression and with no formal health qualification. It was decided to recruit adults without health qualification to maximise the
likelihood of sampling individuals who might not have knowledge of the predominant medical conceptualisation of depression. The researcher also attended meetings at local churches and mosques to discuss the research and identify potential participants. Secondly, participants that confirmed interest in the study either contacted the researcher directly or was contacted by the researcher and the researcher visited and briefed them about the nature and purpose of the study. Thirdly, the researcher conducted semi-structured interviews with participants at a convenient place (i.e. library, church or home). The seven participants (2 men and 5 women) ranged in age from 27-56 years old (Appendix B). One participant was British born and 6 had immigrated to the UK. These 6 participants varied in terms of length of stay in the UK, ranging from 11-28 years. Two were divorced, four were married and one identified as single. All participants, except one, were in full time employment. All participants had college or university education, and two had also completed a Master’s degree. Four out of the 7 participants were recruited from local churches.

**Ethical consideration**

Ethical approval was granted by the University of Surrey, Faculty of Arts and Human Science Ethics Committee (Appendix C). In line with the British Psychological Society (BPS) and the Health & Care Professionals Council code of ethics, the researcher followed recommended guidelines for the conduct of research (i.e. gaining informed consent, debriefing participants, minimising risks, etc.). Each participant gave verbal and written consent (Appendix D). Participants were informed that participation was confidential, anonymous and entirely voluntary. Participants were free to withdraw at any time. Interviews were audio recorded and transcribed by the researcher.

**Procedure**

Participants were given at least 24 hours to read and discuss the information sheet (Appendix E) before deciding whether to participate. Consent was sought prior to participating in the research. Consent forms were signed following verbal agreement. Semi-structured interviews were undertaken by the researcher in suitable locations (i.e. library, church or home) and lasted between 40-60 minutes. This method of data collection was chosen as it
allowed the researcher to gain descriptive information when little is known about a topic (Gerrish & Lacey, 2010). A series of open ended questions based on an interview schedule (Appendix F) were asked. The interview schedule was designed to address the main research question, with the intention of discussing three main areas (perception of depression, cultural beliefs/values and coping). The questions designed were open ended and non-directive. Interviews began with an explanation of the purpose of the study, establishing rapport and gathering demographic information. Questions and probing evolved as the data emerged. Preliminary notes, including nonverbal observations were completed following each interview. All participants were debriefed at the end of the interview (Appendix G).

**Credibility**

To guarantee the credibility of the research Guba and Lincoln (1989) highlights the importance of the researcher to have a sensitive awareness of the methodological literature about the self in conducting enquiry and interpreting data. The researcher independently coded the transcripts and compared them with those identified by the supervisor. During this validation process, slight alterations to the original identified themes were made. The researcher also kept a reflexive journal whilst conducting this study in order to record experiences and reflections. The use of supervision with peers and supervisor was also used as and when appropriate, to discuss reflections and any issues.

**Analytic Strategy**

Given the paucity of extant literature, the research was approached from an inductive systemic process, meaning that any themes identified were directly driven by the data and without pre-determined theories. While the epistemological underpinnings of TA were driven by CR, coding was completed using a clear process for inductive TA as recommended by Braun and Clark (2006) and is outlined below. The analysis of data started following the first interview (Appendix H) and continued as the data collection process developed (See Appendix I and J for themes, selected codes and supporting quotes).
Stage 1

The first stage in TA involves the researcher immersing themselves in the data. To do this, the researcher first listened to each audio recording and transcribed interviews verbatim.

Stage 2

The second stage involved repeatedly listening and reading (and re-reading) each transcript in order to become familiar with the dataset while simultaneously noting patterns or points of interest. This approach enabled the researcher to engage with the data by critically analysing and actively thinking about the meaning of the data.

Stage 3

During this stage, the researcher approached the hard-copy data through a process of complete coding. Complete coding involved systematically reading through the entire dataset and marking everything of interest that could potentially be relevant to the research question. This was approached by firstly coding small chunks of data extracts, line-by-line, in each transcript. Key words and statements were captured and a concise description of the researcher’s analytic perspective was created in order to generate data-derived codes. The researcher reviewed the entire dataset and collated all data excerpts and coded data as a way of ensuring that each code was distinct. The coded name and associated text were inputted and organised into tables in Microsoft Word.

Stage 4

This stage of the analysis involved a broader focus on developing provisional themes which “captured something important about the data in relation to the research question and represents some level of patterned response or meaning within the dataset” (Braun & Clarke, 2006, p.82). Through this process, the researcher was able to develop a number of themes with a central organising concept that unified the data extract. A visual thematic map was designed to visually explore the relationships (hierarchically and/or non-hierarchically)
between themes and helped to organise possible themes into subthemes and develop overarching themes. At this stage, no codes or possible themes were discarded.

Stage 5

This stage involved thoroughly reviewing and refining the overarching themes as to ensure it corresponds with the coded data and the dataset collected. The first step in this stage involved re-reading all the coded and collated data extracts, ensuring that the overarching themes captured the meaning of the data coherently and related to the research question. Secondly, the researcher revisited and re-read all un-coded transcripts to ensure that the overarching themes captured the meaning of the dataset. This phase enabled a recursive analytical process ensuring a coherent and distinctive meaning of the dataset.

Stage 6

During the final stage of analysis, the researcher clearly defined overarching themes and themes to addresses the research question. The researcher then began to select extracts and quotes needed to illustrate the different facets of each theme, thus providing a descriptive form of analysis.

Stage 7

The last stage involved writing and presenting a logically interconnected analysis, and where the researcher was able to draw conclusions from the whole analysis and relate it to the research question.

Findings

This study investigated the understanding of term depression in a small Nigerian sample living in the UK. The analysis uncovered three overarching themes as: (1) conceptualising depression (2) cultural influences and (3) seeking help for depression (see table below for
overarching and sub themes). The following descriptions are represented by participant’s quotes, whose names have been replaced with pseudonyms.

Table 1: Candidate themes

<table>
<thead>
<tr>
<th>Overarching Theme</th>
<th>Theme and sub-theme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conceptualising depression</td>
<td>1. Depression manifestation-Visibility and invisibility</td>
</tr>
<tr>
<td></td>
<td>2. Contextualising depression</td>
</tr>
<tr>
<td>Cultural influences</td>
<td>1. Cultural adaptation</td>
</tr>
<tr>
<td></td>
<td>2. Cultural beliefs</td>
</tr>
<tr>
<td></td>
<td>2.1 Religious/spiritual beliefs</td>
</tr>
<tr>
<td>Seeking help and responding to depression</td>
<td>1. Religious and spiritual support</td>
</tr>
<tr>
<td></td>
<td>2. Social and practical support.</td>
</tr>
<tr>
<td></td>
<td>3. Seeking professional help</td>
</tr>
<tr>
<td></td>
<td>4. Need for information/awareness</td>
</tr>
</tbody>
</table>

1. Overarching theme: Conceptualising depression

Conceptualising depression captures the complexity in defining the nature of depression and causal factors. Participants readily offered their views and described depression as ‘a state of mind’ where individuals become ‘confused’, ‘down’ and ‘helpless’. Descriptions of depression also included references to emotions and moods such as ‘feeling down’ and an
acknowledgement that ‘everyone is vulnerable’. For many, the interviews provided opportunities to discuss depression from the experiences of others or through the media. These examples were consistently underpinned by descriptions of depression either being a reasonable response to life events, although there was the awareness that depression had the potential to become ‘serious’ and could cause people to commit suicide. This was articulated in Neena’s interview: ‘First the d, d means down, press means a pressure, so you're pressed down... it's not a good thing, not a nice thing. You can go mentally potty, it can take you anywhere, and it is dangerous’. Such descriptions were also used to denote a subtle layer of fear, implying that depression itself is something to fear. Through participants interviews, two recurrent themes were identified within this overarching theme: 1) depression manifestation: visibility and invisibility captures participants understanding of the nature of depression 2) contextual accounts of depression captures participants’ understanding of depression stemming from social factors.

Depression manifestation: visibility and invisibility

Related to participants understanding of depression having an emotional component, it was clear that there were different opinions among participants about the way depression manifests. Some participants implied that painful emotions were often masked or suppressed to appear strong both in the public and private domains. Consequently, depression could be prolonged unnecessarily among individuals who internalise painful emotions perhaps because of the implication of being misunderstood, judged or appearing weak.

For example, Aida commented:

Even though they are in that state of sadness people could still be going about their everyday lives and they could have the outward show that everything’s good, everything is fine but their inner self could be feeling very discontented. (Aida)

Another stated:

You can’t really ascertain or really see it except maybe you’re living with the person in the same house but it’s something that has to do with emotions. (Neena)
However, some participants argued that depression is visible and noticeable through one’s behaviour. One of the principal barriers to recognising depression in some Nigerians according to participants is their hesitancy to talk and verbalise distress. Therefore, it is likely that in this context, depression may manifest in shifts in behaviour rather than emotional pain, as Reema and Aida noted:

*It’s how they tend to respond and behave; you know them really and you start noticing differences in their behaviour, like withdrawal. They are tired of life and want to be left alone; they don’t even want to associate anymore, they start withdrawing from social activities.* (Reema)

*People can go to the extent where they feel that they can’t actually get on with their day as well and that’s when it gets even deeper where they feel that they can’t actually go on with their day to day activities...there’s no level of motivation to do anything.* (Aida)

*On the scale of 100, I would say 80 is when the effects starts and when people know the person is depressed so it has to be very bad before it’s recognised.* (Rita)

Rita’s comment above highlights the dangers of not responding to the early signs of depression and likely illustrates the common experience of many Black people who experience a crisis and have a presentation of a more severe form of mental health.

**Contextualising depression**

There was a greater association of social causes among participants, with a variety of social and relational events being identified as contributing to depression. These events included financial difficulties, marital problems, work related issues and life changes. Even when participants referred to emotional and psychological aspects of depression, they connected these aspects to contextual, environmental factors. For example:
If someone encounters a tragedy on a large scale the chances are that could send them into depression. I think that’s the main cause, it’s never usually one event that can cause that but it tends to be sustained situation. (Felix)

It depends on what individuals are going through, their background, the situation they are in. A Job can cause it, when people don’t have job satisfaction, one can be depressed. Relationships can cause it, family can cause it, and finance can cause it. You know, anything can cause depression. (Tony)

I think a situation of high level of stress and therefore leaving them unable to cope. Things like hmmm, having financial difficulties and again the stress levels coming up from there and seems like they’ve got nowhere to turn to. (Rita)

They don’t have work, lack of money, society, maybe they are different and come from another country like me and the people there are not really treating them well, they don’t have the same kind of opportunities. (Reema)

As participants identified primarily with a social model, Reema’s summery of her own experience and situation reflects the significant impact of a broader structural issue (i.e. racism, discrimination, inequalities, etc.) contributing to depression. Some participants suggested that the change in culture was likely to have consequences for the well-being of Nigerians migrating from Nigeria to the UK and having to adapt to a new environment.

2. **Overarching theme: Cultural understanding of depression**

A strong overarching theme that underpinned participant’s interviews was the strong cultural force in understanding depression and psychological distress. This theme captured some of the factors that influenced Nigerian peoples’ understanding of the term depression. For example, the data revealed how some Nigerians apply an Afrocentric worldview to describe how depression is perceived. The basic premise of this worldview is that all life and
experiences are ontologically spiritual and the relationship between the body, mind, and spirit are mutually related (Borum, 2012). This view also accepts that the individual is embedded in his or her social group, therefore implying that individual identity is essentially a collective identity. The implication of this collective and spiritual worldview for psychological distress is that many Nigerians are socialised to believe that depression ‘is not tolerated’ largely because of the cultural discourses around strength which is firmly rooted in the historical experience of many Nigerians. Consequently, such beliefs encourage a disproportionate level of denial and/or an inability to name or acknowledge any form of distress. Two themes were identified within this overarching theme: 1) cultural adaptation captures the understanding and recognition of depression as a probable western construct. 2) Cultural beliefs capture the aspects of the culture that influences participants understanding of depression, a sub-theme of Religious/spiritual beliefs highlights the strong influence of religion/spirituality. Each of these themes echoes a cultural-meaning framework of understanding distress within a Nigerian context.

Cultural adaptation
This theme was expressed in terms of the contrast between Nigerian and British cultures. Many have argued that the concept of depression itself may be a western construct because in some non-western cultures, no word directly translates as depression. However, participant’s understanding and recognition of depression represents a form of cultural adaptation. Acculturation occurs as a function of the level of exposure generated through education and discourse, which is likely to have an impact on Nigerian peoples’ understanding of depression over time. For example, Maya and Reema talked about their awareness of depression, having immigrated to the UK and noting:

*I found out what depression is after a few years here. Nobody says depression in Nigeria but I imagine many people have it. We [Nigerians] don’t really know what to call it or how to describe it.* (Maya)

*Depression is not common in Nigeria. It is not part of the culture. We were not told about depression. They don’t say it, they don’t recognise depression. You won’t hear anybody saying I’m depressed but in the UK, it is common here. You hear it. You can see that people are depressed and they will say it.* (Reema)
For some participants, being in the UK constantly challenges their cultural perspective about depression which creates a cognitive dissonance. For instance, Reema’s comment of seeing people depressed perhaps symbolises a visible sign of western culture that sits uncomfortably for some Nigerians in that despite coming from a culture that does not ‘recognise’ depression, what is revealed through engagement in their experience of being in the UK is the opposite and therefore challenges any attempts to minimise its significance.

A feature of this is:

Well, what I actually understand by depression is that it is synonymous with excessive workload. However, when I came to the UK, I understood that depression was a lot more than that. Here, it relates to the mental state you know; it has to do with a mental state of mind. (Tony)

Tony’s comment above also implies an acute awareness of external and social stigma within the Nigerian community. In his interview, tony talked in depth about the implication of being diagnosed with a mental health problem and the extent to which marriage prospects are severely reduced: ‘You would be wary of a family or individual, single lady who has mental health issues’. Consequently, some Nigerians are likely to minimise or deny depression to avoid being pathologised or as Maya states: ‘I think it’s just a heaviness of words really... don’t say I am depressed’.

Others commented:

I don’t know a lot of people who have openly come out to say I’m depressed but there’s the stigma of mental health/depression, the person is mentally unstable. (Felix)

In my culture, people don’t really say depression, because they would use another word. It’s not that they don’t have it but in Nigeria they don’t really recognise it as depression...they just don’t want to use that word (Reema)
In Nigeria, we don’t like to term things, we don’t like to say this person is suffering from this thing or that thing... they would tell you I’m not depressed. (Aida)

What is constructed through this dialogue is fragile and it appears that some Nigerians may perceive depression as a sign of vulnerability or an admission of something unacceptable.

Cultural beliefs

Viewing depression from a cultural lens implied that the dominant response to depression at a group level is to ‘get on with it’. Participants noted that many Nigerians thereby invoked concepts associated with ‘shame’ and ‘weakness’ as they explained that depression is seen as a personal deficiency that is ‘self-induced’. The concept of shame can be evidenced through internalising the social stigma attached to being depressed. While participants did not necessarily endorse the belief that depressed people are weak, a few identified a lack of strength as a characterisation of people who experience depression.

For example:

Some people cannot handle it, it becomes depression and when they cannot handle it, it turns to something else but it depends on how the individual handles it. (Reema)

It’s the case that you’ve got enough self-control to overcome that situation...there is a network available somewhere to assist you. (Aida)

A depressed person is abusing herself/himself. You are hitting at yourself and your slapping yourself, your say oh it didn’t work, and they made me redundant. You are abusing yourself and effectively you are really saying to your creator, whosoever you call your creator, your saying you didn’t do a good job... yes we are doing it to ourselves, we definitely are, we’re hurting ourselves (Neena).

Endorsing such cultural beliefs encourages self-blame and once internalised, some Nigerians may self-negate or conceal their distress because of the consciousness of violating a cultural
taboo, which frames depression as undesirable and shameful; inadvertently discouraging help seeking.

Religion/Spiritual beliefs

While participants did not necessarily share the view that depression has a religious/spiritual cause there was a definite sense among some participants that religion/spirituality represented a fundamental aspect of their identity, with some participants noting ‘religion is very important’, ‘my culture tend to be quite spiritual about things’ and that the ‘culture is mixed with religion’. In addition to cultural beliefs, the participants felt that religious/spiritual beliefs impacted the way in which depression is viewed. Maya explained how religious beliefs could encourage people to minimise depression: ‘Africans are very religious; they cover everything up and say you’re not praying about it and stuff’. Some participants noted how a religious perspective appeared more understandable in moments of distress because it draws on a widely accepted language and meaning system that has been established. Felix attempted to explain the historical reasons for the strong influence of religion/spirituality:

I think it’s also a hangover, carryover from the historic, ancestors, interpreting things from a spiritual element when they didn’t understand things. When there is a lack of understanding of something…then it tends to be explained by spiritual factors…probably the older generation… people who have more of the ancestral point of view would probably not really know what to say or they would probably still just put it off, you know onto spiritual cause and effect and you know, look for purely spiritual solutions. (Felix)

Another commented on the role of families in disseminating information:

A lot of information would have gone, filtered through family. The family unit has broken down quite widely so people rely on media whether it is social or just rudimentary types of media get an understanding of this [depression]. (Aida)

Epistemologically, a great deal of emphasis is placed on information filtering down and obtaining information from friends and family members about the historically and culturally-
infused concept of distress. Although this view is not easily challenged without incurring the disapproval of others, Aida’s comments above suggest that change is more likely to occur over time.

3. Overarching theme: Seeking help for depression

Seeking help for depression captures the way participants viewed acceptable ways of coping with depression. As highlighted in previous themes, individuals experiencing distress may refuse to accept it, or view it as not being ‘a problem or a big deal’ and beliefs about how to cope with depression varied greatly. Participants understanding of how depression could be managed captured four themes relating to 1) Seeking social and practical support, 2) Seeking religious and spiritual support, 3) Seeking professional help and 4) Seeking information/awareness.

Seeking Social and practical support

All participants acknowledged the importance of ‘getting people to help you out’. Social and practical support was identified as an important role in preventing and coping with depression, partly because the community provides a collectivist framework that entails support and represents a major protective factor. For instance, four participants gave concrete examples of how many Nigerians cope with distress:

‘I’m going out to parties, I’m going out to see my friends...they believe when they are in the midst of people, they won’t be lonely...they can be talking to people... they believe the situation would go away’ (Reema)

People that are depressed tend to hold onto themselves and don’t like expressing themselves but if you create that atmosphere I think it’s like 50% solved because when they are able to say it out then it’s kind of a relief to them (Rita).
What do you need done, let’s get it done in order to feel better because obviously something’s happened to trigger the fault so therefore whatever it is let’s do whatever it takes to resolve it’ (Tony)

There are different types of support systems, they could talk to debt companies and that pressure could be reduced from that respect...have some financial support for women..., and with that support network, their life is turned...a good support is a big thing (Maya).

Although participants valued social and practical support, they also noted conflicting and contradictory views regarding the limitations of family/community support. Some participants felt that further distress could be caused because family members typically focused on practical help as opposed to emotional support.

They [Nigerians] will be sensitive to depression and have sympathy for the individual but only to an extent to say that I understand. These things happen but it’s not to say that’s the end of that...we now have to move on and get the issue resolved. (Aida)

Another commented:

You got a lot of your families and friends but you could still feel as though there’s no one there for you even though you have a lot of people there. The reason is because they don’t want to know what you’re going through, they just want to help you. They kind of forget that you have gone through an experience. (Maya)

Maya’s comment highlights a dilemma for some Nigerian people because if one internalises the view that depression is undesirable as inferred through encounters with others, one may feel obligated to suppress emotions in order to preserve harmony and social acceptance and expressing distress in culturally sanctioned ways.
Seeking religious and spiritual support

All participants identified religious and spiritual support as a commonly preferred method for addressing depression or psychological distress among Nigerians. One explanation for this is that religious leaders are likely to have a similar belief system and/or worldview. Another explanation could be that religious and spiritual support could have a strong protective factor. For example, Aida, who self-identified as a Christian, was able to connect her own experience of faith and found that religion could guide methods of coping, by drawing attention to the ways in which biblical figures could have a positive effect. She stated:

They need to refer to what God has said on the topic and that if they are experiencing this it means that they haven’t referred to the bible and seen what has occurred in somebody else’s life through the bible and how they can resolve it. Job for example...he came through so much affliction and so many problems, he didn’t fall into depression. (Aida)

While it is argued that religion/spirituality could be a protective factor, some participants inferred that religious coping resulted in greater psychological distress, particularly if the person continued to solely seek religious support despite failures to address their distress.

It’s not just about the church in as much as your praying, for example, a single mother who has three children and she has no husband or nobody to help and going through depression, one cannot say let’s go to church and pray... The church and prayer will not bring that finance to her. (Rita)

Personally, I believe God can help with everything we go through but the next step is to go for counselling or speak to professionals to help the person come out of depression (Maya)

I believe everything that has a spiritual side there is also a physical side and that where you want to bring about spiritual healing there’s also got to be physical healing...I think that could work in tandem with the spiritual. (Felix)
Seeking professional help

Participants had a distinct idea about the role of professionals and the way in which professionals could potentially help. However, there was some uncertainty as to whether professionals would understand Nigerian’s people experience of distress. This was partly due to suspicion, fear, and mistrust, which led to resistance and consequently; participants felt that professional help was often sought when distress could not be contained.

For example:

In the UK, there is a fear of judgment. I think it is a very sensitive issue and needs to be handled with care because you think you’re trying to help the person but in the long term you make life more difficult for the person and that may lead to the person becoming mental. (Rita)

The first thing is you know, obviously listening, Listening to them, not criticising them and just listen to what they are actually going through. (Maya)

Professionals need to understand, within my culture, they have a frame of mind regarding this thing called depression. So they should be aware that the person may not be mentally unwell and that could be mistaken for medical depression. They should be able to identify what they are going through. Ask them specifically what they think depression is. (Tony)

They need to understand that the individual may have defences up and will maybe in denial and not prepared to actually except it so they need to be aware of that and they need to be reassured that confidentiality will be upheld. Prescription of drugs may not be received very well. (Aida)

For this group of Nigerians, counselling was cited by all as a helpful strategy to talk about difficulties confidently with culturally competent professionals.
Seeking information/awareness

While participants were not specifically asked about mental health awareness and education within the Nigerian community, the concern evidenced by participants centred on the extent to which Nigerians lacked awareness of mental health problems in general. For example, Aida stated:

*I think it’s because [Nigerians] are not aware of what depression is and how easy it is to slip into that sort of attitude. So I think a lot of people, due to unawareness would not say that person is depressed, they would say what are you depressed about?*

*There is just a lack of information, and information brings about knowledge and knowledge is power, so I think, there’s just been a lack of information about depression and indeed about mental illness. (Felix)*

*It’s not as if depression is not there, it’s just that maybe the awareness is not there but those of us that are becoming educated and becoming more developed and have travelled we now understand that depression is everywhere so it’s about awareness.*

*It’s just something that people don’t talk about and things. If you’re not aware you’ve got a problem then you’re not sure who to go to. (Aida)*

There was a general acceptance among participants that the Nigerian community needed to be ‘more educated’ but struggled to think about how education could be disseminated.
Discussion

This study explored how depression is understood in a small sample of Nigerian men and women. Based on the extensive data collected, three themes emerged from the researcher’s interpretation of the data. These included ways in which depression is conceptualised, cultural influences in understanding depression and seeking help for depression. The following discussion is on the basis of the three identified themes. The majority of participants in this study regarded depression as ‘a state of mind’ related to excessive sadness, helplessness and confusion. Participants associated depression with greater perceptions of severity and as having emotional and behavioural manifestations. According to Gureje, Lasebikan and Ephraim-Oluwanuga (2005) knowledge about depression and mental health, in general, is very poor within the Nigerian community; however, all participants in this study had some knowledge of depression, largely through encounters of other people. This therefore suggests that knowing someone with depression is likely to lead to a greater understanding of psychological distress and could potentially reduce stigmatising views within the Nigerian community (Angermeyer & Dietich, 2006). Moreover, the language used by participants to describe depression showed an ability to engage in a psychological and emotional discourse. Interestingly, previous research suggests that people of African descent have a tendency to provide descriptions of a psychosomatic nature (Mallet et al., 1994). This is noteworthy because it implies that some Nigerians could be encouraged to discuss mood if in distress. The finding that depression stems from adverse social circumstances was not surprising and is in line with other studies. However, the most striking thing about participant’s explanation for depression was the absence of spiritual and supernatural factors as suggested in previous studies (Furnham & Igboaka, 2007; McCabe & and Priebe, 2004). It is likely that this discrepancy in the findings could be due to different methodologies used in or an increase in awareness of depression among participants in this study.

In terms of the cultural understanding of depression, participants highlighted the impact of learned and shared cultural values/beliefs transmitted generationally in understanding depression. The western model of distress is based strongly on the Cartesian distinction of mind and body and is embedded within an illness framework (Gardner, 2003). By contrast, an Afrocentric view represents a complementary balance between the two (Paykel, 2008). Participants in this study highlighted the possible tension created in
navigating these opposing worldviews, in that there is greater pathologising of distress in a western cultural environment. Some have argued (e.g. Jones, 1997; Chernoff, 2002) that an Afrocentric worldview has aided the survival skills and resilience of people of African descent in the face of colonialism and racism and according to Shambley-Ebron and Boyle (2006) people of African descent have been acclaimed for their physical, emotional, and psychological strength that has enabled them to endure tremendous historical hardships. Therefore, it is conceivable that some Nigerians could view their circumstances as just another hurdle to rise above (Shambley-Ebron & Boyle, 2006) and internalise the belief that depression is ‘intolerable’. A strong theme that emerged through the data was cultural beliefs around depression being ‘self-induced’ and controllable. According to participants, depression was constructed as unacceptable; in accordance with cultural scripts which support existing literature reported on positive characteristics of showing strength, perseverance, and self-reliance within Black African communities (Beauboeuf-LaFontant, 2007). Arguably, in Nigeria, there’s a lack of a national social welfare and distressed individuals are often left to persevere or rely on families for support (Furnham & Igboake, 2007). This finding also strengthens the discourse of social stigma and shame as important factors in understanding depression among some Nigerians. Such information is critical for understanding the way depression manifests and could partially explain the current health disparities that people of African descent face. While the stigma associated with mental health is not exclusively an issue for Nigerians, there are dimensions of this which arise specifically for this group as Nigerians have been shown to be not only shameful about mental health but also it is not uncommon for many households with mentally ill persons to hide them for fear of discrimination and ostracism from their communities (Gureje, Victor & Lasebikan, 2005).

The third theme, pertaining to seeking help for depression the value of family and community members in helping people with depression is particularly significant in this study. The social model of depression, adopted by participants implies that support from the community as a form of helps seeking is preferred. These findings also echo those of Constantine, Myers, Kindaichi, & Moore, 2004; Utsey et al., 2000) who suggested that family ties are seen to be of particular importance for people of African descent. However, having awareness of the socially constructed reality that the view of the community would inevitably affect the way an individual sees himself/herself, it is likely, that this could have profound implications on the individual to conform to the values/beliefs of the community in
which the individual belongs. Bhardwaj (2001) points to how cultural (and religious values/beliefs) could potentially act as a double-edge sword in that they can legitimise and perpetuate ‘oppression’ by silencing those in distress; thereby endorsing and limiting actions and ways of being. Equally, participants in this study reinforced previous literature on the significance of religion and spirituality in relation to coping with depression (Taylor, Chatters & Levin, 2004; Williams, 2005). However, participants belief that religion/spirituality could assist in coping with depression did not necessarily correspond with their beliefs about the causes of depression. This is likely to be due Religion has been identified by a number of researchers and scholars as a fundamental attribute of the personality of people of African descent (Akbar, 1991) largely because may afford people opportunities for social support, belonging and connectedness (Carrington 2006; Pargament, 1997). However, while religion is likely to be a protective factor for some individuals, participants in this study equally felt religion/spirituality could often be a hindrance to seeking additional support if in distress. The negative effects of religion has been document by some researchers who highlight the church as a negative place of support for people experiencing depression as well-being is compromised by the fear of being labelled and judged as being spiritually weak (Sadler-Gerhardt, 2007). This is particularly likely to occur if church members share similar cultural beliefs as there be uncertainty about dealing with psychological distress. However, fears around cultural sensitivity could further delay help seeking. Smedley et al. (2003) confirms how mistrust and discrimination of mental health providers is cited as a major barrier to receiving mental health treatment by minority ethnic groups. This was also confirmed by Lipsey and Wilson (2001) in her review of Black women’s experiences in mental health services. Lipsey and Wilson (2001) concluded that the women’s experiences were affected by stereotypical or prejudiced views of their needs. Participants’ responses bring attention to possible inherent power differentials between practitioners/mainstream services and clients. This is particularly salient for African people, whose social positions of being Black is often categorised in numerous disadvantaged ways (Brondolo et al., 2009). Therefore, it is understandable that an already stigmatised community may be acting to protect itself from further stigmatisation by wider society by attempting to conceal their distress. It is noteworthy to mention that the Nigerian participants in this study seemed to value counselling, perhaps as opportunity to speak to a professional who is distant from their situation.
Implications for counselling psychologists

The main findings from this research demonstrate the importance to the counselling psychology profession and the awareness of the complexities of disentangling cultural influences in understanding depression. It further suggests that counselling psychologists must consider ways to enhance culturally sensitive approaches and develop culturally competent practitioners. Existing guidelines within the division of counselling psychology encourages the recognition of ‘social contexts and discrimination and to work always in ways which empower rather than control’ (Guidelines for the Professional practice of Counselling Psychology, 1998). While it is likely that some Nigerians may initially suppress or deny emotional distress, participant’s knowledge of depression and willingness to talk about depression suggests that after developing a good therapeutic relationship, some Nigerians may begin to feel more comfortable expressing more emotional and psychosocial problems. Given counselling psychology’s commitment to understanding human distress in the context and appreciation of social political processes, by positioning distress as difficulties in living (Deurzen & Arnold-Baker, 2005) counselling psychology are well positioned to openly challenge and critique the existing social structure and its use of classification systems. In addition to placing a value on the social context, counselling psychologists should go further in equally recognising the religious and cultural contexts, both at a theoretical and intervention level. In enhancing the skills of cultural competence in counselling psychologists, Collins and Arthur (2005) state that the challenge before counselling psychologists is to “gain self-awareness and come to know others in a way that bypasses cultural barriers and stereotypes and allows us to connect in a real and meaningful way with each other” (p. 61). Primarily, psychological therapy for counselling psychologists would entail working within a relational framework, in a non-directive manner, where inquiries about religious and spiritual beliefs could be used to facilitate discussions. Therefore, the process of developing a therapeutic relationship would involve working in an empathic and non-judgmental way, requiring the therapist to work within the values and strengths of the client (Nobles, 1980). Counselling psychologists could bring their distinct quality of focusing on well-being, which would be more acceptable to this community, rather than a model which focuses on pathology, which would ultimately create social distance and may exacerbate social exclusion further.
There has been some debate about ethnic matching between therapists and clients. Kleinman (1978) suggests that when both the client and practitioner are from the same cultural system, it is more likely that they will have matching explanatory models which reinforce socially constituted “clinical realities.” However, the researcher is of the opinion that it is not a necessary, or indeed, a sufficient condition to ethnically match clients as this may not be possible. Messant (1992) cautions against such an approach, as some people prefer not to see a therapist from their own culture, due to their perception that they can be appear more challenging and less respectful about cultural issues. It may also be useful for counselling psychology to consider integrating other frameworks within the field of psychology. Community psychology, for example, engages with lives of groups/people in context. This approach requires practitioners to define their own mental health needs and strengths, rather than it being imposed. Participants’ understandable fear of mainstream services might suggest a need for counselling psychologists to consider integrating informal networks. Given the strong religious beliefs held by some Nigerians, it is possible that church leaders and churches have the ability to influence communities on their understanding of distress and culturally sanctioned ways of expressing distress. Therefore, it may be useful for counselling psychologists to work with religious leaders to develop a therapeutic space, which could also raise awareness of the role of a counselling psychologist and potentially reduce stigma within the Nigerian community. A core assumption of anti-stigma campaigns has been that the public should be educated to recognise mental health problems by using medical biological frameworks (Read et al., 2006) However, for participants in this study, promoting biological models of distress is likely to create social distance. However, participants’ familiarity with depression, through knowing someone provides a powerful insight into how the participants in this study understand depression. Therefore, increasing social contact with people with depression is likely to increase understanding and thereby decrease stigma. With an increase in diversity, it is recommended that a stronger coordination of services be established. For example, Fernando (2005) recommends the use of multicultural, multidisciplinary teams and specific culturally sensitive services. Such services would allow for a sophisticated understanding of the complexities involved in providing culturally competent and sensitive care. Equally, there has been much debate generated around cultural differences and the importance of understanding cultural and religious perspectives. Black et al., (2002) found that although black churches had many health problems within their communities, few programs existed that linked churches with
mainstream services. Therefore, community participatory exchanges, that incorporate alternative services, provide culturally appropriate education through partnerships between the community and mainstream services.

Limitations of study

The purpose of this study was to elicit a deeper understanding of Nigerian peoples’ views of depression and thus, claims to represent the greater Nigerian population are not made as only 7 people were interviewed. Nevertheless, the rigour of the data analysis allows for the findings to be transferred to community settings that include Nigerian people with similar demographics to the participants in this study. Similarly, the study recruited a community sample and it is likely that there was a greater emphasis about the beliefs of the Nigerian community as opposed to individual, personal beliefs. Similarly, the emphasis on religion as an influence in understanding depression in this sample could be due to all participants self-identifying as ‘Christian’. It is also important to recognise within group differences, a possible age and acculturation effect, which were not considered. Indeed, it is possible that first generation Nigerians and those that have been in the UK for a limited time may have a different understanding of depression. Working within a qualitative methodology that was rooted in critical realism also highlights some biases. For example, the researcher concedes that the use of semi-structured interviews has its limitations, in that the participant’s response may have been orientated to the set of assumptions and epistemological position of the researcher. For example, asking participants how people within their culture may be perceived, could presuppose that individuals with depression are perceived in a certain way. However, despite these limitations, the findings from this study have been useful and valuable.

Future research

It is important to recognise, whilst the findings provide valuable information about the general public’s understanding of depression within the Nigerian community, it does not provide first-hand accounts of depression from the perspective of those that have been diagnosed with depression. Therefore, the next step in this research would be to understand
the experience of having one’s distress professionally labelled as depressed and to explore how that label is made sense of in tandem with one’s cultural and/or religious values. Ideally, it would also be useful to enquire whether some adopt a biomedical model to explain their distress following a medical diagnosis. Considering the government’s recommendation of cognitive behaviour therapy (CBT) for depression, it is widely assumed that CBT is universally applicable, although some argue that it often reinforces a western world view. Therefore, future research could consider the application and efficacy of CBT with ethnic minority groups in order to inform thinking. Given critical realism seeks to integrate qualitative and quantitative methods and endorses methodological triangulation, future work could embrace both qualitative and quantitative methodologies. For example, quantitative methodologies could be beneficial in identifying valuable values about how culture shapes reactions to depression, thus increasing reliability and validity. Equally, data source triangulation, such as the combination of an ethnographic and focus group study could be useful in providing more insight into the lives of Nigerian people who may or may not experience depression or profound distress. In doing so, credibility of the research will be further strengthened.

**Conclusion**

This study reports the findings of a small qualitative study and represents a contextual and population specific exploration of Nigerian peoples’ understanding of depression. The findings from this study shed light on some of the beliefs and attitudes towards depression among the 7 participants and discuss the impact of learned and shared cultural and contextual factors in shaping one’s understanding of depression. This study is considered an asset in contributing to the existing knowledge as it uncovers new information for counselling psychologists about the complexity of some Nigerian peoples’ understanding of depression and the complex social feedback interaction between individuals and their social environment. According to the participants from this study, Nigerian communities want information to reduce social stigma and shame related beliefs, in the hope that that they can talk about their feelings in a culturally sensitive manner. The findings from this study suggest that a significant vehicle for increasing understanding and acceptance of depression within the Nigerian community would be to increase social contact with individuals experiencing distress and thereby decreasing stigma. The identification of cultural influences
has practical value as it paves the way for sensitive enquiry by counselling psychologists and the effective delivery of therapy for Nigerian communities.
References


Advert for Participants

My name is Christiana Abu and I am a trainee counselling psychologist based in the psychology department at the university of surrey. I am researching Nigerian peoples’ views of depression. I am interested in recruiting participants that would be willing to be interviewed and who:

- Age 18 and above
- Originate from Africa
- Live in the UK
- Do not have a formal health qualification

The interview will last about 30-90 minutes. I hope that the findings from this study will contribute towards the limited research on the well-being of African people living in the UK. The research has received favourable ethical opinion from the Faculty of Arts & Human Sciences, University of surrey Ethics Committee.

If you are interested in taking part and/or would like some more information please have a look at the participant information sheet or get in contact with me directly by email c.abu@surrey.ac.uk or phone 07958381211.
APPENDIX B

Participant characteristics

Participant 1

Reema is a 56-year-old black Nigerian woman from the Yoruba tribe. She is divorced and has 3 adult children. She said she was born in Nigerian and migrated to the UK with her two children and husband. She has lived in the UK for 28 years and is a British citizen. She identified herself as an African but says she is ‘part and parcel’ of England. She has a HND and presently owns her own business and she identifies as a Christian.

Participant 2

Aida is a 36-year-old Nigerian woman from the Igbo tribe. She was born in England but says she is rooted in the African heritage. She is married and has three children. She describes herself as a homemaker. She has a Master’s degree and is keen to start her own business. Aida reports that she has a strong religious faith and feels that it is a core part of her identity.

Participant 3

Felix is a 28-year-old Nigerian man from the Yoruba tribe. He migrated to the UK 11 years ago and works in the IT industry. He is single with no children. Felix has a Master’s degree and reports that he regularly attends church services on Sundays.

Participant 4

Maya is a 36-year-old woman. She originates from Nigeria and is from the Delta tribe. She has been living in the UK with her husband for 15 years. She works full time and has a degree in Marketing. She also self identifies as a Christian.
**Participant 5**

Tony is a 40-year-old African man from the Edo tribe in Nigeria. He is married with one child and works as an Engineer. He came to England 11 years ago, where he met his wife. He holds a degree and is currently pursuing further education. He is a Christian but does not have a place of worship.

**Participant 6**

Neena is a 50-year-old Yoruba woman. She has lived in the UK for 28 years and currently own her own business and works in her church voluntarily as a ‘youth worker’. She is divorced with 2 adult children who currently live with her.

**Participant 7**

Rita is a 43-year-old Yoruba woman. She has lived in the UK for 14 years and reports that she has not fully integrated to the ‘UK system. Rita has three children and is married. She owns her own business and regularly attends a Christian fellowship.
APPENDIX C

Chair’s Action

Proposal Ref: 1032-PSY-14

Name of Student/Trainee: CHRISTIANA ABU

Title of Project: Understanding depression in African people

Supervisor: Dr Dora Brown

Date of submission: 27th May 2014

The above Research Project has been submitted to the FAHS Ethics Committee and has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee on the basis described in the protocol and supporting documentation.

The final list of documents reviewed by the Committee is as follows:

Protocol Cover sheet
Summary of the project
Detailed protocol for the project
Participant Information sheet
Consent Form

This documentation should be retained by the student/trainee in case this project is audited by the Faculty Ethics Committee.

Signed: ____________________

Dr Daniel McCarthy
Deputy Chair
Consent Form

Title of research: Understanding depression in African people

Please read this form carefully. If there is anything that you do not understand please feel free to contact the researcher.

☐ I understand that this research is to study African peoples’ understanding of depression and the purpose and nature of the study has been explained to me in writing.

☐ I understand that I am being invited to take part in an interview which will last about 30-90 minutes.

☐ I understand that the interview will be audio recorded and that I am free to stop the tape recorder at any time during the interview.

☐ I understand that if I do not feel comfortable responding to any of the interview questions, I am free to let the researcher know and I am under no obligation to answer.

☐ I understand that my participating is voluntary and from the time of interview to the analysis of data, I can withdraw from the study, without repercussions, by informing the researcher.

☐ I understand that the information I provide will be completely confidential and that anonymity will be ensured through the use of a pseudonym.

☐ I understand that disguised extracts from my interview may be quoted in the thesis and any subsequent publications if I give permission below:

☐ I understand that there are no foreseeable risks involved in my involvement in this study. However, in the unlikely event that I become upset during the interview, I can inform the researcher so that help/counselling support can be arranged.

I………………………………………………………………………………………………………………………………………………………………

agree to participate in Christiana Abu’s research study.
Title of research: Understanding depression in African people

My name is Christiana Abu and I am a doctoral student in the Faculty of Arts and Human Sciences at the University of Surrey. You are invited to take part in a research study investigating Nigerian peoples’ understanding of depression. Before you decide whether you would like to participate, this sheet is designed to help you understand why the research is taking place and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you have any queries about the information provided in this sheet or any other questions that are not addressed here then please do not hesitate to ask me.

What is the purpose of the research?
This study seeks to understand and explore African peoples’ knowledge of depression. If you choose to participate, then you will receive more specific information about the study’s aims once you have completed it.

Why have I been asked to participate?
I am looking for individuals who:

- Are age 18 and over
- Do not have a diagnosis of depression
- Originate from Africa or are of African heritage.
- Live in the UK.
- Are able to communicate in English
- Do not have a formal health qualification

What will the research involve?
You will be invited to take part in an interview which will last about 30-90 minutes. The interview will be recorded, with your consent. During the interview, you will be asked some questions related to your demographic information, your knowledge and understanding of depression. You are free to stop the recorder anytime during the recording.

Will my information be anonymous and confidential?
Yes, any information that you provide will be kept strictly confidential and a pseudonym will be provided to retain your anonymity. In the research write up, your personal details will not be released and all extracts from interviews during the write-up will be anonymised. All interviews and data will be stored in a secure and confidential place, which will be kept for 10 years.

The only time that the researcher would have to break confidentiality and disclose what you have reported during the interview, would be if you said something that suggested that there was a significant risk of harm to yourself or another person. If this were the case then attempts will be made to discuss the way forward with you first.
<table>
<thead>
<tr>
<th><strong>Do I have to take part in the research?</strong></th>
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<tr>
<td>Your participation in this research is completely voluntary. You are under no obligation to respond to any of the interview questions if you do not feel comfortable. If you decide to participate, you are free to withdraw from the research at any time without giving a reason. Likewise, if you decide not to take part, then you do not have to give a reason for your decision.</td>
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<th><strong>Are there any risks involved?</strong></th>
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<tr>
<td>There are no foreseeable risks involved in your involvement in this study. However, in the unlikely event that you become distressed as a result of talking about your understanding of depression, you can decline to answer any of the questions that you are asked and withdraw from the study, if you wish. If you also need additional support, the researcher would be available to discuss your difficult feelings and identify possible supportive agencies.</td>
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<th><strong>What are the benefits of this study?</strong></th>
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<td>Your participation in the research will be very valuable, as the information is likely to be helpful in adding to the current literature in this area. It will also increase awareness around perceptions of depression within this population. In doing so, the research would also help professionals develop better ways in working with African people in the community.</td>
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<th><strong>What if there is a problem?</strong></th>
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<tr>
<td>If you have any concerns or complaints about any aspect of the way in which you have been dealt with during the course of the study, please let the researcher or contact Dr Dora Brown, research supervisor: <a href="mailto:d.brown@surrey.ac.uk">d.brown@surrey.ac.uk</a></td>
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<th><strong>How can I find out about the findings of the study?</strong></th>
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<tr>
<td>If you would like further information about this study or would like to be sent a summary of the final report, please contact Christiana Abu: <a href="mailto:c.abu@surrey.ac.uk">c.abu@surrey.ac.uk</a></td>
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<th><strong>Who has reviewed the study?</strong></th>
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<td>The study has been reviewed and received a favourable opinion from the University of Surrey Ethics Committee.</td>
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<th><strong>What do I have to do if I want to take part?</strong></th>
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<tr>
<td>If you would like to take part please let the researcher know, and you will be given a consent form to read and complete.</td>
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**Thank you for taking the time to read this Information Sheet.**

Signed ..............................................
Date ..............................................

Name of researcher/person taking consent (BLOCK CAPITALS) .....................................................
Signed ..............................................
Date ..............................................
APPENDIX F

Interview Schedule

The following questions serve as a guide to topics addressed in a semi structured interview.

Demographic information: Could we begin by you telling me a bit about yourself? (E.g. age, gender, ethnicity, country of origin, length of stay in UK, marital status, living arrangements, children, education, work).

1. What do you understand by the term depression?

2. Who do you think experiences depression?

3. Within your culture in particular, how do you think people with a diagnosis are perceived?

4. What do you think can be done to help people with depression?

5. What do you think professionals need to know about people that may have depression?
APPENDIX G

Participant Debriefing Form

Thank you very much for participating in this research. As we have talked about, the purpose of this study is to gain insight into African peoples’ understanding of depression. Currently, there is little information detailing views of depression among Black Africans living in the UK. However, there is some suggestion that some African people living in the UK could benefit from psychological support. I’m hoping that the findings from the research will help to understand how some groups understand depression and what some people do when faced with what is regarded as a mental health problem. This will help to inform and improve the way professionals work with individuals from specific communities.

When the research is completed it is likely that it will be submitted for publication and may be presented to other researchers and professionals. The research findings may also be presented to mental health teams and voluntary services. These findings and final report will not include any identifying information but instead will group together the results of all participants. A summary of these findings will be available upon completion of the research. If you would like a copy of this report, please email me at c.abu@surrey.ac.uk and I will be happy to forward a copy of this report to you.

If you feel upset after having completed the study or find that some questions or aspects of the study triggered distress, there are lots of people that you could talk to. If you also need additional support, the researcher would be available to discuss your difficult feelings and identify possible supportive agencies.

Thank you for your help

Christiana Abu
Trainee Counselling Psychologist
Interview transcript: ‘Felix’

Researcher: Thank you for agreeing to participate in the research study.

Felix: Smiles

Researcher: As you are aware, I will be asking you questions about your understanding of depression... but perhaps we could start with you telling me about yourself... For example, you age, marital status, ethnicity, occupation...

Felix: oh, okay... well... I'm 27, I'm single, I work in the IT profession and I have a Masters.

Researcher: Which country do you originate?

Felix: Im Nigerian

Researcher: Okay, you were born there?

Felix: Yes,

Researcher: How long have you been living in the UK?

Felix: About 11 years

Researcher: Okay... that's interesting. Perhaps we could begin with the first question?

What do you understand by the term depression?

Felix: Depression... to me is the state of mind where the person... gets confused... down and feels... hmm... maybe helpless... a state of mind where they feel like they... yeah... because they can't function properly and you know... yeah... they just see lots of bad things about everything in the world... that's my understanding of depression

Researcher: And does anything else come to mind when you think of the term depression... any images, thoughts?

Felix: sort of... sort of images or the sort of impression I get is... that of sadness... hmmm... what else... despair... hmm... having no hope... hmmm... I've heard stories of not being able to... like not being able to get out of bed... hmmm and yeah... hmmm I guess... (inaudible) feeling suicidal sometimes maybe having... (inaudible)

Researcher: Who do you think experiences depression?

Felix: I think anybody can experience depression... any age, any background, yeah... in walk of life... yeah... anyone

Researcher: and what is your sense about what might cause depression?

Felix: That's a big one... what might cause it? Hmmm... I guess... life experiences... hmmm if someone encounters tragedy on a large scale to them... then... chances are that... that... that could send them into depression... so to speak... hmmm... what else could cause it? Yeah... yeah... I think that's the main cause... to my understanding would be so... an experience could be... ah... but I do remember hearing... hearing something from Samaritans... on the Samaritans website where they said that... (inaudible) like suicidal end of depression, if there is such a thing... that is never usually one event that can cause that but it tends to be... (inaudible) sustained kind of a situation over time then...
that's the kind of thing that could cause someone to feel so low and to feel like...to take their life. So...to answer your question, depression is caused by something very bad happening to someone that makes...cause them to feel like there's no hope to a situation that [...inaudible]...

Researcher: Within your culture in particular, how do you think people with a diagnosis of depression are perceived?

Felix: (coughs) hmmm...I think it's probably two ways that it's perceived in my culture. I think the first way is because my culture tend to be quite spiritual about things and so...if they heard...if someone was to hear of another person that was diagnosed with depression they would...one of the first thing that would come up...their sort of comment would be something along the lines of it being a curse or some sort of an attack of a negative spiritual force...hmmm...and the other thing that I know that can be said and probably is said is that it's just a state of mind or it's just phase kind of thing...hmmm...and something that (...inaudible)...the person diagnosed just need to get over...

Researcher: So how might that person who has depression be perceived?

Felix: yeah...so...I guess they would be perceived as someone as possessed with an evil spirit as their known or just someone that...that has just given up on life...

Researcher: so...do you know whether there is a word for depression in your culture?

Felix: No...not that I know of...I'm not sure...I don't think I know of a word...apart from depression...

Researcher: So you mentioned the spiritual element about that...Could you say a bit more in relation to depression...

Felix: About how people...

Researcher: Yeah because it seems like religion is important within your culture

Felix: Yes...yes...religion is very important. The...hmmm...in my culture...the spiritual is very much...is very real to people...and so...depression would be viewed as...I guess...as an attack or as a curse or something...basically something that has originated in spiritual side of things and hmmm...and something that would need to be...I guess...be removed also primarily in a spiritual way...

Researcher: Be removed in a spiritual way?

Felix: Spiritual way as well...I think that's...the point it would be believed as it started...it would be believe that the cause is spiritual then the remedy is also spiritual and yeah...that's what...yeah...what generally heard...is perceived...

Researcher: And would you think the person themselves would know that they have depression?

Felix: Ah...yes...would the person know...hmmm...I think some people would...could...can...think they have depression...I think yes...that could go both ways because someone can think they have depression and they not have it or they not be diagnosed with being clinically depressed but they may just feel so low and they may just think...wow...maybe this is what depression feels like...hmmm...but if someone has been diagnosed with depression...but they can't come out and talk about it...maybe because they don't think they would get the help that they need and I guess that probably won't help and they may just feel lower because they can't get help...hmmm...so I think...I
## APPENDIX I  Candidate themes with selected codes

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<td><strong>2.1 Cultural adaptation</strong></td>
<td><strong>2.2.3 Religious/spiritual beliefs</strong></td>
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<tr>
<td>It’s not visible</td>
<td>Greater social support in Nigeria-less isolation</td>
<td>Default position is spiritual</td>
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<tr>
<td>Depression isn’t always visible</td>
<td>Depression common in UK</td>
<td>Initial response linked to spiritual beliefs –</td>
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<tr>
<td>Discrete/ not visible</td>
<td>Better understanding of depression in UK</td>
<td>Spiritual beliefs about mental health</td>
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<td>Depressed people can be recognised</td>
<td>Difference between Nigeria and UK</td>
<td>Spiritual attributes generational</td>
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<tr>
<td>Depressed people are dependent on others</td>
<td>Depression is being lazy</td>
<td>Historic beliefs? Passed to generations?</td>
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<tr>
<td>It is visible as result of social issues</td>
<td>Inability to organise</td>
<td>People holding on to spiritual beliefs</td>
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### 1.1 Depression manifestation - Visibility and invisibility
- Default position is spiritual
- Initial response linked to spiritual beliefs –
- Spiritual beliefs about mental health
- Spiritual attributes generational
- Historic beliefs? Passed to generations?
- People holding on to spiritual beliefs

### 2.1 Cultural adaptation
- Greater social support in Nigeria-less isolation
- Depression common in UK
- Better understanding of depression in UK
- Difference between Nigeria and UK
- Depression is being lazy
- Inability to organise
- Inherent in individual

### 2.2 Cultural beliefs
- It’s in the control of the individual
- Inability to be independent
- Individual held responsible
- Depression is being lazy
- Inability to organise
- Inherent in individual

### 2.2.3 Religious/spiritual beliefs
- Requires spiritual healing
- Church best method of coping
- Seek pastoral counselling
- Support systems within the church
- Services focused on resolution

### 3.1 Religious and spiritual support
- Socialising with others cures
- Reaction of others/support can help to overcome
- Importance of talking
- Significant of others around
- Social gatherings offer distraction
- Shared experience- not alone

### 3.2 Social and practical support
- Requires spiritual healing
- Church best method of coping
- Seek pastoral counselling
- Support systems within the church
- Services focused on resolution

### 3.3 Seeking professional help
- Socialising with others cures
- Reaction of others/support can help to overcome
- Importance of talking
- Significant of others around
- Social gatherings offer distraction
- Shared experience- not alone

### 3.4 Need for information/ awareness
- Professionals not misdiagnosing
- Implications of professionals imposing views
- Sensitivity and understanding required
- Importance of having a holistic view
- Contextualising the info and aetiology
- Sensitivity and patience required

- Lack of information regarding depression
- Information needs to be readily available
- Importance of mental health awareness
- Advertising/becoming more aware
- Question of accessibility
<table>
<thead>
<tr>
<th>Depression could easily be missed</th>
<th>Sense of failure</th>
<th>‘exposed/educated’</th>
<th>An Individual problem</th>
<th>Importance of religion</th>
<th>Refer to scripture to overcome</th>
<th>Reaching out to people</th>
<th>Risk of making assumptions</th>
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<tr>
<td>An ‘internal process’</td>
<td>Depression is carrying burdens alone-no support Stress/ excess workload</td>
<td>Acculturation-likely to know about depression in UK</td>
<td>Unable to handle issues</td>
<td>religion emphasises religion</td>
<td>Church best method of coping</td>
<td>Importance of others</td>
<td>Differing levels of support needed-holistic?</td>
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<tr>
<td>Withdrawal</td>
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<td>Awareness from living in the UK</td>
<td>Depression is intentional</td>
<td>spiritual/religious etiology is familiar</td>
<td>Pastoral counselling solution</td>
<td>Social and physical support</td>
<td>Avoidance of health professionals</td>
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<td>Described by change in mood</td>
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<td>Very apparent in UK</td>
<td>Individual has control</td>
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<td>Support systems within the church</td>
<td>Intervention involves interaction</td>
<td>Important to know cultural group</td>
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<td>It is negative-‘it has ramifications’</td>
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<td>No word for depression in Nigeria</td>
<td>No room for depression</td>
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<td>There’s a solution for everything-embbed in the scripture</td>
<td>Level of care limited-being present?</td>
<td>Fear? Judgment</td>
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<td>Signifies that one is ‘in a bad pace’</td>
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<td>Depression not in cultural script</td>
<td>Importance of appearing strong</td>
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<td>No awareness of depression</td>
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<td>It influences social and financial circumstance</td>
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<td>Concerns about being perceived as weak</td>
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<td>Importance of awareness</td>
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<td>Mental health problem leading to suicide</td>
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<td>Advertising needed</td>
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<td>It is debilitating Mental health problem leading to suicide It is negative ‘Not something to have’ Depression makes one feel rejected and isolated Depression has a negative outcome suicide Depression has levels of severity Suicide</td>
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<td>Struggle initiating conversation with others Stigma of mental health problem Not keen to diagnose someone with depression Prefer not to use that word Implications of diagnosis marriage Depression does not warrant a diagnosis</td>
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<td>Denial/rejection of the word</td>
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APPENDIX J Themes and examples of supporting quotes

Depression manifestation- Visibility and invisibility

You can’t really ascertain or literally really see it except maybe you’re living with the person in the same house and but it’s something that has to do with emotions, you can only see the effect of depression.

On the scale of 100, I would say at 80% is when the effects start that when they know the person is depressed so it has to be very bad before its recognised.

person bowed down...looking down, the weight of the world is on his or her shoulders...lacking in self-esteem, thoughts are messed up and cannot make it in life because he/she thinks she cannot...but that is not true.

I know people have been saying it...I thank God I don’t have it.... but I have many friends...they will be saying that they are depressed.

First the d.. d means down, press means a pressure, so you’re press down and that is my understanding of it, its not a good thing, not a nice thing.

You can go mentally potty, it can take you anywhere, it is dangerous. I think any mental disease is more dangerous than a physical one on your body because it determines who you are ultimately and what you do and how you live your life. It’s horrible, to an extent I think it’s almost like a mirage because it’s in our control. People tend to get depressed and the part which is affected is the mind as a result of that everything else gets affected but since we, as individuals are in control of our minds,

I could tell because they would not have confidence in what they do...
It's how they tend to respond and behave; you know them really and you start noticing differences in their behaviour, like withdrawal. They are tired of life and want to be left alone; they don’t even want to associate anymore, they start withdrawing from social activities.

People can go to the extent where they feel that they can’t actually get on with their day as well and that’s when it gets even deeper where they feel that they can’t actually go on with their day to day activities...there’s no level of motivation to do anything.

On the scale of 100, I would say 80 is when the effects starts and when people know the person is depressed so it has to be very bad before it’s recognised.
it could be...even though they are in that state of sadness people could still be going about their everyday lives with that and they could have the outward show that everything’s good, everything is fine but their own inner self, they could be feeling very discontented.

.....How outspoken and how they tend to respond and behave; you know them really real and when you start noticing differences in their behaviour, like withdrawal, they are tired of life and want to be left alone; they don’t even want to associate anymore- that’s another effect, like they start withdrawing from asocial activities

Its not something that looks like something- it’s more of a feeling than a physical thing.

It’s a difficult thing to ascertain because it is something internal. It is related to ones emotions than the outside but sometimes people’s attitudes.

...I think when people are really low, when they are down...when they are kind of...isolating themselves or down ummm.... emotionally.

I don’t know a lot of people who have openly come out to say I’m depressed but I...you know...to an extent, I can tell when someone is not themselves or just feeling really low.

which an individual ummmm...is experiencing....what kind I say the traits of it to be...deep state of sadness, ummmm...I think it can manifest itself in different ways...

I think definitely about destruction as well...the person being very destructive in thoughts...not being able to concentrate necessarily on what they are actually doing ...cos their mind has gone somewhere else...its always pulling up negativity and being negative

**Contextualising depression**

I guess....life experiences...hmmm if someone encounters tragedy on a large scale to them...then... chances are that....that could send them into depression...so to speak. Hmmm...what else could cause it? Yeah...yeah.... I think that’s the main cause...to my understanding would be so.....an experience could be....ah...but I do remember hearing...reading something from Samaritans...on the Samaritan’s website where they said that ....(inaudible) like suicidal end of depression, if there is such a thing...that it is never usually one event that can cause that but it tends to be ...(inaudible) sustained kind of a situation over time then that’s the kind of thing that could cause someone to feel so low and to feel like...to take their life. So...to answer your question, depression is caused by something very bad happening to someone that makes...cause them to feel like there’s no hope to a situation that ...(inaudible)

oh...things like their marriage doesn’t work, their child dies. Things like their work, they don’t have work, lack of money, society, maybe they are different come from another country like me and the people there are not really treating them well...they don’t have the same kind of opportunities.
If I explain it in a literal way... I would say it is when you have difficulty in a particular area of your life— it affects you generally, in my own personal view.

If someone encounters a tragedy on a large scale the chances are that could send them into depression. I think that’s the main cause, it’s never usually one event that can cause that but it tends to be sustained situation.

It depends on what individuals are going through, their background, the situation they are in. A Job can cause it, when people don’t have job satisfaction, one can be depressed. Relationships can cause it, family can cause it, and finance can cause it. You know, anything can cause depression.

I think a situation of high level of stress and therefore leaving them unable to cope. Things like hmmm, having financial difficulties and again the stress levels coming up from there and seems like they’ve got nowhere to turn to.

They don’t have work, lack of money, society, maybe they are different and come from another country like me and the people there are not really treating them well, they don’t have the same kind of opportunities.

probably they rely on other people... and they are not sure of themselves... they don’t know what they worth or what they capable of so it seems that they depend on other people or they are like... very low when it comes to... moody or like... segregating themselves... isolating themselves sort of. Sometimes they will be low or sometimes they be happy when they are in the midst of people. And they can be angry sometimes or take their anger on other people... yeah, they like taking their anger on other people... you know... getting angry unnecessarily.

Anybody can experience depression. It depends on individual circumstances... it depends on what individuals are going through... their background... the situation they are in... job can cause it, family can cause it, finance can cause it, relationship can cause. You know... anything can cause depression... The pressures... the problem... you can read it all over them. Job can cause it as well... when people don’t have job satisfaction... job can also cause... one can be depressed... relationship can cause it. I cannot say it is a particular person... It happens between black and white so like I said it depends on the situation or the circumstances that each individual finds themselves.

If somebody loses his or her job when someone loses his or her job and he has children and has to pay all their bills and if no help is coming from anywhere. Another thing is relationship, If a relationship breaks down, like husband and wife... let’s say a man moves out and the woman has little children, she may not be able to handle it or if they are teenagers for example... She may not be able to handle it. So things like that could cause depression so anybody can have it... it depends on how people handle their situation or the challenges or the problems they find themselves in.
Like if you have been doing everything and nothing comes out of it and you try, try, try and no help ....just fed up of things, of everything, of life...that nobody is there for you to listen or to help...so its kind of...Im fed up....

I think Ill be naïve to say that anybody is...hmmm...immunised against...I think in terms of situations that cause it....that would be easier for me...do you understand? I think anybody...absolutely anybody, including children could experience depression...I think it more to do with what triggers it, what’s the situation. I think it’s also to do with the support system. I definitely think its to do with the support system as well.

if a person is stressed and can’t cope with that level of stress it would allow them to fall into a medical breakdown and that can be portrayed or perceived as depression as well. So again, a situation of high level of stress and therefore leaving them unable to cope ...things like hmmm...having financial difficulties and again...the stress levels coming up from there and literally ...seems like they’ve got nowhere to turn to...can lead a person to feel...I should I put it of ...of depression...so to speak and hmmm....mainly lead the person leading on from there to feel suicidal, so to speak.

It could be financial, it could be emotional, it could be just some sort of...you know...deep rooted unhappiness...I think...that could lead to someone having funny thoughts or acting in a certain way. Feeling very low. Being low as in just feeling really low and sometimes it could lead to things like being suicidal....but I know it’s a state of one’s mental health.

what I actually understand by depression is actually synonymous with excessive workload where has been bombarded with a lot of stuff where he or she is finding it difficult to cope and needing time to organise his/herself and taking time to rest. Depression was about workload, family, domestic, pressure...it had to do in pressure, being tired, needing some time.

Working class mum, very busy individual with workload, working. People that have a lot of workload, work long hours, have a lot on their table. People that may have been traumatised by death in the family, business wreck...things that could make people feel really down.

would say within the culture, it is not seen as something that is severe. Unless it is a severe case but sometimes they tend to associate people with depression ...especially when they manifest the after effect as people that are derailed, people that are mentally unstable and on occasions; witchcraft. The person is not in the right state of mind and sometimes they behave in a way that is not really acceptable so they tend to perceive the person as though they are a witch or insane but they forget that fact that there is something triggering that act of depression.

....if a person is stressed and can’t cope with that level of stress it would allow them to fall into a medical breakdown and that can be portrayed or perceived as depression as well. So again, a situation of high level of stress and therefore leaving them unable to cope ...things like
hmmm...having financial difficulties and again...the stress levels coming up from there and literally...
...seems like they've got nowhere to turn to...can lead a person to feel...I should I put it of ...of
...depression...so to speak and hmmm....mainly lead the person leading on from there to feel suicidal,
so to speak.

Again, someone might feel depressed because their life has been turned around. Maybe a partner
left them or something like that and they feel like they can't cope or go on any further.

**Cultural adaptation**

There has been a shift, especially among those educated souls that have gone through the system,
whether abroad or back home. The educated ones seem to understand what depression really
means and they can be in a better place to help those experiencing depression

Depression was about workload, family, domestic, pressure...it had to do with pressure, being tired,
needing some time. However, when I came to the UK, I came to understand that depression is a lot
more than I thought. Here, it relates to the mental state and behavioural ability...you
now...comprehension it has to do with mental state of mind

You're encouraged to take the back seat but down here, it's been known to be a mental problem
and they should seek support.

We've never associated to ...like I said...down here in the UK...to the mental state of one's mind
They don't see it as a negative...in the UK. I got to understand that depression is a mental state of
mind...anyone known to have a mental state of mind has a stigma attached to them

Back home, it's not a big issue. We don't see it, you don't diagnose someone with depression
because it's not seen a health problem.

I found out what depression is after a few years here. Nobody says depression in Nigeria but I imagine
many people have it. We [Nigerians] don't really know what to call it or how to describe it.

Depression is not common in Nigeria. It is not part of the culture. We were not told about depression.
They don't say it, they don't recognise depression. You won't hear anybody saying I'm depressed but
in the UK, it is common here. You hear it. You can see that people are depressed and they will say it.

So in Nigeria, in particular, they don't recognise depression. They don't, it may be there but they
don't recognise it as a problem...

It is not part of the culture, in Nigeria. We are not brought up....or told about depression. They don't
say it, they don't recognise depression...people would have it but they would rather put it in another
way...rather than say depression.

They don't recognise what is depression in my country but they could just think I am fed up ...I am
fed up, oh this life is hard, its difficult, things like that. So in Nigeria it's not really like...depression
In Nigeria, we don’t like to term things, we don’t like to say this person is suffering from this thing or that thing… they would tell you I’m not depressed.

When I came to the UK, I came to understand depression - the word we use like a good morning word was a no go area...a better understanding instead of using the word randomly.

Well, what I actually understand by depression is that it is synonymous with excessive workload. However, when I came to the UK, I understood that depression was a lot more than that. Here, it relates to the mental state you know; it has to do with a mental state of mind.

Nigerian government introduce that and bring the awareness of what is called depression to the people...people that have it will know....oh...so I’m suffering from depression but they don’t recognise what is depression in my country but they could just think I am fed up ...I am fed up...oh this life is hard...its difficult...things like that. So in Nigeria it’s not really like...depression.

the individual may not be aware that they are depressed themselves. They might just look at it as though they’re going through a rough patch and there’s this thing about not talking about certain things, that’s why I mentioned religion. Like...you’re feeling low, pray about it and search the scriptures and stuff but sometimes you need to actually say okay... I’m feeling like this... I’m not sure what to do...let me talk to somebody about it. It’s just something that people don’t talk about and things. If you’re not aware you’ve got a problem then you’re not sure who to go to.

I don’t know a lot of people who have openly come out to say I’m depressed but there’s the stigma of mental health/depression, the person is mentally unstable.

In my culture, people don’t really say depression, because they would use another word. It’s not that they don’t have it but in Nigeria they don’t really recognise it as depression...they just don’t want to use that word.

Cultural beliefs

I think it’s something that is definitely not discussed. It’s almost taboo to have that discussion because people are always very highly motivated and always taught to be driven you know...and there no time or space to be depressed...it’s a get on with it type attitude so it’s almost to say that if a person is feeling depressed that they can snap out if it and move on to state that it only last for short period of time then it shouldn’t be dwelled upon...there’s always a solution...so...I think that’s how its regarded...it’s not tolerated

...Self induced or controlled depression could potentially side tracked it if they took away their focus...to way themselves...to be honest from the focus point and sort a high being or sought they need to go though this trial in order to come,
A cultural background that I have personally is that we are very self driven... do you understand...so...its the care that its almost perceived that the person depressed is almost... as if they’re doing it un purpose... as I said... from my understanding that not everybody does it deliberately... ummm... as in its not... it can be chemically induced as well... um... but its a state of okay... your depressed because something hasn’t gone the way that you wanted it to go... you know... it can be... somebody’s died... it can be very understandable but its the case that you’ve got enough self-control to overcome that situation that there is a network available somewhere to assist you... to support the person in one way or the other... to allow them to get over this season.

I think we abuse ourselves... a depressed person is abusing herself/himself... you are hitting at yourself and your slapping yourself... your say... oh it didn’t work... they made me redundant. You are abusing yourself and effectively you are really saying to your creator... whosoever you call your creator... your saying you didn’t do a good job... you should have come to help me after all... your suffering... you should have stopped this... well you can’t... so effectively saying creator... your not even creator so let me take this and let me handle it... yes we are doing it to ourselves... we definitely are... we hurting ourselves by ourselves.

Some people cannot handle it, it becomes depression and when they cannot handle it, it turns to something else but it depends on how the individual handles it.

It’s the case that you’ve got enough self-control to overcome that situation... there is a network available somewhere to assist you.

A depressed person is abusing herself/himself. You are hitting at yourself and your slapping yourself, your say oh it didn’t work and they made me redundant. You are abusing yourself and effectively you are really saying to your creator, whosoever you call your creator, your saying you didn’t do a good job... yes we are doing it to ourselves, we definitely are, we’re hurting ourselves.

so its almost to say that if a person is feeling depression that they can’t snap out if it and move on to state that it only last for short period of time then it shouldn’t be dwelled upon... there’s always a solution.

its not tolerated because it’s to say that look... there are solutions there... lets... what do you need done... let’s get it done... in order to feel... because obviously something’s happen to trigger... that the perception that something has happened to trigger the fault... so therefore whatever it is... let’s do whatever it takes to resolve.

Religious/spiritual beliefs

In my culture, some people may be seen as possessed by a particular spirit; an evil spirit and something is moving them to do whatever they are doing so they don’t really see depression as something that is affecting he/she. It’s just seen as some that is really possessed.
Africans are very religious they cover everything up...you’re not praying about it and stuff but actually it’s something that can happen quite easily and it has that stigma, I think.

I think it’s also a hangover, carryover from the historic, ancestors, interpreting things from a spiritual element when they didn’t understand things. When there is a lack of understanding of something...then it tends to be explained by spiritual factors...probably the older generation...people who have more of the ancestral point of view would probably not really know what to say or they would probably still just put it off, you know onto spiritual cause and effect and you know, look for purely spiritual solutions.

A lot of information would have gone, filtered through family. The family unit has broken down quite widely so people rely on media whether it is social or just rudimentary types of media get an understanding of this [depression].

**Social and practical support**

if someone has a friend and they know that I am always in a happy mood, and we talk, then all of a sudden, I had a baby or I got married and I start becoming really cold, like the light in me is not there. That is when one needs to step in because the person should know that there is something wrong- either the persons depressed or going through a particular situation in life and where he or she needs help. The best way I think you can go about it is not just seeking for professional help but among friends and trying to identify people that are not in their normal state.

Like if you have a friend and you have a friend very well. How outspoken and how they tend to respond and behave; you know them really real and when you start noticing differences in their behaviour, like withdrawal, they are tired of life and want to be left alone; they don’t even want to associate anymore- that’s another effect, like they start withdrawing from asocial activities and all that so when you have people around you, friends and family and they start withdrawing and things then its best to have a conversation, which can help out with people that are depressed.

People that are depressed tend to hold onto themselves and don’t like expressing themselves but if you create that atmosphere to say what they are going through or what is leading them to depression, I think its like 50% solved because when they are able to say it out then its kind of a relief to them.

It doesn’t come from the heart, so both the man that does not know Jesus and you in the church behave the same way to the person that is depressed...that is not the way it should be. As for those who don’t know God, my culture...ummm...they probably would care for them if they are relatives...they would... but if as a result of the depression, they begin to behave funny, eventually they are going to let them go or look for a way to get them out of the house or whatever...something will happen but they will not be taken care of. That is what happens to us.
people stay away, very rarely did she have visits, in the fact...there’s a third one but she’s not Nigerian. People stay away. In my Church for example, this third one was in our Church and people did not really reckon with her.

‘I’m going out to parties, I’m going out to see my friends...they believe when they are in the midst of people, they won’t be lonely...they can be talking to people... they believe the situation would go away’.

People that are depressed tend to hold onto themselves and don’t like expressing themselves but if you create that atmosphere I think it’s like 50% solved because when they are able to say it out then it’s kind of a relief to them.

What do you need done, let’s get it done in order to feel better because obviously something’s happened to trigger the fault so therefore whatever it is let’s do whatever it takes to resolve it’

There are different types of support systems, they could talk to debt companies and that pressure could be reduced from that respect...have some financial support for women..., and with that support network, their life is turned...a good support is a big thing.

There are some people that need to talk to people but they would just stay inside their house but if they refer them to the psychologist at least to people...counsellors, psychologists that can listen to them then they would know that somebody is there that would listen to me, that would help me...so they could hear their voice so they won’t feel rejected or isolated so they would think that they don’t have anybody...no friends, nobody like me, nobody would listen to me...at least the psychologist would listen to them.

they can arrange many things...they do it....like arranging people going to the park...maybe people that are single, lonely, widow, you know...

its again about the support system which can overcome it because that same person who was almost suicidal with a good support system, again using money as a thing...a situation could find that debts has been thrown at them...you know... but there is different types of support systems...

so I’ll just say with that regard...they will be sensitive to depression and have sympathy for the individual but only to an extent to say that...I understand... You’re real...these things happen but its not to say that’s the end of that...we now have to move on and get the issue resolved.

When somebody is associated with a mental state then the person is sick, mentally unstable...depression is looked at something that can be overcome...getting the right load, getting people to help you out Yes, domestic support, work support, family support ...encouraging you to sleep, yes and it is expected that once someone has got all that, he or she would be fine
You got a lot of your families and friends but you could still feel as though there’s no one there for you even though you have a lot of people there. The reason is because they don’t want to know what you’re going through, they just want to help you. They kind of forget that you have gone through an experience.

Yeah, people use words liked depressed...if he uses it they assume that you need a hand, when someone voices out...depressed/...tired goes together...people see it as you have lot going on and addressing it as one at a time.

They [Nigerians] will be sensitive to depression and have sympathy for the individual but only to an extent to say that I understand. These things happen but it’s not to say that’s the end of that...we now have to move on and get the issue resolved.

**Religious and spiritual support**

yes...religion is very important. In my culture...the spiritual is very much...is very real to people...and so...depression would be viewed as...I guess....as an attack or as a curse or something...basically something that has originated in spiritual side of things and hmmm and something that would need to be...I guess...be removed also primarily in a spiritual way...

its viewed largely as a...oh...this is a problem that you've got to get some prayer for...get some spiritual help for....spiritual healing for...to move on from that...because I believe everything that spiritual side there is also a physical side and that...hmmm...where you want to bring about spiritual healing there’s also got to be physical healing and that if you don’t understand the physical side then the spiritual side could be misappropriated...can be misused basically.

They need to refer to what God has said on the topic  and that if they are experiencing this it means that they haven’t referred to the bible and seen what has occurred in somebody else’s life through the bible and how they can resolve it. Job for example...he came through so much affliction and so many problems, he didn’t fall into depression.

If people perceive depression in that way, they will most likely take the person to church for prayer or seek spiritual help from deities. That is the most acceptable way of handling people in a depressed state.

In my culture, they would take the person to church for prayer. Personally, I believe God can help with everything we go through but the next step is to go for counselling or speak to professionals to help the person come out of depression and try to look for the culprit of the depression. If its something to help whoever is going through it and recover from depression.
It’s not just about the church in as much as your praying, for example, a single mother who has three children and she has no husband or nobody to help and going through depression, one cannot say let’s go to church and pray... The church and prayer will not bring that finance to her.

Personally, I believe God can help with everything we go through but the next step is to go for counselling or speak to professionals to help the person come out of depression.

I believe everything that has a spiritual side there is also a physical side and that where you want to bring about spiritual healing there’s also got to be physical healing...I think that could work in tandem with the spiritual.

now you are a Christian, you have the education but you are not even applying your life-style to that person because you are a Christian, there is a way that Christians behave that non-Christians don’t?

Jesus in the forefront ...putting yourself in the forefront you know....and understanding that as humans ...we are going to have trials...you know...God has given us a mandate to say that we’re going to have trials and tribulations but he has also said that he would be there for us so....I think that in its very right has given people mainly without faith falling into...

the church goes out and seeks homeless individuals. Some of those homeless individuals could be experiencing deep levels of depression...its not mandatory ...its not even...its nothing....its not even required or talked about...whether...what their religious background is. It’s a case of...you need food...come and get a hot meal...do you understand....and moving on from there ...there is an opportunity to discuss what allows the person to be in that situation in the first place and to seek resolution. Some people do go further and turn their life around through the support system...some people go back out and continue the lifestyle they had but their know that that door is there...so...its not necessary for them to have any affiliation with the church to benefit from the services.

Like...you’re feeling low, pray about it and search the scriptures and stuff but sometimes you need to actually say okay... I’m feeling like this...

They now know that its not just about the church in as much as your praying, for example, a single mother who has like three children and she has no husband or nobody to help and find it difficult to look after the kids- going through a depression, one cannot say lets go to church and pray. She would need physical help, she needs people around her, she needs finance. The church and prayer will not bring that finance to her. They would need to talk it through or a social worker to help with the children because honestly speaking he/she is not in her right state of mind so he/she really needs to be monitored. Remember if its someone who has kids then we’re talking about a bigger picture because other people are effected. In the UK, they have a system in place to handle such issues.

...I think that could work in tandem with the spiritual...with the spiritual understanding... spiritual knowledge...hmmm...I believe that God gives the ability to people to learn about the human body
and learn how to cure illnesses and things like that and yeah...I believe that there’s room... speaking objectively, speaking...hmmm..., it would probably be difficult, it would probably take a lot of time and a lot of hard work and there would probably be quite a lot of closed doors just because...and also because people may not see it as something that need to be dealt with...yeah as a problem.....as a big deal...I mean, even though it is...and it should be...I do believe that there is room and it can happen...yeah.

**Seeking professional help**

Professionals need to understand...within my culture, they have a frame of mind...regarding this thing called depression. So they should be aware that the person may not be mentally unwell and that could be mistaken for medical depression...they should be able to identify what they are going through. Ask them specifically what they think depression is. One could be misdiagnosed, especially from the African. The individual could take offense...the person is actually saying I need time off then the person is being diagnosed with medical breakdown....they need to understand what is used randomly, where they are coming from.

There are some people that need to talk to people but they would just stay inside their house but if they refer them to the psychologist at least to people...counsellors, psychologists that can listen to them then they would know that somebody is there that would listen to me, that would help me...so they could hear their voice so they won’t feel rejected or isolated so they would think that they don’t have anybody...no friends, nobody like me, nobody would listen to me...at least the psychologist would listen to them.

There is a fear of judgment. I think it is a very sensitive issue and needs to be handled with care because you think you’re trying to help the person but in the long term you make life more difficult for the person and that may lead to the person becoming mental.

The first thing is you know, obviously listening, Listening to them, not criticising them and just listen to what they are actually going through.

Professionals need to understand, within my culture, they have a frame of mind regarding this thing called depression. So they should be aware that the person may not be mentally unwell and that could be mistaken for medical depression. They should be able to identify what they are going through. Ask them specifically what they think depression is.

I guess they would need to know when it started....and what sort thing could have started it. Maybe have they talked to someone you know...how was it received and just yeah... how things have progressed and how long they dealt with it...yeah...I guess....they need to know that because it is possible that it’s something that was brought about in a spiritual way but maybe not so I think...yeah...just having all that information into hand is necessary

However, if services are free, like in the UK, the fear of judgment. Imagine a mother who is depressed goes to the NHS and says she is depressed she would fear that they will take the children
away and the family would rather wait and see whether she recovers from that state of depression. Unfortunately that would make a person more depressed because it would be an issue that led to depression but will also be thinking about his or her children being taken away from them, I think it is a very sensitive issue and needs to be handled with care because you think you’re trying to help the person but in the long term you make life more difficult for the person and that may lead to the person becoming mental.

They should not assume that they know about depression within a Nigerian context. They should handle people on a neutral ground because people from my culture don’t really understand what depression is so they should be very sensitive and patient so you can get more from them. It depends on how that issue has been presented. It should not be presented as a stigma. It’s about letting them know that it is a normal thing to be depressed but how you overcome it is important.

I think that’s where it’s really important. People around you are of great importance when it comes to depression. A doctor from nowhere cannot really just diagnose the person as depressed except if the doctor is currently receiving treatment or if the person is bold enough to cry for help, such as I’m depressed because I’m stressed, I can’t look after my kids, or can’t do what I am meant to do, or because of failure so most times, the people around you are the first people to notice depression and in the better place to help.

They could seek advice, talk to people, like psychologist …because many people…may not want to go to a psychologist…but they could do advertisement or teaching people…telling people or through referral…GP can refer people for counselling for people that would help them and people that could give them kind of talk, advice or counselling. At least they would know that people are there to talk to…at least they would know that people are there to talk to…not that they would carry their burdens or all the problems upon themselves…they could go to the doctor or psychologists to open up their minds and open their heart and they could get help, get advice.

what I know about my cultural group, in terms of my ethnic background, I think they need to know it needs to be highly confidential…they need to know that the person….may be conscious that they’re going to be judged or seen as being weak…do you understand….that the person may defend…denial…should I say or….avoid being diagnosed in the first place.

they need to understand that the individual may…will…have defences up…do you understand…and…will maybe strongly ...(inaudible) in denial and not prepared to actually except it so they need to be aware of that and confident…they need to be reassured that confidentiality will be upheld…that sort of…prescription of drugs may not be received very well… that they may be some avoidance in regards to taking any level of medication.

Seeking information/awareness

I think if there’s forum for sufferers to come confidently to a place where they won’t be judged, be condemned... be able to come forward to talk about what they are going through…what works…and…you know…like if they have meds…I just remembered that I was reading some tweets
from someone actually...who is...hmmm...who lives in the country I come from...its good that I just remembered that because I guess that’s an example of someone who would be interested in a forum to create awareness and to help sufferers because she’s a public figure and she’s speaking out about it and its obviously very personal.

Because Nigerian culture is kind of...how would I put it...in traditional way...because it’s a third world country and not everybody I going out to be exposed but if they can bring the awareness to them in...saying it on the telly...go to the hospitals...bring the awareness to people....if they are feeling bad...let the doctors test them and make referral....

They don’t really show it in Nigeria but if people...through referral or through connection. For example, if you come to my country now and I know you and see one of my family or friends that is always getting fed up of life, I could introduce them to you or if the government, in Nigeria, is aware of your job, they could introduce your role, your profession to the country, to the people...you know.

I think with the understanding that depression is medical and its come from chemicals not being produced and stuff like that. I don’t think its general knowledge...I don’t think that’s general knowledge...not just with my cultural group...I don’t think that’s general knowledge at all.

I think it’s because people are not aware of what depression is and how easy it is to slip into that sort of attitude...I don’t think attitude is right too but slip into being depressed. So I think a lot of people, due to awareness would say that person is depressed...what are you depressed about and I think sometimes.

I think it’s because [Nigerians] are not aware of what depression is and how easy it is to slip into that sort of attitude. So I think a lot of people, due to unawareness would not say that person is depressed, they would say what are you depressed about?

There is just a lack of information, and information brings about knowledge and knowledge is power, so I think, there’s just been a lack of information about depression and indeed about mental illness.

It’s not as if depression is not there, it’s just that maybe the awareness is not there but those of us that are becoming educated and becoming more developed and have travelled we now understand that depression is everywhere so it’s about awareness.

It’s just something that people don’t talk about and things. If you’re not aware you’ve got a problem then you’re not sure who to go to.
I think some people would...could...can...think they have depression....I think yes...that could go both ways because someone can think they have depression and they not have it or they not be diagnosed with being clinically depressed but they may just feel so low and they may just think...wow...maybe this is what depression feels like...hmmm...but if someone has been diagnosed with depression...but they can’t come out and talk about it maybe because they don’t think they would get the help that they need and I guess that probably won’t help and they may just feel lower because they can’t get help....hmmm...so I think...I think either way, it’s just basically...it’s not talked about. ...it’s not really...there’s definitely a lack of understanding...

There has been a shift, especially among those educated souls that have gone through the system, whether abroad or back home. The educated ones seem to understand what depression really means and they can be in a better place to help those experiencing depression.
APPENDIX H

Journal of Counseling Psychology - Notes for contributors

Format

- Have you checked the journal’s website for instructions to authors regarding specific formatting requirements for submission (8.03)?

- Is the entire manuscript—including quotations, references, author note, content footnotes, and figure captions—double-spaced (8.03)? Is the manuscript neatly prepared (8.03)?

- Are the margins at least 1 in. (2.54 cm; 8.03)?

- Are the margins at least 1 in. (2.54 cm; 8.03)?

- Are the margins at least 1 in. (2.54 cm; 8.03)?

- Are the title page, abstract, references, appendices, content footnotes, tables, and figures on separate pages (with only one table or figure per page)? Are the figure captions on the same page as the figures? Are manuscript elements ordered in sequence, with the text pages between the abstract and the references (8.03)?

- Are all pages numbered in sequence, starting with the title page (8.03)?

Title Page and Abstract

- Is the title no more than 12 words (2.01)?

- Does the byline reflect the institution or institutions where the work was conducted (2.02)?

- Does the title page include the running head, article title, byline, and author note (8.03)? (Note, however, that some publishers prefer that you include author identification information only in the cover letter. Check with your publisher and follow the recommended format.)

- Does the abstract range between 150 and 250 words (2.04)? (Note, however, that the abstract word limit changes periodically. Check APA Journals Manuscript Submission Instructions for All Authors for updates to the APA abstract word limit.)
Paragraphs and Headings

- Is each paragraph longer than a single sentence but not longer than one manuscript page (3.08)?
- Do the levels of headings accurately reflect the organization of the paper (3.02–3.03)?
- Do all headings of the same level appear in the same format (3.02–3.03)?

Abbreviations

- Are unnecessary abbreviations eliminated and necessary ones explained (4.22–4.23)?
- Are abbreviations in tables and figures explained in the table notes and figure captions or legends (4.23)?

Mathematics and Statistics

- Are Greek letters and all but the most common mathematical symbols identified on the manuscript (4.45, 4.49)?
- Are all non-Greek letters that are used as statistical symbols for algebraic variables in italics (4.45)?

Units of Measurement

- Are metric equivalents for all nonmetric units provided (except measurements of time, which have no metric equivalents; see 4.39)?
- Are all metric and nonmetric units with numeric values (except some measurements of time) abbreviated (4.27, 4.40)?

References

- Are references cited both in text and in the reference list (6.11–6.21)?
- Do the text citations and reference list entries agree both in spelling and in date (6.11–6.21)?
- Are journal titles in the reference list spelled out fully (6.29)?
• Are the references (both in the parenthetical text citations and in the reference list) ordered alphabetically by the authors’ surnames (6.16, 6.25)?

• Are inclusive page numbers for all articles or chapters in books provided in the reference list (7.01, 7.02)?

• Are references to studies included in your meta-analysis preceded by an asterisk (6.26)?

Notes and Footnotes

• Is the departmental affiliation given for each author in the author note (2.03)?

• Does the author note include both the author’s current affiliation if it is different from the byline affiliation and a current address for correspondence (2.03)?

• Does the author note disclose special circumstances about the article (portions presented at a meeting, student paper as basis for the article, report of a longitudinal study, relationship that may be perceived as a conflict of interest; 2.03)?

• In the text, are all footnotes indicated, and are footnote numbers correctly located (2.12)?

Tables and Figures

• Does every table column, including the stub column, have a heading (5.13, 5.19)?

• Have all vertical table rules been omitted (5.19)?

• Are all tables referred to in text (5.19)?

• Are the elements in the figures large enough to remain legible after the figure has been reduced to the width of a journal column or page (5.22, 5.25)?

• Is lettering in a figure no smaller than 8 points and no larger than 14 points (5.25)?

• Are the figures being submitted in a file format acceptable to the publisher (5.30)?

• Has the figure been prepared at a resolution sufficient to produce a high-quality image (5.25)?

• Are all figures numbered consecutively with Arabic numerals (5.30)?
• Are all figures and tables mentioned in the text and numbered in the order in which they are mentioned (5.05)?

Copyright and Quotations

• Is written permission to use previously published text; test; or portions of tests, tables, or figures enclosed with the manuscript (6.10)? See Permissions Alert (PDF, 13KB) for more information.

• Are page or paragraph numbers provided in text for all quotations (6.03, 6.05)?

Submitting the Manuscript

• Is the journal editor’s contact information current (8.03)?

• Is a cover letter included with the manuscript? Does the letter
  o include the author’s postal address, e-mail address, telephone number, and fax number for future correspondence?
  o state that the manuscript is original, not previously published, and not under concurrent consideration elsewhere?
  o inform the journal editor of the existence of any similar published manuscripts written by the author (8.03, Figure 8.1)?
  o mention any supplemental material you are submitting for the online version of your article?
Perceived Ethnic Discrimination, Shame Related Beliefs and Emotional Well-Being of Black Africans Compared to White British Adults

Abstract

It is well established that perceived ethnic discrimination is associated with poor emotional well-being (i.e. depression and anxiety) in minority ethnic groups. Yet, Black Africans living in the United Kingdom (UK) have substantially lower rates of depression and anxiety compared to White British adults. Shame and stigma associated with mental health problems have been identified as one main reason why Black Africans underreport their experiences of mental health problems. The goal of this study was to gain a better understanding of the emotional well-being of a minority Black African group compared to a majority White British group. The study used a multiple mediation model to test the hypothesis that perceived ethnic discrimination and two shame beliefs (i.e., external shame and internal shame) mediates the relationship between culture and emotional well-being and to explore the indirect effect of cultural values (i.e. horizontal individualism, horizontal collectivism, vertical individualism, and vertical collectivism) on the relationship between culture and shame beliefs towards emotional problems (i.e., community/family shame, external shame, internal shame, family reflected shame and Self reflected shame). White British (n=90) and Black African (n=87) adults completed paper copy or online questionnaires. Results suggested that Black Africans reported significantly greater experiences of perceived ethnic discrimination. A significant level of shame related beliefs towards emotional problems and individualist values were also reported among African participants. External shame beliefs separately mediated the relationship between culture and emotional well-being and Vertical collectivism specifically mediated the relationship between culture and self-reflected shame beliefs. The study highlights a number of implications for counselling psychologists and emphasises the need for future research to examine the complex interplay between culture and emotional well-being.

Key words: discrimination, shame beliefs, culture, individualism-collectivism, well-being
Perceived Ethnic Discrimination, Shame Related Beliefs and Emotional Well-Being of Black Africans Compared to White British Adults

The experience of ethnic discrimination is greater among Black people relative to other minority ethnic groups (Gary, 2005, MIND, 2013) and evidence indicates a link between discrimination and vulnerability to depression and anxiety (Karlsen, Nazroo, McKenzie, Bhui & Weiche., 2005; Anglin, Lighty, Greenspoon & Ellmann, 2014). However, epidemiological studies in the UK have shown considerable differences in ethnicity and emotional problems (i.e. depression/anxiety). Studies predominantly involving Black Caribbeans report higher rates of depression (Odell, Surtees, Wainwright, Commander & Sashidharan, 1997; Nazroo, 1997; Shaw, 1999). However, the detection of depression/anxiety among Black Africans, in particular, has been found to be substantially lower compared to their White British and Black Caribbean counterparts (Maginn, Boardman, Craig, Haddad, Heath & Stott, 2004; Weich et al. 2004). Maginn et al. (2004) found that the strongest predictor of detection of anxiety/depression in their primary care service study was the patient’s willingness to speak to their General Practitioner (GP) and that Black Africans were less likely to consult their GP. Studies comparing cultural differences in illness perception in other European countries as well as African Americans in North America confirm that members of these ethnic groups are less likely to utilise mental health services (Karasz, 2005). Several hypotheses have been proposed to account for these ethnic variations among people of African descent. One hypothesis proposes differences in conceptual models of depression, where emotional difficulties do not constitute depression as a diagnostic category in an African context. Research indicates that some Africans are more likely to attribute depression to social circumstances or are more likely to explain depression based on their cultural and religious beliefs. For example, among some West Africans, deeply entrenched beliefs of demonic possession, sorcery, and affliction by God or gods have been used to explain and understand psychological distress (Aina, 2004; Adebowale & Ogunlesi, 1999). Consequently, individuals are likely to deny or ‘normalise’ psychological distress (Kessler et al., 1999) and avoid GP consultations.

2 For the purpose of this study, the term Black people refers to men and women whose ancestral heritage is linked to the continent of Africa and the Caribbean’s. The term acknowledges the wide variations and recognises the homogeneity in the sense of a shared experience of discrimination, racism and oppression (Alleyne, 2005).
A second hypothesis attributed to the underreporting of emotional problems in people of African descent is shame and stigma (Gureje, Victor, Lasebikan, et al., 2005). Sadly, mental health remains a taboo within the African community (Gureje, & Lasebikan, 2005) and consequently, many Black people needlessly endure psychological distress and often delay support until crisis point because of shame and fear of being stigmatised in their communities (Adewuya et al., 2009) or because they do not want to shame their families (Health Forum and the Migrant & Refugee Communities’ Forum, 2005). It is important to understand attitudes towards mental health within African communities because empirical evidence indicates that cultural beliefs could influence an individual’s view about psychological distress and access to mental health service (Chen & Mak, 2008). This is because the first feedback a distressed person receives is typically from friends/family within their cultural context. This is relevant for people of African descent as one important factor that has been implicated in the extant literature among some African communities is the significance of communal support and religion. Consequently, Cohen et al (2005) conclude that poorer outcomes are likely to exist whenever care is not accessed. Yet research investigating depression/anxiety in people of African descent is scarce. The limited research, in part, could reflect the tension between depression as a diagnostic category, commonly found within the Diagnostic and Statistical Manual of Mental Disorder (DSM) and the conceptual appropriateness of applying a Western diagnostic criteria to Black people (and other minority ethnic groups), whose language of distress does not incorporate the dominant medical model of a biological predisposition, biochemical imbalance or a neurological condition. The medicalised conceptualisation of depression has increasingly been contested and there has been much debate surrounding the term ‘depression’ as the word itself is absent from the languages of many cultures (Hamdi, Amin, & Abou-Salch, 1997) and used rarely in some cultures (Abusah, 1993). Others have drawn attention to the limitations of using depression as a diagnostic category when studying minority ethnic groups. Undoubtedly, this is a major dilemma for researchers studying well-being in Black people, however; the researcher is of the opinion that research in this area is desperately needed as current literature on psychosis and schizophrenia indicate greater levels of distress within this population. Therefore, research investigating well-being within a cultural context could be useful in identifying and decontextualising the complex web of cultural values, socio-political and economic structures (e.g. family, community, racism, discrimination, poverty, inequality, and acculturation) that maintain the status quo (Fenton & Sadiq, 1991). Indeed, these
sentiments are echoed through counselling psychology’s commitment to understanding human distress in the context and appreciation of social political processes. By positioning distress as difficulties in living (Van tucker Deurzen & Arnold-Baker, 2005) counselling psychologists are well positioned to openly challenge and critique the existing social structure and its use of classification systems. In view of these conceptual challenges, the researcher will utilise validated measures and report data on well-being as subclinical levels of depression rather than labelling participants as ‘depressed’ and/or ‘anxious’. Moreover, a critical-realistic approach is incorporated by the researcher to develop a sophisticated understanding of well-being in an African sample and the impact of sociocultural structures such as culture, religion, language and politics. The view put forward here is that a critical realist position acknowledges the material reality of the subject ‘depression’, yet conceptualises it as a complex phenomenon that is only discursively constructed as ‘depression’ within a specific historical and cultural context (Ussher, 1999).

Moreover, there have been calls for research to elucidate the role of gender, culture and ethnic factors in emotional problems and its relationship to discrimination in BME (Dein & Bhui, 2013). This is an area of particular relevance for the field of counselling psychology given its historical interest and commitment to social injustice (Milton, 2014) and multiculturalism (Tucker et al., 2011). Therefore, the present study aims to address the paucity of research in this area by investigating two distinct pathways influencing emotional well-being in African people. Perceived ethnic discrimination and the impact on emotional well-being constitute one pathway and the significant value placed on stigma and shame related beliefs towards mental health problems form the second. Understanding these mechanisms are particularly important for the practice of counselling psychology, because as will be argued, counselling psychologists are well situated to meet the emotional needs of individuals experiencing ethnic discrimination and preventing stigma related issues impeding help seeking. The remainder of this section focuses on expounding the two pathways before proceeding to the rationale and aims of the study.
**Perceived ethnic discrimination and emotional well-being**

Experiences of ethnic discrimination are being recognised as important realities given the deep rooted psychological impact to individuals across the age span (Greene, Way, & Pahl, 2006; Brody et al., 2007). Considerable evidence has accumulated documenting the association between perceived ethnic discrimination and mental health problems including, depression/anxiety (Brondolo et al., 2008; Williams & Mohammed, 2009). Based on several empirical studies conducted in the United States (US) Clark (2003) theorised that the more ethnic discrimination perceived across time and contexts, the greater the emotional impact. In a recent cross-sectional study of African-American and Latino students, Brittainn et al. (2015) found that African-American students reported significantly higher ethnic group discrimination compared to Latino students. The authors also found that ethnic group discrimination was positively associated with depressive symptoms in both groups. In a similar study in the UK, Cassidy et al. (2005) found a strong relationship between anxiety and perceived ethnic discrimination and that the relationship between depression and perceived ethnic discrimination was mediated by anxiety among Chinese, Indian and Pakistani people. A small number of longitudinal and prospective studies have also yielded similar results. For example, in their 4 year-longitudinal study, Hurd, Varner, Caldwell and Zimmerman (2014) found that perceived racial discrimination in Black adults contributed to escalations in anxiety symptoms, depressive symptoms, and unhelpful coping styles. Similar findings were also reported by Sellers and Shelton (2003) in their longitudinal study. Ong, Fuller-Rowell and Burrow (2009) examined daily diaries of reported racial discrimination. A significant association between racial discrimination and daily distress, including anxiety, negative affect, and depression was found in their sample of African-American students. Consistent with this idea, Inman, Pratyusha, Tummala-Nerra et al. (2015) reported the qualitative nature of the emotional impact of discrimination.

There is presently uncertainty in the field of cultural psychology on the prevalence of emotional problems in Black Africans living in the UK. However, research predominantly conducted in US, has demonstrated that compared to the White majority group, minority group members endorse higher levels of discrimination and subsequently, experience depression/anxiety. In the UK, a number of authors have highlighted that unlike their White British counterparts, Black people, due to their stigmatised ethnic status, experience inequitable treatment involving discrimination, rejection and devaluation (Crocker et al., 1998; Gary, 2005, MIND, 2013). In light of this, the researcher argues that Black Africans in
the UK are at a greater risk of developing depression/anxiety because of their experiences. Despite the frequency in the literature with which discrimination has been cited as a risk factor for emotional problems, there are a handful of empirical studies investigating the association between discrimination and emotional well-being. Therefore, it is imperative to examine the nature of this association to determine whether discrimination will have a similar impact on emotional well-being in Back Africans.

**Shame and culturally related beliefs towards mental health problems**

Shame derives from an innate motive for attachment, group belonging and concern with one’s relative social place (Gilbert, 1998) and has potentially paralyzing effects (Corrigan, 1998). Shame related to mental health can be experienced in three distinct ways: *internal shame* (negative feelings towards oneself as a result of internalised stigma; Gilbert, Bhundia, et al., 2007), *external shame* (negative views of others towards an individual or a belief that he/she would be rejected if their needs were exposed; Gilbert, 1998) and *reflected shame* (the shame one can bring to their family or others can bring shame to the self; Gilbert, 2002). Empirical evidence has conceptualised and studied internal and external shame as a trait or disposition with both being implicated in exacerbating depression (Covert, Tangney, Maddux, & Heleno, 2003; Kim, Thibodeau, & Jorgensen, 2011) and anxiety (Tangney, Wagner, & Gramzow, 1992). Far less attention has been paid to the different types of shame related to stigma, such as mental health (Gilbert, 1998). For example, Okazaki’s (2000) study exploring the impact of shame beliefs on treatment delay among Asian American mental health patients and their relatives found that family members reported lower levels of reflected shame (than the patients themselves) in comparison to the patients who reported feelings of shame, embarrassment and higher levels of worry about the stigmatizing effects of their mental health problem. Similar findings were found by Gilbert, Gilbert and Sanghera (2004) who reported that reflected shame and maintaining family honour was a salient concern for the South Asian women in their study. Gilbert, Bhundia, Mitra, McEwan, Irons and Sanghera (2007) contrasted UK South Asian students with non-Asian female students on shame related beliefs towards mental health problems found that South Asian students scored higher on external shame beliefs, family reflected shame beliefs and shame related perceptions of mental health problems within the community/family. There were no differences in internal shame beliefs between the two groups, therefore suggesting the concept of shame relating to one’s community and family was a salient concern for
In a similar study, Hampton and Sharp (2014) found among their Asian, Latino and Caucasian American students that shame related beliefs towards mental health problems appeared to differ depending on the degree to which the individual perceived his/her family environment positively or negatively and evidence suggests that how people perceive their social environment depends on their cultural background (Chiu, Morris, Hong, & Menon, 2000). The limited studies on shame related beliefs towards mental health problems illustrate the significance of cultural differences in the values placed on different shame types and its potential to impede individuals reporting their distress. However, no studies exist examining shame beliefs in a Black African UK population. Therefore, further investigation is warranted as current findings may not capture the experiences of Black Africans. Research into cultural psychology highlights the contribution that cultural worldviews could add to our understanding of Black Africans underreporting emotional problems.

Culture undoubtedly plays a crucial role in shaping conceptualisation, perception and responses to mental health problems (Knipscheer et al, 2000). In Western society such as the UK, the medical model is the prevalent framework for understanding mental health problems (Dein, 2010). According to the medical perspective, mental health problems are attributed to environmental and/or hereditary factors such as chemical imbalances, genetic factors, etc. (Chen & Mak, 2008; Sheikh & Furnham, 2000). However, for Black African people, whose cultural heritage differs from that of the majority group, well-being of the mind and the body are seen as inseparable (Nobles, 1980). Additionally, the African worldview of mental health problems are deeply rooted in a relational or spirituality/supernatural view, where spiritualism and religion are the main source of treatment (Aina, 2004; Adebowale & Ogunlesi, 1999; Loewenthal & Cinnirella 1999). Mental health problems within Black communities are understood as a sign of failure and something to be feared (Health Forum and the Migrant & Refugee Communities’ Forum, 2005) so it is likely to be supressed Nazroo (1997). Consequently, negative attitudes and perceptions of mental health problems within African families and communities prevent individuals from seeking help (Adewuya & Makanjuola, 2008; Gureje, 2005). As Sellers et al. (2006) states, depression; therefore, may be denied or expressed physically within the African community.

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3 Culture is broadly defined as the set of values and beliefs that impact on individual thoughts, feelings and behaviours (North, 1990). Culture directly influences behaviour in a myriad of ways and encompasses the development of interpersonal connections, religious practices and the cultivation of collective and individual identity (Kleinman, 2004).
Anthropologists have identified the individualism and collectivism dimension as a salient cultural value influencing worldviews and as an explanatory framework in understanding self-conscious emotions such as shame. Briefly, collectivist values (e.g. Middle Eastern and Asian countries; Green et al., 2005) embody interdependence, family kinship ties, and communalism (Green et al., 2005) in contrast to individualist values (e.g. Western Europe, North America; Green et al., 2005) which stresses individuality, uniqueness, individual achievement and competition (Triandis, 1995). A review of the literature found that the majority of research examining individualist-collectivist values has focused on help seeking behaviour in different cultures. Three studies have examined the association between self-conscious emotions such as shame and individualist-collectivist values. For example, Mesquita (2001) found that in collective cultures, shame is more linked to how behaviours reflect on others, whereas in individualist cultures pride and shame relate to reflections on the self. In another study, Fischer, Manstead, Rodriguez and Mosquera (1999) examined cultural differences in descriptions of expressive emotions (i.e. shame, pride, and anger) in countries reflecting individualist values versus collectivist/honour-based values. They found that participants with collectivist/honour-based values were likely to associate shame with situations in which their honour was publicly affected and were likely to be more concerned with the social implications of shameful events. The observed findings were consistent with another by Mosquera, Manstead and Fischer (2000) who highlighted the relevance of collectivist and honour based cultures in reflected shame beliefs and indicates potential implications for mental health. Conversely, ideas of rejection or possible abandonment might be more central in awareness when shame is experienced within a collectivist culture (Gilbert, 1998). This may be particularly relevant to the African culture which is generally described as collective in nature (Tata & Leong, 1994). The collective nature of African countries in particular, encourages group stability, obedience and socialises individuals to conform and avoid conflict (Gyekye, 1996) so that one’s personal worth is determined interpersonally. Wallace and Constantine (2005) found that African-American students that greatly adhered to cultural values emphasising communalism, unity, harmony, spirituality, and authenticity were more likely to have greater self-concealment about their mental health problems to avoid enhancing feelings of external and reflected shame. As Aloud and Rathur (2009) states, this is because; stigma not only attaches itself to the individual with the mental health problem but also attaches to the family. Consequently, Ezeobele, Malecha, Landrum and Symes (2010) highlight that fear of being ostracised and a desire to maintain social
acceptance within some African communities, results in individuals denying or concealing emotional problems.

Presently, there are limited and inconsistent findings examining individualism-collectivism in people of African descent (Tata & Leong, 1994). Further research is required to firmly establish these values in an African sample in the UK through a multi-dimensional approach (Triandis, 1989) encompassing horizontal (valuing equality) and vertical (emphasising hierarchy) dimensions, embedded within the individualist-collectivist framework. More importantly, the present literature on worldviews illustrates the crucial role of cultural values in determining and influencing emotional expression. Therefore, it seems theoretically plausible that individualism-collectivism might better explain differences in shame than culture alone. Given the significant value that African people place on shame and stigma towards mental health and the potential effect this could have on seeking help, further investigation is required to expand our understanding of shame related beliefs and cultural values because previous findings cannot be generalised to a sample of Black Africans in the UK.

The current study

Emotional well-being in Black Africans in the UK is poorly understood as there is a significant absence of research investigating this area. The current study aimed to expand on the limited research and gain a better understanding of emotional well-being by examining two influential pathways of ethnic discrimination which is likely to increase depression/anxiety in Black Africans and shame related beliefs towards emotional problems which leads to underreporting and exacerbation of depression/anxiety (Ezeobele et al., 2010). Including a broader conceptualisation of cultural worldviews which includes cultural values (i.e. Horizontal individualism, Horizontal collectivism, Vertical individualism, and Vertical collectivism) could perhaps help to recognise the complexity of origins of shame related beliefs in Black Africans. Therefore, the study sought to examine differences in perceived ethnic discrimination and emotional well-being, shame related beliefs towards emotional problems and cultural values in a community sample of Black Africans compared to a White British UK sample. Such insights could contribute to the theoretical understanding of emotional problems in African people and could inform the practice of counselling psychologists through cultural awareness when working with this client group. Having an awareness of the social and psychological impact of discrimination in African people is critical for counselling
psychologists because individuals accessing psychological services do not exist independent of society, culture and context (Elefheriadou, 2003). Therefore, this research is likely to challenge counselling psychologists to engage in on-going and creative dialogue in effecting social justice (Milton, 2014). Also, this study could potentially inform counselling psychologists’ understanding on the cultural influences of shame in general. In keeping with previous research suggesting that discrimination is a risk factor for depression and anxiety (Cassidy, O’Connor, Howe & Warden, 2005) and on evidence indicating cultural differences in shame related beliefs (Gilbert, 2008) and cultural values the following hypotheses were made:

Hypothesis 1: Black African participants will report more experiences of perceived ethnic discrimination than White British participants.

Hypothesis 2: Black African participants will report either lower or higher levels of subclinical depression and anxiety compared to White British participants.

Hypothesis 3: Black African participants will have a higher score on the broad dimension of collectivism (either horizontal or vertical) compared to White British participants who will embrace higher individualist values.

Hypothesis 4: Black African participants will score higher than White British participants on general shame beliefs in the community/family, external shame beliefs and reflected shame beliefs (i.e. family and self-reflected shame). There will be no difference in internal shame beliefs.

Hypothesis 5: As diagrammed in figure 1, the relationship between cultural group and shame related beliefs towards emotional problems will be mediated by cultural values. Specifically, Black African participants will be positively associated with collectivism worldviews which in turn will be positively associated with shame beliefs towards emotional problems.

Hypothesis 6: The relationship between cultural group and depression/anxiety will be mediated by perceived ethnic discrimination and shame beliefs (i.e. internal and external shame). That is, Black Africans’ greater experiences of perceived ethnic discrimination and internal and external shame scores will be positively associated with depression and anxiety. A conceptual model has been proposed in figure 2.
Figure 1. *Cultural values as a Mediator of Cultural Differences in Shame*

![Diagram showing cultural values as mediators of cultural differences in shame.]

Figure 2. *Shame and discrimination as a Mediator of Cultural Differences in Depression and Anxiety*

![Diagram showing the role of shame and discrimination as mediators of cultural differences in depression and anxiety.]

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Method

This research takes a critical realist position as it assumes that there exists a “real world” which is independent of our thinking (Bhaskar, 1998). This position sees individuals constructing their reality through a process of perception and communication (Eatough & Smith, 2008). While quantitative designs are anchored within a positivist epistemology with the aim of producing objective, value-free and universal findings, the researcher is aware that questionnaires may be considered reductionist by nature. However, one of the central tenets of critical realism is that it embraces the fallibility of theory, measures and observations and is critical of our ability to know reality with certainty (Willig, 2009). For critical realist, the goal of the research is to develop explanations that result in understanding what structures and/or mechanisms underpin phenomena.

Design

A quantitative self-report approach was used to explore perceived ethnic discrimination, cultural worldviews, shame related beliefs towards mental health problems and emotional well-being (i.e. depression and anxiety) in African and White British people living in the UK. Data were collected by means of a questionnaire approach handed individually to participants or through a secured website.

Participants and procedure

Participants were recruited through a number of approaches having received ethical approval (Appendix A). Firstly, sampling began with an examination of local community centres, organisations and local businesses. Presentations were given about the study at two local community centres, four organisations and three church groups (with a majority of Black African members). During the presentations, information sheets were passed out and a poster, detailing the purpose of the research and eligibility criteria was left at the premises for individuals to call if they were interested in participating online or face-to-face (Appendix B). Additional recruitment strategies consisted of distributing posters at three libraries and utilising a convenience sampling strategy. The majority of White British participants were recruited through these sources and questionnaires were completed in the researcher’s
presence. A further group of participants were obtained through snowballing sampling. Specifically, Black African participants who completed questionnaires face-to-face were asked to invite their friends via social networks, which resulted in the majority of Black African participants completing questionnaires online. While this method calls into question the representativeness of the sample, it was deemed necessary in this case as Black Africans are described as a fairly closed community (Hughes et al., 1995). African and White British men and women, who were 18 years of age and over, residing in the UK and did not have an identified mental health problem, were eligible to participate in this study. Overall, 221 people participated in the research. Sixty-three participants (28.5%) completed paper copy questionnaires and 158 (71.5%) completed questionnaires online and of these, 28 dropped out (26 online and 2 paper copies) before completing the demographics questionnaire and were therefore excluded. Ninety were identified as White British (M=40.45 years, SD=13.30), 87 identified as African (M=33.46 years, SD 9.02) and 16 participants that self-identified as ‘other’ (M=34.94, SD=8.91) were excluded because they did not meet the inclusion criteria. The final sample size consisted of 177 participants. The Black African participants originated from sub-Saharan Africa and the most frequently endorsed country was Nigeria (56%) followed by Ghana (14%). There was an overrepresentation of females in both groups. The Black African sample was likely to be affiliated to a religion in comparison to White British participants. Twelve participants reported having a mental health problem, although it is not known whether participants were formally diagnosed. Individuals invited to participate in the study were given a participant information sheet (Appendix C) and asked to read and complete 2 consent forms (Appendix D) which was kept in a separate envelope. Consent was also indicated by ticking the agreement box to confirm that participants understood the purpose of the study online. Participation was voluntary without any form of compensation and all data were treated confidentially for research purposes only.
**Table 1 Participant Demographic Characteristics**

<table>
<thead>
<tr>
<th></th>
<th>White British</th>
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<th>Black African</th>
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<td></td>
<td>N</td>
<td>%</td>
<td>N</td>
<td>%</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
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<tr>
<td>Male</td>
<td>13</td>
<td>14.4</td>
<td>28</td>
<td>66.4</td>
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<tr>
<td>Female</td>
<td>77</td>
<td>85.6</td>
<td>58</td>
<td>32.6</td>
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<tr>
<td>Age</td>
<td></td>
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<td>10</td>
<td>11.2</td>
<td>11</td>
<td>14.1</td>
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<td>30</td>
<td>33.7</td>
<td>33</td>
<td>42.3</td>
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<td>35-44</td>
<td>8</td>
<td>9</td>
<td>26</td>
<td>33.3</td>
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<tr>
<td>45-54</td>
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<td>27</td>
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<td>7.7</td>
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<tr>
<td>Time in UK</td>
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<tr>
<td>Born in UK</td>
<td>88</td>
<td>97.8</td>
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<td>41.7</td>
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<tr>
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<td>19</td>
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<td>11-20 years</td>
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<td>18</td>
<td>39.1</td>
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<tr>
<td>21-30 years</td>
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<td>19.6</td>
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<td>Religion</td>
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<td>89.4</td>
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<td>0</td>
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<tr>
<td>Islam</td>
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<td>1.1</td>
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<td>0</td>
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<tr>
<td>Other</td>
<td>4</td>
<td>2.2</td>
<td>5</td>
<td>5.9</td>
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<tr>
<td>Mental Health Difficulty</td>
<td>7</td>
<td>7.8</td>
<td>5</td>
<td>5.7</td>
</tr>
</tbody>
</table>
Material

Individualism-Collectivism. Singelis, Triandis, Bhawuk and Gelfand (1995) attitude scale was used to measure individualism and collectivism within cultures (See Appendix E for questionnaires). The scale is composed of 32 questions with four subscales: Horizontal individualism (uniqueness; e.g. “I like my privacy”), Vertical individualism (achievement orientation; e.g. “winning is everything”), Horizontal collectivism (cooperativeness; e.g. “pleasure is spending time with others”) and Vertical collectivism (dutiffulness; e.g. “parents and children must stay together as much as possible”) measured on a nine-point scale (strongly disagree=1 to strongly agree=9). The scale is scored by calculating items for each subscale. Higher scores reflect individuals with a stronger orientation. According to Singelis et al., (1995), Cronbach alpha coefficients were reported to be in the range of .67–.74. Cronbach’s alpha for this and other scales are presented in Table 3.

Perceived Ethnic Discrimination. The Perceived Ethnic Discrimination Questionnaire (PEDQ; Contrada et al., 2001) identifies four dimensions of interpersonal ethnic discrimination reflecting experiences of devaluation (e.g. implied you must be dishonest or unintelligent), threats or aggressive treatment (e.g. threatened to hurt you), verbal rejection (e.g. ethnic name calling) and avoidance (e.g. others avoided social contact) within the past three months. The scale is measured using a 7-point scale (1 = never to 7 = very often) and is scored by creating a mean score for each subscale. For the purpose of this study, a total global discrimination score was calculated by computing the mean for the four subscales.

Shame related beliefs. The Attitudes Towards Mental Health Problem Scale (ATMHP; Gilbert, Bhundia, et al., 2007) is comprised of 35 statements measuring shame related beliefs and attitudes towards depression and anxiety across five domains: Community/family shame (e.g. “my community sees mental health problems as something to keep secret”), external shame (e.g. “I think my community would look down on me”), internal shame (e.g. “I would see myself as inadequate”), family reflected shame (e.g. “my family would blame me for my problems”) and self-reflected shame (e.g. “I would worry that others would not wish to be associated with me”). Participants indicate the extent to which they agree with statements using a 4-point Likert scale (0=Do not agree at all to 3=completely agree) and items are summed to provide a mean score for each section, with high scores representing high levels of shame. Gilbert et al., (2007) report Cronbach’s alpha reliabilities of the subscales ranged from .85 to .97.
Depression and Anxiety. The Hospital Anxiety and Depression Scale (HADS; Snaith & Zigmond, 1994) consists of 14 items, with 7 items comprising of the anxiety (e.g. “worrying thoughts go through my mind”) and depression (e.g. “I have lost interest in my appearance”) subscale. Participants are instructed to select one of four options to indicate how they have been feeling over past seven days. Individual items are summed to provide a mean anxiety and depression score. The maximum score for each scale is 21, with higher scores indicating a greater number of distresses. The HADS is a well-validated and reliable self-report instrument for assessing anxiety and depressive states across populations (Bjelland, Dahl, Haug, & Neckelmann, 2002).

Ethics

The study was reviewed and received ethical approval by the University of Surrey, Faculty of Arts and Human Sciences Ethics Committee. The researcher endeavored to operate within the guidelines of the BPS Code of Human Ethics (2011), BPS Ethics Guidelines for Internet-mediated Research (2013) and the Health & Care Professionals Council code of ethics for students (2012). For example, prospective participants were made aware of their right to withdraw from the study at any time or to avoid completing questions they found uncomfortable. Also, participants completing questionnaires face to face were required to sign and date the consent form; however, Ryen (2004) notes that written consent may be more acceptable in some cultures and that participants concerns may be heightened. Therefore, the researcher provided the option for participants to complete questionnaires online, where a tick box was used to gain consent in order to minimise concerns around written consent. In order to maintain confidentiality, all consent forms were separated from completed questionnaires and participants that declined to participate were not asked to provide a reason for their refusal. Given the sensitive nature of this study exploring ethnic discrimination and shame related beliefs towards emotional problems, debriefing was made available to participants that completed questionnaires face to face to monitor any unforeseen negative effects, given the sensitive topics on ethnic discrimination and shame related beliefs towards emotional problems. A debrief information sheet (Appendix F) was also provided to all participants that completed the study which contained supportive helpline numbers.
Results

The current study investigated whether there are cultural differences in perceived ethnic discrimination, cultural worldview, shame beliefs towards depression and anxiety and emotional well-being. In addition, the study also examined two multiple mediation models exploring whether discrimination and/or shame mediated the relationship between culture and emotional well-being and whether cultural values mediated the effects between culture and shame types. The data were analysed using SPSS version 22. Seven hypotheses formed the basis of the investigation, which utilised multivariate analysis of variance (MANOVA), t-test, and bias-corrected bootstrapping to examine the data.

Data Screening and missing data

A missing values analysis was conducted to identify the proportion of data which were missing across the four measures. Unfortunately, data comparisons of those that dropped out could not be conducted because there was no indication of ethnicity. Of the 177 included in the analyses, 171 (96.6%) had no missing data, 172 (97.2%) completed the individualism-collectivism questionnaire, 175 (98.9%) completed the PED questionnaire, 175 (98.9%) completed the ATMHP questionnaire and 176 (99.4%) competed the HADS questionnaire. Given that less than 5% of data were missing for each scale, missing data was not treated as a substantial problem. Therefore, pairwise exclusion of missing values was used and scores for all scales/subscales were computed as item mean for each participant.

Distribution of data

Distribution tests were examined for skewness, kurtosis, Z scores, Kolmogorov test of normality, and a visual examination of the frequency histograms. Most variables were in the normal range for skewness (see table 3). However, five variables (Horizontal individualism, Horizontal collectivism, Perceived Ethnic Discrimination, Self-reflective Shame and HADS depression) had skewed distribution as they had skewness above ± 1 and kurtosis values below ± 3 (Field, 2009). Kolmogorov tests indicated that all data, except Vertical collectivism subscale violated the assumptions of normality (p>.05). Attempts to correct the distribution of the scales with skewness greater than 1, using log10 and reflection transformation (Tabachnick & Fidell, 2001) showed improvement in distribution, which were used for analysis. Z scores were computed to identify any problematic outliers above ± 3.29. This resulted in two outliers being identified, one involving Horizontal individualism and the
other involving Vertical individualism, each from different participants. These scores were removed from the subscale and parametric tests were used.

**Initial correlation**

Pearson’s correlation between all measures were calculated and shown in table 2. There were a number of significant associations varying from small to large positive correlations. Overall, the strongest correlations were between family reflected shame and self-reflected shame, between external shame and community and family shame and between depression and anxiety. Depression was significantly positively correlated with all shame subscales. A significant association was observed between anxiety and community/family shame, external shame and internal shame. There was a non-significant correlation between perceived ethnic discrimination and both anxiety and depression. Horizontal individualism was positively related with community/family shame. Verbal collectivism was significantly associated with family reflected shame and self-reflected shame and vertical individualism correlated with all shame scales with the exception of internal shame.
**Table 2 Bivariate correlations and psychometric properties of all scales**

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<td>2. Horizontal collectivism</td>
<td>.26**</td>
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<tr>
<td>3. Vertical collectivism</td>
<td>.32**</td>
<td>.53**</td>
<td>-</td>
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<td>4. Vertical individualism</td>
<td>.37**</td>
<td>.10</td>
<td>.42**</td>
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<td>5. Perceived Ethnic Discrimination</td>
<td>.21**</td>
<td>-.01</td>
<td>.19**</td>
<td>.294**</td>
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<tr>
<td>6. Community/Family Shame</td>
<td>.15*</td>
<td>-.10</td>
<td>.08</td>
<td>.275**</td>
<td>.300**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. External Shame</td>
<td>.08</td>
<td>-.10</td>
<td>.05</td>
<td>.192*</td>
<td>.245**</td>
<td>.760**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Internal shame</td>
<td>-.07</td>
<td>-.02</td>
<td>.02</td>
<td>.106</td>
<td>.067</td>
<td>.281**</td>
<td>.425**</td>
<td>-</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>9. Family reflected shame</td>
<td>.06</td>
<td>.02</td>
<td>.22**</td>
<td>.171*</td>
<td>.239**</td>
<td>.375**</td>
<td>.568**</td>
<td>.484**</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Self reflected shame</td>
<td>.06</td>
<td>.05</td>
<td>.25**</td>
<td>.179*</td>
<td>.224**</td>
<td>.382**</td>
<td>.573**</td>
<td>.478**</td>
<td>.980**</td>
<td>-</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Anxiety</td>
<td>-.01</td>
<td>-.09</td>
<td>.00</td>
<td>.151*</td>
<td>.094</td>
<td>.238**</td>
<td>.246**</td>
<td>.339**</td>
<td>.125</td>
<td>.119</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>12. Depression</td>
<td>.01</td>
<td>-.12</td>
<td>.04</td>
<td>.236*</td>
<td>.118</td>
<td>.283**</td>
<td>.347*</td>
<td>.366**</td>
<td>.200**</td>
<td>.187*</td>
<td>.688**</td>
<td>-</td>
</tr>
<tr>
<td>M</td>
<td>6.46</td>
<td>6.51</td>
<td>5.07</td>
<td>4.36</td>
<td>1.64</td>
<td>1.01</td>
<td>.98</td>
<td>1.17</td>
<td>.89</td>
<td>.56</td>
<td>.92</td>
<td>.53</td>
</tr>
<tr>
<td>SD</td>
<td>1.23</td>
<td>1.18</td>
<td>1.33</td>
<td>1.48</td>
<td>.94</td>
<td>.78</td>
<td>.75</td>
<td>.90</td>
<td>.78</td>
<td>.78</td>
<td>.58</td>
<td>.48</td>
</tr>
<tr>
<td>Skewness</td>
<td>-.125</td>
<td>-.102</td>
<td>-.10</td>
<td>.36</td>
<td>1.68</td>
<td>.64</td>
<td>.52</td>
<td>.45</td>
<td>.82</td>
<td>1.39</td>
<td>.46</td>
<td>1.25</td>
</tr>
<tr>
<td>Kurtosis</td>
<td>3.42</td>
<td>2.67</td>
<td>-.10</td>
<td>-.32</td>
<td>2.34</td>
<td>-.18</td>
<td>-.48</td>
<td>-.79</td>
<td>-.06</td>
<td>1.19</td>
<td>-.45</td>
<td>1.45</td>
</tr>
<tr>
<td>K-S</td>
<td>.00</td>
<td>.20*</td>
<td>.01</td>
<td>59</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
<td>.00</td>
</tr>
<tr>
<td>A</td>
<td>0.71</td>
<td>0.71</td>
<td>0.70</td>
<td>0.79</td>
<td>0.87</td>
<td>0.92</td>
<td>0.95</td>
<td>0.94</td>
<td>0.90</td>
<td>0.94</td>
<td>0.83</td>
<td>0.80</td>
</tr>
</tbody>
</table>

P<.05,P<.01**
Cultural group comparisons on the main variables

An independent-samples t-test was used to compare differences on self-reported discrimination in Black Africans and White British participants. Four separate multivariate analyses of variance (MANOVA) were also conducted to examine mean differences among the two cultural groups on the remaining variables (i.e., Horizontal individualism and Horizontal collectivism, Vertical individualism and Vertical collectivism, Community/Family Shame, External Shame, Internal shame, Family reflected shame and Self reflected shame, Anxiety and Depression. This method was used because it is useful for comparing one or more independent variable across several dependent variables and also helps to control for the chance of a Type 1 error. Preliminary assumption testing was conducted to check the assumption underpinning MANOVA (i.e. normality, linearity, homogeneity of covariance, and homogeneity of error variances). Table 3 shows the MANOVA between-subjects effects statistics results, including the F statistic, p-value, and partial eta-squared (effect size) for each between groups comparison.

Table 3: Cultural Group differences in scores from Individualism-Collectivism, AMHP and HADS scales

<table>
<thead>
<tr>
<th>Variables</th>
<th>White British M</th>
<th>SD</th>
<th>Black African M</th>
<th>SD</th>
<th>F</th>
<th>p</th>
<th>Δη²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Horizontal individualism</td>
<td>.43</td>
<td>.12</td>
<td>.50</td>
<td>.16</td>
<td>10.54</td>
<td>&lt;.01</td>
<td>.91</td>
</tr>
<tr>
<td>Horizontal collectivism</td>
<td>.45</td>
<td>.13</td>
<td>.49</td>
<td>.12</td>
<td>2.58</td>
<td>&gt;.05</td>
<td>.92</td>
</tr>
<tr>
<td>Vertical collectivism</td>
<td>4.55</td>
<td>1.16</td>
<td>5.60</td>
<td>1.29</td>
<td>32.11</td>
<td>&lt;.01</td>
<td>.15</td>
</tr>
<tr>
<td>Vertical individualism</td>
<td>3.87</td>
<td>1.37</td>
<td>4.87</td>
<td>1.42</td>
<td>22.59</td>
<td>&lt;.01</td>
<td>.11</td>
</tr>
<tr>
<td>Community/Family Shame</td>
<td>.79</td>
<td>.72</td>
<td>1.24</td>
<td>.78</td>
<td>15.66</td>
<td>&lt;.01</td>
<td>.08</td>
</tr>
<tr>
<td>External Shame</td>
<td>.85</td>
<td>.70</td>
<td>1.13</td>
<td>.78</td>
<td>6.28</td>
<td>&lt;.01</td>
<td>.03</td>
</tr>
<tr>
<td>Internal shame</td>
<td>1.21</td>
<td>.94</td>
<td>1.14</td>
<td>.86</td>
<td>.30</td>
<td>&gt;.05</td>
<td>.00</td>
</tr>
<tr>
<td>Family reflected shame</td>
<td>.70</td>
<td>.71</td>
<td>1.10</td>
<td>.79</td>
<td>12.1</td>
<td>&lt;.01</td>
<td>.06</td>
</tr>
<tr>
<td>Self-reflected shame</td>
<td>.19</td>
<td>.16</td>
<td>.29</td>
<td>.16</td>
<td>13.5</td>
<td>&lt;.01</td>
<td>.07</td>
</tr>
<tr>
<td>Anxiety</td>
<td>.98</td>
<td>.51</td>
<td>.86</td>
<td>.12</td>
<td>1.76</td>
<td>&gt;.05</td>
<td>.01</td>
</tr>
<tr>
<td>Depression</td>
<td>.16</td>
<td>.12</td>
<td>.16</td>
<td>.12</td>
<td>0.01</td>
<td>&gt;.05</td>
<td>.00</td>
</tr>
</tbody>
</table>
**Discrimination** As predicted, there was a significant difference in perceived ethnic discrimination scores for African participants (M=.25, SD=.07) and White British participants (M=.07, SD=.13), indicating that Black African participants reported significantly more experience of Perceived Ethnic Discrimination within the past three months t= (144.753) = 6.28, p<.001, which supports hypothesis 1.

**Depression and anxiety** MANOVA results report that there were no significant differences in scores on subclinical anxiety and depression between the two groups.

**Cultural worldviews** Levene’s test of Equality of Error Variances showed that the assumption of homogeneity of variance was met for all cultural values except Horizontal individualism. Box’s M indicated that there were no significant differences between the covariance matrices, therefore; the assumption was not violated and Wilk’s Lambda was used as an appropriate test. Using an alpha level of .05, Wilk’s Lambda test was significant, indicating that there were significant differences among cultural values. Three variables reached statistical significance: Horizontal individualism, Vertical individualism, and Vertical collectivism. Contrary to hypothesis 2, Black African participants endorsed significantly higher Horizontal individualism and Vertical individualism values than White British participants. However, African participants also scored significantly higher on the Vertical collectivism orientation which partially supports hypothesis 2.

**Shame beliefs.** All four dependent measures were used with no violations of homogeneity being noted, although Box’s Test indicated that the data violated the assumption of homogeneity of variance-covariance matrices. Therefore, Pillai’s Trace was used as an appropriate test because it is reported to be robust and not highly linked to assumptions about the normality of the distribution of the data. There was a statically significant difference between cultural groups on the combined dependent variable. When the results of the dependent variable were considered separately, four variables reached statistical significance: community/family shame, external shame, family reflected shame and self reflected shame. An inspection of the mean scores confirmed hypothesis 4 indicating that African participants reported significantly higher levels of shame beliefs on all variables except internal shame. There was no statistical difference in scores on internal shame in both Black African and White British participants, as hypothesised.
Mediation Analyses

To test the proposed mediation models for hypotheses 5 and 6, mediation analyses using bias-corrected bootstrapping were undertaken. In comparison to the widely used Baron and Kenny (1986) causal step approach, Preacher and Hayes (2008) suggest that bias-corrected bootstrapping offers greater statistical power for detecting specific indirect effects as it relies on the basis of the theoretical reasoning rather than the association between an independent variable (culture, coded as 1= Black African participants, 2= White British) and a dependent variable (shame/emotional well-being) being statistically significant before proceeding with mediation analysis. In addition, the bootstrapping method does not require data to be normally distributed and can be employed on relatively small samples without loss of statistical power (Hayes, 2009). The 95% confidence interval of each indirect effect was obtained with 1000 bootstrap resamples using SPSS macro (Preacher & Hayes, 2004). MacKinnon (2008) suggests that the partially standardised effect size measure can be used to determine the effect size of a direct and indirect effect. Preacher & Kelley (2011) state that the partially standardised effect size can be interpreted using Cohen (1988) guidelines defining small (.01-.09), medium (.10-.25), and large (.25 +) effect sizes.

Cultural values as a Mediator of Cultural Differences in Shame

A multiple mediation model was used to explore whether four cultural values (i.e. Horizontal individualism, Horizontal collectivism, Vertical individualism and Vertical collectivism) taken from the Individualism-Collectivism scale significantly mediated the relationship between culture and five shame dependent variables (refer to figure 1). Results indicated that cultural group had a significant negative direct effect on Community/Family Shame \( (c'=-.37, t (173)=-3.01, p<0.05) \) indicating that Black African participants had greater beliefs in Community/Family Shame. An examination of the specific indirect effects showed that only Vertical individualism had a significant negative indirect effect \( [a_3b_3=-.10, 95\%\ CI\ (-.2443, -.0113)] \) as zero is not contained in the confidence intervals. This implied that Vertical individualism mediated cultural group difference in Community/Family Shame beliefs. The partially standardised effect size was -.12 \( (95\%\ CI= -.0971, -.2583) \). There was a non-significant direct effect of cultural group on External Shame beliefs \( (c'=-.22, t (173)=.07, p>0.05) \) and on Internal shame beliefs \( (c'= .13, t (173)=.90, p>0.05) \). Similarly, there were no significant specific indirect effects on the relationship between culture and External and Internal shame beliefs.
An examination of the bootstrapping method showed a direct effect of cultural group on Family reflected shame beliefs ($c' = -0.28$, $t (173) = -2.22$, $p < 0.05$) signifying that Black African participants were associated with significantly higher beliefs in family reflected shame. There were no significant individual indirect effects. A significant and negative direct effect of cultural group on self-reflected shame beliefs was found ($c' = -0.66$, $t (173) = -2.34$, $p < 0.05$). The specific indirect effect of vertical collectivism on the relationship between cultural group and Self reflected shame beliefs was also significant [$a_{4b4} = -0.0263$, 95% CI (-0.0591, -0.0013)] and the partially standardised effect size was -0.15 (95% CI = -0.3420 to 0016). This suggests that vertical collectivism mediated cultural group difference in self-reflected shame beliefs. However, when considering the total indirect effects across all four mediators, cultural values did not mediate the relationship between cultural group and the five shame beliefs, suggesting that all four cultural values played a minimal role in African people’s high shame scores.

**External and Internal shame beliefs and Perceived Ethnic Discrimination as Mediators of Cultural Differences in anxiety and depression**

The bootstrap analysis indicated a significant direct effect of cultural group on anxiety ($c' = 0.16$, $t (175) = 2.06$, $p < 0.05$) indicating a suppression effect. There were no individual indirect effects and no significant total effect across the three mediators ($\beta = -0.07$; 95% CI = -0.1811 to 0.0291) suggesting that internal and external shame beliefs and discrimination did not play a significant role in the relationship between cultural group and anxiety. Regarding depression, there was no evidence of a direct effect of cultural group on depression ($c' = 0.01$, $t (175) = 0.98$, $p > 0.05$). An examination of the individual indirect effects showed that External Shame alone had a significant indirect effect on the relationship between cultural group and depression [$a_{4b1} = -0.01$, 95% CI = -0.0275, -0.0024]). The partially standardised effect size was -0.08, 95% CI = -0.2117 to 0.0192). This suggests that African participants’ higher level of External Shame resulted in higher depression levels. Overall, there was a non-significant total effect across all three mediators ($\beta = -0.0164$; 95% CI = -0.0405 to 0.0047).

**Supplementary analyses**

Direct and indirect effects of shame beliefs and discrimination on the relationship between cultural group and anxiety and depression with age and gender as covariates were examined. The bootstrap analysis showed that the indirect effect of External Shame on the
relationship between cultural group and depression was no longer significant \([a_1b_1 = -.00, 95\% \text{ CI (-.0238, .0001)})\] suggesting that age and gender could account for the causal relationship.

A MANOVA was used to compare the two administration types (paper copy vs. online) on any of the subscales. Significant group differences were found in cultural worldviews \(F(1, 173)= 4.73, P<.05\), with online participants reporting higher Horizontal individualism values \(M=.48, \text{SD}=.16\) than those who completed paper questionnaires \(M=.44, \text{SD}=.16\). Participants online were also more likely to report higher perceived ethnic discrimination \(M=.20, \text{SD}=.21\) compared to those who completed paper questionnaires \(M=.08, \text{SD}=.13\), \(t(170.781)=-4.72, p<.001\). However, supplementary analyses controlling for the two variables obtained the same results as those reported above.

MANOVA was used to compare group means on cultural values for African participants’ nativity. There were no statistical differences in scores on Horizontal individualism, Horizontal collectivism, Vertical individualism and Vertical collectivism in Black Africans born in and outside the UK.

A post hoc power analysis was used to calculate the observed power for each of the main MANOVA and regression models obtained similar power estimates as those reported above. Moreover, bias-corrected bootstrapping was used to calculate the indirect effects of the two mediation models, with both models showing a medium effect size ranging from .10-.25. This suggests that power estimate is sufficient to support the analysis.
Discussion

People of African descent are more likely to experience racial discrimination than any other minority group which, in turn, is reported to elevate the risk of depression/anxiety (Jaskinkaja-Lahti, 2006). Consequently, many people experiencing emotional problems do not always seek help because of the stigma and shame associated with mental health problems within African communities (Ezeobele et al., 2010). There are a limited number of studies conducted on the emotional well-being of African people; therefore, the goal of the current study was to address this paucity by determining the validity of the association between discrimination and emotional well-being and cultural values and shame related beliefs towards emotional problems in an African sample. The results of analyses of cultural differences in discrimination supported the hypothesis that Black Africans, compared to White British adults would report more experiences of perceived ethnic discrimination. This result was not surprising and was consistent with other studies that have examined perceived ethnic discrimination in minority and majority groups (Clark, Anderson, Clark, & Williams, 1999). Results also indicated that there was no average difference between groups in subclinical levels of depression and anxiety. A multiple mediation model used to examine whether the relationship between cultural group and depression/anxiety was mediated by perceived ethnic discrimination revealed a direct effect of cultural group on anxiety. While no mean differences were found between the two groups on anxiety scores, the mediation analysis indicates a likely suppression effect. This suggests that Black Africans higher levels of discrimination are likely to increase the likelihood of anxiety; however, when controlled for discrimination, Black Africans otherwise report lower anxiety. Future studies may be needed to replicate and confirm this finding. Perceived ethnic discrimination did not mediate the relationship between cultural group and emotional well-being in this sample of Black Africans. This finding is inconsistent with the overwhelming evidence base indicating a link between perceived ethnic discrimination and emotional well-being in people of African descent (Karlsen & Nazroo, 2002) and could suggest a presence of a buffer that maintains the emotional well-being of Black African participants. For example, researchers have indicated positive coping resources (e.g. communalism, religion, etc.) a strong ethnic identity and positive self-esteem which could buffer the proliferation of depression and anxiety among Black Africans (Plummer & Slane, 1996). Others (e.g. Jackson & Sears, 1992) also highlight the importance of an African worldview in coping with stressors that provide people of African descent to cope more effectively. Moreover, given that the Black African
sample overwhelmingly identified with a religion, it is likely, as the research suggests; religious practice and communality could protect against psychological distress. However, Clark, Anderson, Clark and Williams (1999) suggestion that psychological distress is likely to occur when it is appraised as exceeding the individual’s capacities could suggest that overtime, Black Africans may still be at risk of developing emotional problems.

Two shame beliefs (external and internal shame) were also examined as a potential mediator of the relationship between cultural group and emotional well-being. The results of this mediation analysis indicated that externally shamed beliefs towards mental health problems mediated the relationship between cultural group and depression; that is, the significantly greater External Shame beliefs endorsed by African participants accounts for their increase in subclinical levels of depression. This result validates the notion that external shame beliefs, in particular, may be a relevant issue among Back Africans and is congruent with the findings of Kim, Thibodeau and Jorgensen (2011) who suggests that External Shame may show stronger associations with depressive symptoms compared with Internal shame due to primitive anxieties related to the possibility of abandonment or rejection by significant others. This may have some relevance for Black Africans as studies have noted that some Black Africans have a fear of being ostracised by families if a family member experiences depression (Ezeobele, Malecha, Landrum and Symes (2010). This has been evidenced among some Nigerian communities and given that the African sample was not ethnically represented, it is possible that the higher scores in external shame related beliefs could reflect beliefs of mostly Nigerians. However, supplementary analyses suggest that differences between cultural groups in age and gender could account for the mediated effect of external shame between cultural group and depression.

Regarding shame related beliefs towards emotional problems, there were strong similarities between the study findings and results from previous studies examining shame related beliefs in minority groups (Gilbert et al., 2007). The results indicated that Black African participants believed that their Community/Family held stigmatising views and shame related beliefs towards people with mental health problems and that this would result in being externally stigmatised if they had a mental health problem such as depression and/or anxiety. Deep concerns regarding family reflected shame and self-reflected shame were also identified. These findings suggests that Black African participants have a strong sense of shame related beliefs towards mental health problems and their high scores on four shame types is likely to impinge on seeking help. However, a notable feature of the findings on
mean differences on cultural values was the significant presence of the broad dimension of Individualism in African participants compared to White British participants. It is likely that high individualism scores among Black African participants could be as a result of the majority of Black African participants being British born and it would, therefore, be expected that participants would be socialised into a Western culture and values. Another interesting finding was African participants’ high score on vertical dimensions (Vertical individualism, followed by Vertical collectivism, and Horizontal individualism) which indicated a greater acceptance of inequality and a strict social hierarchy, emphasising achievement, status, comparison with others, and competition within the group. A possible explanation for the vertical attribute endorsed by African participants could lie in the African culture placing emphasis upon obedience and group thought, composed of communities whose authority ranking is well defined and where individuals are expected to comply with values and customs (Gyekye, 1996). While it is commonly believed that people of African descent endorse collectivist values (Waters, 1999) this research has provided greater understanding to the inconclusive findings in this area.

A multiple mediation model used to examine whether cultural values (i.e. Horizontal individualism, Horizontal collectivism, Vertical individualism and Vertical collectivism) mediated the effect of cultural group and shame related beliefs showed that Vertical individualism significantly and negatively mediated the relationship between culture and Community/Family Shame related beliefs and that Vertical collectivism was a significant mediator between cultural group and Self reflected shame. Vertical individualism has been associated with a cultural pattern expressing uniqueness and social status acquired through achievement and competition (Triandis, 1995). Therefore, it seems logical that Black Africans endorsement of vertical individualism may be indicative of an adaptive strategy used to further success within a vertically individualist society like the UK and might reflect identification with and belief in British values which could argueable make them more aware of the strong shame related beliefs towards mental health problems held within their own community and family. Certainly, Fung and Wong (2007) point out that acculturation to a more Westernized belief system arguably lowers the levels of stigma. However, the endorsement of Vertical collectivism may reflect interdependent relationships with the acceptance of inequality, comparison and competition with others (Green et al., 2005; Triandis, 1995) which could otherwise evoke strong Self reflected shame beliefs as there may be a strong desire to keep the family member/relative at distance to avoid being alienated.
The findings on cultural values and shame related beliefs towards mental health problems suggest that while Africans living in the UK may embrace their African culture at a group level, they may also be influenced by individualist attitudes at an individual level or in specific situations (Triandis, 1995). Therefore, it seems likely that African participants may have salient group identities that largely embrace individualist attitudes in general but their belief system regarding shame beliefs towards mental health problems may be embedded in the African culture. Given that culture is a dynamic process, and that attitudes towards others, and oneself evolve over time (Matsumoto, Kudoh, & Takeuchi, 1996; Gushue & Constantine, 2003). Research has increasingly highlighted the importance of attending to acculturation (Berry, 1980) and biculturalism (Kirmayer, 2012) as critical components in shaping attitudes.

**Implications for counselling psychology**

The findings relating to African participants’ greater experience of perceived ethnic discrimination suggests that counselling psychologists need to explore the social and cultural contexts when working with this client group. Counselling psychology prioritises and emphasises a contextual understanding of the client, recognising the impact of social, political dimensions on experience (Division of Counselling Psychology, 1998; Steffen & Hanley, 2014). While, perceived ethnic discrimination was not associated with emotional problems, a support group that acknowledges the experience of ethnic discrimination may be of some benefit to Black Africans. Counselling psychologists could seek to empower individuals that are disadvantaged through discrimination by drawing on the extraordinary strengths and resources that enable some Black Africans to maintain emotional well-being. Also, advocacy may be an additional important element of the role of counselling psychologists through active ongoing debates and/or engaging with mainstream and social media regarding social injustice and the potential risk factors for well-being.

Given the value placed on shame beliefs towards mental health in the Black African sample, many people may be unwilling to seek help. Adewuya et al. (2009) argues that the stigma attached to any suggestion of mental health is likely to influence the decision when deciding whether to acknowledge a problem and seek treatment and that Black Africans may avoid being labelled with a mental health problem. Milton (2014) argues that the process of receiving a diagnosable condition may have an impact on the meaning the difficulties have
for the individual. Therefore, counselling psychologists need to show an awareness of and
engagement with cultural specific shame related beliefs.

African participants’ high score in the beliefs and stigma towards mental health
problems within one’s community/family is of particular concern. Given that the literature
suggests that people of African descent are likely to seek communal or family support during
times of distress (Nobel, 1980), it is highly conceivable that an individual that perceives
shame beliefs to be high in his/her community and family may be more likely to internalise
negative stereotypes and subsequently avoid disclosing emotional problems, particularly if
he/she fears that they may be externally shamed. Therefore, it is imperative that counselling
psychologist develop anti-stigma education to this population. Working in the community
and in partnership with other organisations (e.g. religious leaders) would also be vital to
reduce stigma and

**Limitations and Future research**

There are limitations of the present study that impact on the conclusions drawn. First,
due to the cross-sectional design of this study, any claims to generalisation are made with
cautions. Longitudinal studies may be needed to firmly establish conclusions about the
direction of causality regarding the link between external shame beliefs and depression.
Future studies may need to explore other factors related to well-being (i.e. stress, fatigue,
etc.) to increase our understanding of the ways in which discrimination may impact on people
of African descent. Another limitation is that as a result of employing a snowball sampling
technique, there was an overrepresentation of one ethnic group. Black African participants
primarily comprised of British born Nigerians and results are most likely to be reflective of
the beliefs and experiences of Nigerians. Also, the unequal representation of Black Africans
being affiliated to a religion, in comparison to White British participants, mean that the
findings cannot necessarily be generalised to non-Nigerians without a religion. Specifically,
any conclusions drawn regarding shame related beliefs, cultural values, perceived ethnic
discrimination and well-being should bear in mind the actual sample achieved for this study.
The heterogeneity and individual differences within the sample, findings from this study may
not equally apply to a larger population that vary tremendously in culture, religion,
acculturation and historical experiences. Further studies may be needed to explore individual
differences (e.g. acculturation, ethnic identity, self-esteem, etc.) that could influence our
understanding of perceived ethnic discrimination shame related beliefs and cultural values.
For example, longitudinal studies could explore the long-term impact of exposure to multiple sources of discrimination or shame related beliefs by examining the trajectories of cultural values or acculturation among people coming from Africa. Third, the study relied on self-report measures. This is problematic because participants may have minimised any strong beliefs they held because of concerns about social desirability. Consequently, this may mean that responses gained from participants may be underestimates of their beliefs and experiences, for example, of depression and anxiety. Qualitative studies or mixed methods methodology may be necessary to gain further understanding on the complex interplay between culture and emotional well-being. While being mindful of these limitations the study also has a number of strengths. The participants in the study were more than adequate, particularly for Black African participants who have been identified as being a hard to reach group. As far as is known, the current study is the first to explore cultural differences and the mediating role of cultural values between culture and shame beliefs towards emotional problems and the potential mediating role of discrimination and shame in the link between cultural group and emotional well-being in a UK sample of African adults.

**Dissemination**

In light of the above findings it is anticipated that this study will be written up for publication in a peer-reviewed journal and be presented at relevant conferences with a particular focus on discrimination and shame/stigma towards mental health problems.

**Conclusion**

This study contributes to the limited research on people of African descent and emotional well-being in the UK. What has emerged from the findings is that this sample of Black Africans does experience greater levels of ethnic discrimination which could increase the likelihood of anxiety. However, this sample’s higher shame related beliefs and in particular, external shame, towards emotional problem could prevent them from reporting experiences of distress to their family, community and/or health professionals. In addition to the challenges of experiencing ethnic discrimination and shame beliefs related to emotional well-being, the study also highlights the significant challenges the Black African sample could face adjusting between two cultural values and worldviews. Therefore, this study could be a valuable resource to professionals working with some Black Africans as it can provide a
strong starting point to contextualise and understand the experiences of some Black Africans living in the UK. This study also emphasises the role of counselling psychologists recognising inequalities in society and addresses ways to deal with culturally related issues of shame. Given the paucity of research on this population, further research is strongly recommended to confirm these findings.
References


The King’s Fund (2016). Mental health - black & minority ethnic communities.  


APPENDIX A

Faculty of Arts and Human Sciences
Ethics Committee

Chair's Action

Proposal Ref: 1107-PSY-15
Name of Student/Trainee: CHRISTIANA ABU
Title of Project: A quantitative study examining shame, perceived discrimination, and attitudes towards mental health among Africans and non-Africans
Supervisor: Dr Michele Birtel
Date of submission: 16th March 2015
Date of confirmation email: 21st April 2015

The above Research Project has been submitted to the FAHS Ethics Committee and has received a favourable ethical opinion from the Faculty of Arts and Human Sciences Ethics Committee with minor conditions. Confirmation has been received that the conditions stipulated after ethical review have now been addressed and compliance with these conditions has been documented.

The final list of documents reviewed by the Committee is as follows:

- Protocol Cover sheet
- Summary of the project
- Detailed protocol for the project
- Participant Information sheet
- Consent Form

This documentation should be retained by the student/trainee in case this project is audited by the Faculty Ethics Committee.

Signed and Dated: [Signature]
[Date]
Chair

Please note: If there are any significant changes to your proposal which require further scrutiny, please contact the Faculty Ethics Committee before proceeding with your Project.
APPENDIX B

Invitation to online participants

Hello,

Thank you for your interest in my study exploring cultural differences in attitudes towards mental health problems. You are eligible for this study if you are 18 years old or above, live in the UK and self-identify as White British or of African heritage. If you meet these requirements, please click on the link below which will tell you more about the study. To take part in the study, you will need to complete a consent form and a set of questionnaires, measuring different aspects of culture, attitudes towards mental health, perceived discrimination and well-being. This will take approximately 15 minutes to complete. All information collected will be kept strictly confidential and participants will remain completely anonymous.

Study link: http://surveys.fahs.surrey.ac.uk/mental_health_attitudes/.

Best wishes,

Christiana Abu
Trainee Counselling Psychologist
APPENDIX C

Participant information sheet

<table>
<thead>
<tr>
<th>Title of research: A quantitative study examining shame, perceived discrimination, and attitudes towards mental health among Africans and non-Africans</th>
</tr>
</thead>
<tbody>
<tr>
<td>My name is Christiana Abu and I am a doctoral student in the Faculty of Arts and Human Sciences at the University of Surrey. You are invited to take part in a research study. Before you decide whether you would like to participate, this information sheet is designed to help you understand why the research is taking place and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. If you have any queries about the information provided in this sheet or any other questions that are not addressed here then please do not hesitate to ask me.</td>
</tr>
</tbody>
</table>

What is the purpose of the research?

This study seeks to understand the impact of culture on shame and perceptions of mental health and discrimination. If you choose to participate, then you will receive more specific information about the study’s aims once you have completed it.

Why have I been asked to participate?

I am looking for individuals who:

1. Are 18 years and over.
2. Do NOT have a mental health problem
3. Are of African heritage or White British
4. Live in the UK

What will the research involve?

The study involves completing a questionnaire. You will be asked to answer questions about your culture, attitudes towards mental health, perceived discrimination and well-being. This will take approximately 15 minutes to complete.

Will my information be anonymous and confidential?
**Yes,** any information that you provide will be kept strictly confidential and will be completely anonymous. Any identifying information (e.g. name, demographics, etc.) will be removed from the questionnaires and you will be asked to provide your own personal code to retain your anonymity. Any publication of the results will only report group data. All information collected will be coded and stored to ensure confidentiality. Data will be handled in accordance with the Data Protection Act 1998 and stored for 10 years in a secure place.

**Do I have to take part in the research?**

Your participation in this research is completely voluntary. You are under no obligation to fill out questionnaires if you do not feel comfortable. If you decide to participate but subsequently change your mind, you can withdraw without giving your reasons, up until the study is completed and your data will be destroyed if you wish. All you need to do is mention your personal code, which you will generate at the end of the study, to the researcher.

**Are there any risks involved?**

There are no foreseeable risks involved in your involvement in this study. However, in the unlikely event that you become distressed as a result of completing questionnaires, you can decline to answer any of the questions that you are asked and withdraw from the study at any time, if you wish. If you are concerned about yourself and like to receive support, these helplines can offer expert advice: Your GP, The Samaritans- 08457909090, Careline- 08451228622

**What are the benefits of this study?**

Your participation in the research will be very valuable, as the information is likely to be helpful in adding to the current literature in this area. It will also provide a better understanding of how culture plays a role in psychological distress and possible interventions to improve well-being.

**What if there is a problem?**

If you have any concerns or complaints about any aspect of the way in which you have been dealt with during the course of the study, please let the researcher know or contact Dr Michele Birzel, research supervisor: m.birtel@surrey.ac.uk
<table>
<thead>
<tr>
<th>How can I find out about the findings of the study?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you would like further information about this study or would like to be sent a summary of the final report, please contact Christiana Abu: <a href="mailto:c.abu@surrey.ac.uk">c.abu@surrey.ac.uk</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Who has reviewed the study?</th>
</tr>
</thead>
<tbody>
<tr>
<td>The study has been reviewed and received a Favourable Ethical Opinion (FEO) from the University of Surrey Faculty of Arts and Human Sciences Ethics Committee.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>What do I have to do if I want to take part?</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you would like to take part please let the researcher know, and you will be given a consent form to read and complete.</td>
</tr>
</tbody>
</table>

Thank you for taking the time to read this Information Sheet.
APPENDIX D

Consent Form

A quantitative study examining shame, perceived discrimination, and attitudes towards mental health among Africans and non-Africans

Please read this form carefully. If there is anything that you do not understand please feel free to contact the researcher.

- I understand that this research is investigating the role of culture and perceptions of mental health, shame and discrimination and the purpose and nature of the study has been explained to me in writing.
- I understand that I am being invited to take part to complete a questionnaire which will last about 15 minutes.
- I understand that if I do not feel comfortable responding to any of the questions, I am free to let the researcher know and I am under no obligation to answer.
- I understand that my participating is voluntary and I can withdraw during the course of the study, without repercussions, by informing the researcher.
- I understand that the information I provide will be completely confidential and that anonymity will be ensured through the use of a personal code.
- I understand that there are no foreseeable risks involved in my involvement in this study. However, in the unlikely event that I become upset during the study, I can inform the researcher so that help/counselling support can be arranged.

I agree to participate in Christiana Abu’s research study.

Signed ........................................................

Date ......................................
APPENDIX E

Questionnaires

Attitudes towards mental health problems

How much do you agree or disagree with the following statements?

<table>
<thead>
<tr>
<th></th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Slightly Disagree</th>
<th>Slightly Agree</th>
<th>Agree</th>
<th>Strongly Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>I prefer to be direct and forthright when I talk with people.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>2.</td>
<td>My happiness depends very much on the happiness of those around me.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>3.</td>
<td>I would do what would please my family, even if I detested that activity.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>4.</td>
<td>Winning is everything</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>5.</td>
<td>One should live one's life independently of others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>6.</td>
<td>What happens to me is my own doing</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>7.</td>
<td>I usually sacrifice my self-interest for the benefit of my group</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>8.</td>
<td>It annoys me when other people perform better than I do.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>9.</td>
<td>It is important to maintain harmony within my group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>10.</td>
<td>It is important that I do my job better than others</td>
<td>1</td>
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<tr>
<td>11.</td>
<td>I like sharing little things with my neighbors.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>12.</td>
<td>I enjoy working in situations involving competition with others</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>13.</td>
<td>We should keep our aging parents with us at home</td>
<td>1</td>
<td>2</td>
<td>3</td>
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<td>5</td>
</tr>
<tr>
<td>14.</td>
<td>The well-being of my co-workers is important to me</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>15.</td>
<td>I enjoy being unique and different from others in many ways</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>16.</td>
<td>If a relative were in financial difficulty, I would help within my means</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>17.</td>
<td>Children should feel honoured if their parents receive a distinguished award</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>18.</td>
<td>I often “do my own thing”</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
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</tr>
<tr>
<td>19.</td>
<td>Competition is the law of nature.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>20.</td>
<td>If a co-worker gets a prize, I would feel proud.</td>
<td>1</td>
<td>2</td>
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</tr>
<tr>
<td>21.</td>
<td>I am a unique individual.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>22.</td>
<td>To me, pleasure is spending time with others.</td>
<td>1</td>
<td>2</td>
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<td>5</td>
</tr>
<tr>
<td>23.</td>
<td>When another person does better than I do, I get tense and aroused.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>24.</td>
<td>I would sacrifice an activity that I enjoy very much if my family did not approve of it.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>25.</td>
<td>I like my privacy.</td>
<td>1</td>
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<td>5</td>
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<tr>
<td>26. Without competition it is not possible to have a good society.</td>
<td>1</td>
<td>2</td>
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<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>27. Children should be taught to place duty before pleasure.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>28. I feel good when I cooperate with others.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>29. I hate to disagree with others in my group.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>30. Some people emphasize winning; I'm not one of them.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>31. Before taking a major trip, I consult with most members of my family and many friends.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>32. When I succeed, it is usually because of my abilities.</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>
How often over the past 3 months has each form of discrimination been directed at you?

<p>| | | | | | |</p>
<table>
<thead>
<tr>
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<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>1.</td>
<td>Others made offensive ethnic comments aimed directly at you.</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Others engaged in ethnic name calling.</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Others made offensive comments about your ethnic group.</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Others avoided social contact with you because of your ethnicity.</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Others avoided physical contact with you because of your ethnicity.</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Others made you feel you don’t fit in because of your ethnicity.</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>Others implied you must be dangerous because of your ethnicity.</td>
<td>6</td>
<td>7</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
8. Others implied you must be dishonest because of your ethnicity.  

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

9. Others implied you must be unintelligent because of your ethnicity.  

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

10. Others implied you must be lazy because of your ethnicity.  

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

11. Others had low expectations for you because of your ethnicity.  

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

12. Others implied you must be dirty because of your ethnicity.  

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

13. Others threatened to hurt you because of your ethnicity.  

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

14. Others threatened to damage your property because of your ethnicity.  

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

15. Others damaged your property because of your ethnicity.  

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

16. Others physically hurt you because of your ethnicity.  

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |

17. Others nonverbally harassed you because of your ethnicity.  

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
Read each statement carefully and circle the number that best describes how much you agree with each statement. **For this first set of questions please think about how your community and family view mental health problems such as depression and anxiety with a difficulty to cope in everyday life.**

<table>
<thead>
<tr>
<th></th>
<th>Do not agree at all</th>
<th>Agree a little</th>
<th>Mostly Agree</th>
<th>Completely Agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. My community sees mental health problems as something to keep secret</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. My community sees mental health problems as a personal weakness</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. My community would tend to look down on somebody with mental health problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. My community would want to keep their distance from someone with mental health problems</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
5. My family see mental health problems as something to keep secret  

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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</table>

6. My family see mental health problems as personal weakness  

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
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7. My family would tend to look down on somebody with mental health problems  

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
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<th>3</th>
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</table>

8. My family would want to keep their distance from someone with mental health problems  

<table>
<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
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<th>3</th>
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</table>

For the next set of question please think about how you might feel if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life.

9. I think my community would look down on me  

<table>
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<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
</tr>
</thead>
</table>

10. I think my community would see me as inferior  

<table>
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<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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</table>

11. I think my community would see me as inadequate  

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<thead>
<tr>
<th></th>
<th>0</th>
<th>1</th>
<th>2</th>
<th>3</th>
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</table>

12. I think my community would see me as weak  

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<thead>
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<th></th>
<th>0</th>
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<th>3</th>
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</table>

13. I think my community would see me as not measuring up to their standards  

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<th></th>
<th>0</th>
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14. I think my family would look down on me  

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<th>0</th>
<th>1</th>
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<th>3</th>
</tr>
</thead>
</table>
15. | I think my family would see me as inferior | 0 | 1 | 2 | 3 |
16. | I think my family would see me as inadequate | 0 | 1 | 2 | 3 |
17. | I think my family would see me as weak | 0 | 1 | 2 | 3 |
18. | I think my family would see me as not measuring up to their standards | 0 | 1 | 2 | 3 |

For the next set of questions please think about how you might feel about yourself if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life.

19. | I would see myself as inferior | 0 | 1 | 2 | 3 |
20. | I would see myself as inadequate | 0 | 1 | 2 | 3 |
21. | I would blame myself for my problems | 0 | 1 | 2 | 3 |
22. | I would see myself as a weak person | 0 | 1 | 2 | 3 |
23. | I would see myself as a failure | 0 | 1 | 2 | 3 |

For the next set of questions we would like you to think about how you might feel if you suffered from mental health problems such as depression and anxiety with a difficulty to cope in everyday life. This time consider how worried or concerned you would be on the impact on your family.

24. | My family would be seen as inferior | 0 | 1 | 2 | 3 |
25. | My family would be seen as inadequate | 0 | 1 | 2 | 3 |
26. My family would be blamed for my problems | 0 | 1 | 2 | 3
27. My family would lose status in the community | 0 | 1 | 2 | 3
28. I would worry about the effect on my family | 0 | 1 | 2 | 3
29. I would worry that I would be letting my family's honour down | 0 | 1 | 2 | 3
30. I would worry that my mental health problems could damage my family's reputation | 0 | 1 | 2 | 3

For the next set of questions we would like you to think about how you might feel if one of your close relatives suffers from mental health problems such as depression and anxiety with a difficulty to cope in everyday life. This time consider how worried or concerned you would be on the impact on you.

31. I would worry that others will look down on me | 0 | 1 | 2 | 3
32. I would worry that others would not wish to associated with me | 0 | 1 | 2 | 3
33. I would worry that my own reputation and honour might be harmed | 0 | 1 | 2 | 3
34. I would worry that if this were known one would lose status the community | 0 | 1 | 2 | 3
35. I would worry that others might think I might also have a mental health problem | 0 | 1 | 2 | 3
# HAD Scale

Read each item and place a tick in the box opposite the reply which comes closest to how you have been feeling in the past week.

Don’t take too long over your replies, your immediate reaction to each item will probably be more accurate than a long thought-out response.

Tick only one box in each section.

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<td>1. I feel tense or “wound up”</td>
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<td>2. I still enjoy the things I used to enjoy</td>
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<td>Only a little</td>
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<td>3. I get a sort of frightened feeling as if something awful is about to happen</td>
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<td>Very definitely and quite badly</td>
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<td>Yes, but not too badly</td>
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<td>4. I can laugh and see the funny side of things</td>
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<td>As much as I always could</td>
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<td>5. Worrying thoughts go through my mind</td>
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<td>6. I feel cheerful</td>
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<td>7. I can sit at ease and feel relaxed</td>
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For Office use only:

Total odd = X _
Total even = X _
Finally, please answer a few questions about yourself

Please write down your personal code here. We ask for this code only so that we can identify your responses in the event that you would like us to remove them from the summary of results. Please note that your participant code will not be associated with your name and surname. In fact, you are the only person who will be able to identify your questionnaire on the basis of this code. Please write down the first three letters of your mother’s maiden name and your month of birth, e.g. [PAL-03]:

Personal code: _ _ _ - _ _

1. What do you think this study was about?

_________________________________________________________________________

2. Gender  Male □  Female □

3. Age ______________________

4. What is your country of birth?_______________________________________________

5. For what length of time have you been living in the UK?
   __________________________

6. What is your cultural background?
Black African □           White British □           Any
other_______________________________

7. What is your religion? Please choose one option:
   □ No religion             □ Jewish
   □ Christian              □ Muslim
   □ Buddhist               □ Sikh
   □ Hindu                  □ Other religion, please specify:
                              ____________________

8. Do you have a mental health problem?    Yes □     No □

If yes, please specify: ____________________

Thank you very much for participating in this survey.
Your help is greatly appreciated.
APPENDIX F

Participant Debriefing Form

Title of research: A quantitative study examining shame, perceived discrimination, and attitudes towards mental health among Africans and non-Africans

The purpose of this study is to investigate the relevance of culture in shaping the dynamics of shame, psychological distress, and discrimination. While the link between perceived discrimination and mental health problems is well established, little is known about the causal relationship between shame, discrimination and mental health problems in culturally distinct groups. Your willingness to participate in this study is greatly appreciated. By taking part, you have provided valuable information by helping to understand factors that may influence psychological distress in culturally distinct groups. This will help to inform and improve the way professionals work with individuals from diverse communities.

When the research is completed it is likely that it will be submitted for publication and may be presented to other researchers and professionals. The research findings may also be presented to mental health teams and voluntary services. These findings and final report will not include any identifying information but instead will group together the results of all participants. A summary of these findings will be available upon completion of the research. If you would like a copy of this report, please email me at c.abu@surrey.ac.uk and I will be happy to forward a copy of this report to you.

For some people, the subject matter of the questionnaires you completed could cause distress. If answering any of these questions led you to feel distressed and you would like to speak to someone, please contact one of the following:
• The Samaritans: 08457909090
• MIND Infoline: 0330 123 3393
  • Careline: 08451228622
• Your GP will be able to provide you with more information and support for any outstanding issues or concerns.

Thank you very much for your participation!
APPENDIX G

Journal of Counseling Psychology- Notes for contributors

Numbers following entries refer to relevant section numbers in the Publication Manual.

Format

- Have you checked the journal’s website for instructions to authors regarding specific formatting requirements for submission (8.03)?
- Is the entire manuscript—including quotations, references, author note, content footnotes, and figure captions—double-spaced (8.03)? Is the manuscript neatly prepared (8.03)?
- Are the margins at least 1 in. (2.54 cm; 8.03)?
- Are the title page, abstract, references, appendices, content footnotes, tables, and figures on separate pages (with only one table or figure per page)? Are the figure captions on the same page as the figures? Are manuscript elements ordered in sequence, with the text pages between the abstract and the references (8.03)?
- Are all pages numbered in sequence, starting with the title page (8.03)?

Title Page and Abstract

- Is the title no more than 12 words (2.01)?
- Does the byline reflect the institution or institutions where the work was conducted (2.02)?
- Does the title page include the running head, article title, byline, and author note (8.03)? (Note, however, that some publishers prefer that you include author identification information only in the cover letter. Check with your publisher and follow the recommended format.)
- Does the abstract range between 150 and 250 words (2.04)? (Note, however, that the abstract word limit changes periodically. Check APA Journals Manuscript Submission Instructions for All Authors for updates to the APA abstract word limit.)
Paragraphs and Headings

- Is each paragraph longer than a single sentence but not longer than one manuscript page (3.08)?
- Do the levels of headings accurately reflect the organization of the paper (3.02–3.03)?
- Do all headings of the same level appear in the same format (3.02–3.03)?

Abbreviations

- Are unnecessary abbreviations eliminated and necessary ones explained (4.22–4.23)?
- Are abbreviations in tables and figures explained in the table notes and figure captions or legends (4.23)?

Mathematics and Statistics

- Are Greek letters and all but the most common mathematical symbols identified on the manuscript (4.45, 4.49)?
- Are all non-Greek letters that are used as statistical symbols for algebraic variables in italics (4.45)?

Units of Measurement

- Are metric equivalents for all nonmetric units provided (except measurements of time, which have no metric equivalents; see 4.39)?
- Are all metric and nonmetric units with numeric values (except some measurements of time) abbreviated (4.27, 4.40)?

References

- Are references cited both in text and in the reference list (6.11–6.21)?
- Do the text citations and reference list entries agree both in spelling and in date (6.11–6.21)?
- Are journal titles in the reference list spelled out fully (6.29)?
• Are the references (both in the parenthetical text citations and in the reference list) ordered alphabetically by the authors’ surnames (6.16, 6.25)?
• Are inclusive page numbers for all articles or chapters in books provided in the reference list (7.01, 7.02)?
• Are references to studies included in your meta-analysis preceded by an asterisk (6.26)?

Notes and Footnotes

• Is the departmental affiliation given for each author in the author note (2.03)?
• Does the author note include both the author’s current affiliation if it is different from the byline affiliation and a current address for correspondence (2.03)?
• Does the author note disclose special circumstances about the article (portions presented at a meeting, student paper as basis for the article, report of a longitudinal study, relationship that may be perceived as a conflict of interest; 2.03)?
• In the text, are all footnotes indicated, and are footnote numbers correctly located (2.12)?

Tables and Figures

• Does every table column, including the stub column, have a heading (5.13, 5.19)?
• Have all vertical table rules been omitted (5.19)?
• Are all tables referred to in text (5.19)?
• Are the elements in the figures large enough to remain legible after the figure has been reduced to the width of a journal column or page (5.22, 5.25)?
• Is lettering in a figure no smaller than 8 points and no larger than 14 points (5.25)?
• Are the figures being submitted in a file format acceptable to the publisher (5.30)?
• Has the figure been prepared at a resolution sufficient to produce a high-quality image (5.25)?
• Are all figures numbered consecutively with Arabic numerals (5.30)?
• Are all figures and tables mentioned in the text and numbered in the order in which they are mentioned (5.05)?

Copyright and Quotations
• Is written permission to use previously published text; test; or portions of tests, tables, or figures enclosed with the manuscript (6.10)? See Permissions Alert (PDF, 13KB) for more information.

• Are page or paragraph numbers provided in text for all quotations (6.03, 6.05)?

**Submitting the Manuscript**

• Is the journal editor’s contact information current (8.03)?

• Is a cover letter included with the manuscript? Does the letter
  - include the author’s postal address, e-mail address, telephone number, and fax number for future correspondence?
  - state that the manuscript is original, not previously published, and not under concurrent consideration elsewhere?
  - inform the journal editor of the existence of any similar published manuscripts written by the author (8.03, Figure 8.1)?
  - mention any supplemental material you are submitting for the online version of your article?