Doctoral Thesis
Deborah Habibah Mbabazi
Mind the Generational Gap?
Exploration of the Expression of Mental Wellbeing / Distress and Help seeking Behaviours by Mothers and their daughters of East African Descent in UK: a Mixed Methods study.

UNIVERSITY OF EXETER

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Submitted by **Deborah Habibah Mbabazi** to the **University of Exeter** as a thesis for the degree of **Doctor of Clinical Practice, December 2023**.

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Supervisors:

Dr Janet Smithson

Dr Marta Bolognani

(**53, 007 words** excluding abstract, appendices, references, and table of contents)

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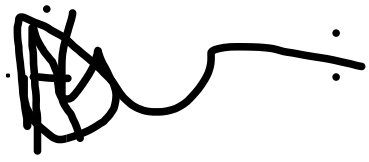
Signed: 

Acknowledgements

I am deeply grateful to the women who participated in this study for sharing your stories with me so courageously. To the young women who taught me new 'street' lexicon, I feel privileged. Thank you too for teaching me the 'art' of resilience. I am equally thankful to the community leaders and other members of the various East African communities in London and Essex who worked so hard with me during the recruitment stage.

I am also very grateful to Dr Janet Smithson for being there throughout the entire doctoral journey from the initial interview to this day and being far more optimistic than I have been! To my other supervisors, Dr Cordet Smart, Dr Maggie Cairns, Richard Mizen, and Dr Marta Bolognani, I am so thankful for all your time and support. To fellow doctoral pilgrims, I can only thank you for staying the course!

To my colleagues, friends, and family, thank you for all the support and being patient with me. Joyline Ghozo, Hawa Meheux and Liz Mensah, thank you for encouraging, cajoling, and finally losing your patience with all my feeble excuses and deciding to serve me with ultimatums. I am eternally indebted to you, my sisters!

Lastly but far from the least, I would like to express my deepest gratitude to my children, Hope and Ayaan for having to endure so much so that I can do this. I love you very much and salute you both. I am so honoured to be called your mother.

To God be the Glory.

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Exploration of the Expression of Mental Wellbeing / Distress and Help seeking Behaviours by Mothers and their daughters of East African Descent in UK: a Mixed Methods Study.

ABSTRACT

Introduction: This study explores the expression of mental wellbeing and help seeking for mother - daughter dyads of East African descent in UK using systemic theory and enquiry. The researcher interviewed women who are UK residents, and they, or their families came from the East African countries of Uganda, Kenya, Tanzania, Rwanda, and the Democratic Republic of Congo (DRC). There are cultural similarities in these countries such as Swahili, a Bantu language that is spoken as a first and national language by many people from these countries (Wilson, 1985; Ally & Brennan, 2015). Similarly, religious / spiritual beliefs and the use of traditional healers are themes that are shared by many people from these countries. Some studies have indicated that women from minority ethnic backgrounds who tend to seek medical help in a crisis have poorer outcomes than their European counterparts. Some of the elucidated explanations for hospital crisis presentations and poorer health outcomes include racism (real or perceived), a lack of trust in the Western (Eurocentric) medical models and conceptualisations, lack of awareness and cultural incongruence among others.

Method: The research was undertaken using mixed methods. A Department of Health (DoH) questionnaire regarding attitudes to mental illness was administered to 50 participants. Two focus groups, each comprising of 7 participants, with mothers living in North London and Essex were conducted. Their adult daughters participated in two focus groups that were organised on separate occasions from those of their mothers. Three mother-daughter dyads who had participated in the focus groups were interviewed after the focus groups had been conducted. The focus groups and mother-daughter dyad interviews used semi structured interviews which were audio taped, coded, and transcribed. Data generated from the focus groups and interviews were analysed using thematic narrative analysis. The survey data was analysed using the Statistical Package for the Social Sciences (SPSS).

Findings: Three overarching topics were identified. These were: expression of mental distress / wellbeing, emotional health / distress and help seeking behaviours. Through these topics, themes, and sub-themes, were variously recognised. The findings indicated that there were some differences in how these mothers and their daughters conceptualise, communicate, and seek help for their distress. Both qualitative and quantitative findings indicated on the other hand, that these mothers and their daughters had some similarities regarding their conceptualisation of causes of emotional / mental ill health, distress, or wellbeing. The mothers in this study seemed to differ from their daughters in terms of how they would readily seek help from professionals.

Conclusion: Co-constructing systems that are meaningful to individuals and families as well as their communities can help to bridge the generational gaps, reduce familial conflicts, and mitigate disparities in help seeking and access to timely healthcare service provisions.

Keywords: *Mother-daughter dyads; Emotional wellbeing; Focus groups; Thematic Narrative analysis; East Africa; Systemic thinking / theory; Spirituality; African Traditional Religion (ATR), BAME.*

Chapter one: Introduction

I felt completely alone.
Yet not hollow alone.
I know my people are somewhere.
I don't even have to look.
My black mother.
She is stronger.
I came from her womb…
Cece Alexandra – Matriarchal dreams (Linton & Walcott, 2018 :43)

Studies indicated that African women tend to seek medical help in crisis and have poorer outcomes when compared to the general UK population. Some of the elucidated explanations for hospital crisis presentations and poorer health outcomes include racism (real or perceived), a lack of trust in the Western (Eurocentric) medical models and conceptualisations, lack of awareness and cultural incongruence among others (Browne, 2013).

The notion of the 'myth of maladaptive communities' is disputed as a simplistic narrative (Sewell, 2010). Whilst extending on Ogbu (1995) in UK and Boykin in USA (1986) work cited by Sewell (2010), Sewell (2010) argued that there is no such thing as a maladaptive community. Sewell (2010) argued that collective problems that are faced by people from ethnic communities are distinguished by their narrations. In advancing the idea that maladaptive communities are a myth, Sewell (2010) advanced the idea of a 'triple quandary' for African Caribbean communities in UK and African American communities in USA and how they negotiate the triple quandary within which they find themselves. Sewell (2010, pp. 81, 82) elucidates that the minority experience "consists of being exposed to a set of culturally, politically, socially and economically oppressive conditions that have reduced black people's chances". Secondly, Black cultural familiarity of these issues "relates to the way in which…certain coping strategies to negotiate multiple contexts and demands by a perceived White Middle-class mainstream are developed". The third quandary according to Sewell (2010, pp. 81) is how "the mainstream (White) experience entails the conventional assumption of assimilation into the dominant culture". I would therefore agree with Sewell (2010) that given the *triple quandaries* that people from Black, Asian, and Minority Ethnic (BAME) communities experience, there is no such thing as a maladaptive community. I would argue that if individuals and communities are offered equal and fair access, all the communities in UK would thrive.

However, environmental triggers for mental ill health in those who are predisposed are acknowledged. *This study* explored two generations of East African women in the United Kingdom (UK) - mothers and their daughters – for two main reasons. Much recent research on families with African origins, for example research on gun and knife crime in UK, seems to have focused extensively on black boys and their 'absent' fathers (Sewell, 2010). Others have explored black boys' relationships with their mothers in single parent homes (David Lammy MP in press 2012; Eliacin, 2013). Thoughts on what happens to the other members of the families of young black boys who engage in youth offending, and how they express their distress do not seem to have been explored. Similarly, by virtue of group or ethnic density many of these women and their daughters live in communities where they are likely to continue with culturally designated roles as carers in the community.

The study interviewed women who are UK residents who or their families came from the East African countries of Uganda, Kenya, Tanzania, Rwanda, and the Democratic Republic of Congo (DRC). There are cultural similarities in these countries such as Swahili, a Bantu language that is spoken as a first and national language by many people from these countries (Wilson, 1985; Ally & Brennan, 2015). Similarly, religious / spiritual beliefs and the use of traditional healers are themes that are shared by many people from these countries.

There are however significant differences in some traditional rituals like courting and marriage, preparation of food, tribal languages, and rituals among others. Akyeampong (2015) cautions against presupposing a common African culture that produces a generic African individual. Apart from the DRC, all the other five countries belong to the East African Community, a political and economic bloc where English and Swahili are the two recognised official languages. The DRC has applied to join the East African Community but is yet to be ratified. Owen (2008) reported that more women than men from East Africa have settled in the United Kingdom (UK) over the last 20-year period. Arguably, the available records do not take into consideration the illegal and undocumented migrants.

East African cultures are largely patriarchal. The Oxford dictionary defines patriarchy as a social system that is male dominated. Dallos and Draper (2005, pp. 114) suggested that some Feminist approaches tend to view society as 'largely based upon patriarchal notions which tend to confer a lower status on the activities and roles of women'. Christ (2016) talks about her

multipronged interpretation of patriarchy as an intrinsic system: male domination is executed by violence which is a consequence of war; the control of female sexuality secures the transfer of private property and slaves which are the plunder of war in the male line; and religion legitimises the entire system. Christ (2016) continues to argue, basing on the new research on matriarchies (which are not necessarily congruous with patriarchies) that patriarchy is not eternal or comprehensive, but that it rose out of history, and is entangled with the increase of warfare and other types of control. Similarly, Folbre (2021) offers that patriarchal societies are based on male dominance which perpetuates gender inequality.

Continuing challenging political and economic conditions in Africa have led to substantial migration abroad. There has been an increasing economic and asylum migration of Africans to UK over the last 20 years. A study commissioned by the DoH titled '*A diversity among Black African Communities Study*' specifically selected only four groups (Nigerian, Ghanaian, Ugandan and Somali communities (Sawyer, Hylton and Moore, 2010). It is not clear why the DoH (or rather the researchers) chose only those four communities but Elam and Chinouya (2000) had suggested earlier that there were varied causes for migration for these four communities to the UK since the 1950's. For the Ugandan community, Elam and Chinouya (2000) offered that there were diverse reasons for migration, ranging from voluntary migrants following Uganda's independence in 1962, large numbers of asylum seekers in the 1970's and another large wave of asylum seekers in the 1990's. There were fewer Ugandans who came to UK for purposes of education (when compared to say, Nigerians). Experiences of starting a new life can be traumatic and disturbing as it involves a break from familiar surroundings and cognitive comprehension of the world (Owen, 2008; Bailey, 2012).

1.2: Defining Wellbeing

According to the Department of Health (DoH), "wellbeing is about feeling good and functioning well and comprises an individual's experience of their life; and a comparison of life circumstances with social norms and values".

Two aspects to wellbeing exist:

"Subjective wellbeing (or personal wellbeing) asks people directly how they think and feel about their own wellbeing and includes aspects such as life satisfaction (evaluation), positive emotions (hedonic), and whether their life is meaningful (eudemonic)."

"Objective wellbeing is based on assumptions about basic human needs and rights, including aspects such as adequate food, physical health, education, safety etc. Objective wellbeing can be

measured through self-report (e.g., asking people whether they have a specific health condition), or through more objective measures (e.g., mortality rates and life expectancy)". (DoH, 2014, p.6; Stevenson & Rao, 2014, p.19; Quick, 2015, p. 7).

For this study wellbeing refers mainly to subjective wellbeing and how this is expressed by individual participants. Wellbeing can be considered as an essential and crucial part of any individual's life. The state of complete wellbeing is not limited to the physical fitness or body health, instead the state confines of the overall health of a person. This state or condition extends to physical and mental wellbeing of the individual. In addition to this, the mental wellbeing of the individual encompasses emotional and psychological wellbeing. The combination of physical and mental wellbeing can be classified as the definition of complete wellbeing of the individual. In comparison to physical wellbeing, the mental wellbeing of the individual may require more attention and care according to the statistics based on distress or mental health issues prevalence among the population. Nochaiwong, et al., (2021) research on global prevalence of mental health issues among the general population found that approximately, 50% of the population are suffering from psychological distress, 36.5% from stress, 26.9% from anxiety, 24.1% from symptoms of posttraumatic stress, 28% from depression, and nearly 27.6% from insomnia.

It is possible to infer that individuals' mental well-being is more likely than their physical well-being to result in a high mortality rate, based on the growing number of individuals suffering from mental health issues in the general population (World Health Organisation (WHO, 2020; Robson and Gray, 2007). This statement has generated debate among members of the health-care community as well as the general public, since physical health is often seen as the foundation of an individual's overall well-being. Although there is some evidence to support the idea that mental health is a regulator of physical health based on the skill of studying the effects of chemical composition linked between the body and the mind, this theory is not without its limits, as will be discussed further below. Moreover, the study performed by Ohrnberger et al. (2017), seemed to assert that there is a link between mental and physical health via the use of mediation analysis. Similarly, some studies have suggested that some mental health issues are the underlying cause of a variety of non-communicable diseases (NCDs). Depressive disorders, for example, have been found to be associated with a variety of chronic illnesses like arthritis, cardiovascular disease (heart disease), asthma, diabetes, and even cancer among the health problems (Liew, 2012; Thornicroft, 2018).

Individuals with abnormal sleeping patterns or insomnia, which may result in breathing problems, can be included in the same category. As Thornicroft (2018) argues, there continues to be a 20-year mortality gap for men, and 15 years for women, for people with mental illness in high income countries that is brought about by the combination of lifestyle risk factors, higher incidences of unnatural deaths and poorer physical healthcare. This scandal of premature mortality disregards international conventions for the 'right to health' (DoH, 2014).

Globally, mental / emotional health issues can pose significant challenges that may contribute to public health and socioeconomic conundrums (Gureje et al., 2008; Patel and Stein, 2015). Mental / Emotional issues are generally recognised as important and relevant in terms of public health, but this awareness is yet to permeate into the general public so as to be paid the attention that they deserve (Akyeampong et al., 2015). Lack of appropriate healthcare policy as well as services, lack of awareness about mental health treatment, and economic uncertainties, or a combination of these factors can contribute. Throughout the world, and particularly among poorer countries, there are many who are unaware of mental health issues or the importance of mental well-being (Patel & Stein, 2015). Unlike with high income countries, in low-income countries also known as the global south, lack of knowledge and awareness may be ascribed to a variety of reasons, including scarcity of healthcare resources, social norms, and religious beliefs, to mention a few (Akol et al., 2018; Okello and Ssegane Musisi, 2015). Individuals seeking mental health therapy in East Africa, for example, may find themselves in conflict with social norms, which may be linked with the manifestation of poor mental wellbeing (Akol et al., 2018). Some people have also drawn a connection between the portrayal of mental healthcare services as dangerous, scary, and unpredictable in the media and their own personal experiences with healthcare services.

Similarly, cultural stereotypes that portray individuals with mental/ emotional issues as mentally unstable and therefore dangerous are common. Additionally, the individuals that are willing to seek help from mental healthcare services may receive inadequate or poor support and guidance from the healthcare services. A study by Kakuma, et al. (2010) found that people seeking mental health care in many parts of the world received improper care or given inadequate guidance by the healthcare providers. In a similar vein, a study by Kaas, et al., (2003) concluded that the insufficient provision of sound healthcare and knowledge to patients was related to the inconsistent adherence as well as healthcare providers lack of experience in mental/ emotional health. Although these barriers are common across the globe, in UK the same barriers are likely to be more exacerbated

within the Black, Asian and minority ethnic (BAME) groups when compared to their Caucasian counterparts (Bhui et al., 2005; Sotubo, 2020).

1.3: Mental Health Conditions among the Minority Groups

It is far from being a niche topic of idiosyncratic interest on the periphery of sociological inquiry that the study of the mental health of racial and ethnic minorities addresses concerns that are central to the discipline's theoretical and empirical framework. Classical social theory, particularly in its formulation of the ideas of "alienation" and "alienation from one's own culture," "Anomie" was an attempt to analyse and describe the interaction between the two parties involved in examining the relationship between the person and society as well as the ways in which micro level subjective experience is incorporated into macro level objective social structures (Johnson, 2008).

1.3:1 Social / Ethnic considerations

There is no specific data in UK for mental health conditions among people of East African descent. The main reason being that most people of African descent are 'coded' in UK ethnic groups as either "Black British – African" or "African". This stratification presents us with some consternations: the relationship between race, culture, ethnicity, and racism, amongst them. According to Melanie Suchet (2004:432), "Race touches and marks us all". However, the complexities surrounding the articulating of the notions of 'race', ethnicity, culture, or racism remain treacherous and poorly understood regardless of the compelling forces involved in distinguishing colour, and physical features (Nayak, 2017).

Moreover, there is increasing evidence that people from BAME are less likely than their majority counterparts to seek mental health treatment from mainstream healthcare providers (Bhui and Bhugra, 2004; Eliacin et al, 2013; Dein and Littlewood, 2020). In the context of medical care utilisation for a variety of physical as well as mental health conditions, a similar pattern of inequalities has been documented (Lyratzopoulos, Elliott, Barbiere, et al. 2009). Similarly, Abolarin, Foster, Jones, et al. (2020) under the National Mental Health Intelligence Network, authored a report for the DoH which analysed the literature confirming these discrepancies and linked their origins to four sources, with each source proposing a different set of causes, consequences, and cures for the differences in outcomes.

On the other hand, Garkisch, Heidingsfelder and Beckmann (2017) undertook a study under the International Organization for Migration (IOM) framework that includes the investigation of disparities in mental health care utilisation. Disparities in clinical need were shown to be the most significant source of variations in care utilisation rates. The second issue was disparities in access to health-care services among different racial and ethnic groups.

1.3:2 Economic considerations

Differences in access are caused by inequalities in socioeconomic characteristics that influence the cost of care, such as differences in the proximity to and availability of providers, among others (White, Adams and Heywood, 2009). Differential interactions and treatment of persons from different racial/ethnic groups was the third source of disparity in health care outcomes (Sotubo, 2020). Many members of the BAME community including those of East African descent are among UK's low-income earners. Many are employed in jobs that pay minimum wages or less (Williams, 2010; Platt and Warwick, 2020). Accessing healthcare can be hindered by limited or lack of finances. Many people on low incomes where many people from East African descent fall are not entitled to prescription exemptions as an example (Sotubo, 2020). Similarly, talking therapies are inaccessible to many people on low incomes including many in East African communities, who probably would have liked to access them, due to the prohibitive costs that are involved in accessing private therapy. NHS talking therapy services usually have very long waiting lists that may not favour those with moderate to severe emotional / mental health needs (Cummins, 2018; Lawton, McRae and Gordon, 2021). During the Covid-19 pandemic, a report by Aldridge, Lewer, Katikireddi and others (2020) proposed that factors that can help to reduce economic and other inequalities may include ample protection of incomes, offering culturally and linguistically appropriate public health information as well as reducing barriers to accessing healthcare for people in low-income groups including those from BAME communities. As a mental health professional, this material is particularly useful in situations where diagnoses are made through patient interviews, and when cultural differences in the experience and expression of mental disease symptoms hinder diagnosis and treatment (Gray and Robinson, 2007).

1.3.3: Cultural considerations

Differences in patient preferences, beliefs, and perceived stigma, all of which may have an impact on the perceived need for therapy and the conduct of those who seek treatment in the first place. Those who belong to minority groups and those who are concerned about the general welfare

of society are particularly concerned about these inequities. Racial and ethnic minorities endure a disproportionately large burden of unmet mental health needs and, as a result, suffer a disproportionately higher loss in overall health and productivity (Gureje et al., 2008). Mental illnesses are extremely disabling for people of all ages and backgrounds. Patel, Saxena, Lund et al., (2018) collaborated on a landmark study that was jointly funded by WHO, the World Bank, and Harvard University and was published in the Lancet. The study found that mental disorders are so disabling that they rank second only to cardiovascular disease in terms of their impact on disability in established market economies such as the United States, France, and UK. Also, another study found that approximately one-third of adults (ages 18-65) with learning disabilities living in the community reported experiencing mental or emotional distress which contributed to their disability (Whittaker et al., 2005; Hubert, 2006).

Members of the BAME communities are less likely than the majority groups to seek mental health treatment, and often receive lower-quality care, while having similar prevalence of mental problems in the general population (Stevenson and Rao, 2014; Smith, Bhui and Cipriani, 2020). Minority populations have a larger proportion of individuals with unmet mental health needs than the general population, owing to a combination of lower usage and poorer quality of care in comparison to the general population. Furthermore, minorities are overrepresented among the five most vulnerable and high-need categories across various countries, such as the homeless and the incarcerated (Cummins, 2018). Individuals from these subpopulations have greater rates of mental problems than their counterparts who live in the same community. The impairment burden associated with unmet mental health requirements is disproportionately high for racial and ethnic minorities when compared to the population of the dominant group (Akyeampong, Hill and Kleinman, 2015; Ochieng and Hylton, 2010).

On the other hand, social capital and ethnic density are considered to be mitigating and protective factors for mental and emotional wellbeing among ethnic minorities (Eliacin, 2013; Stevenson and Rao, 2014; Smith, Clark, Smuk, et al., 2015). Social capital refers to those parts of social life that have the potential to be beneficial, and it is built via the formation of shared networks, norms, and trust. It is commonly described as having two components: cognitive social capital, which are subjective factors that act to keep networks together (and are measured by indicators such as trust, social support, and neighbourhood satisfaction); and structural social capital, which is attachment to organisations such as churches and is measured by attendance and the strength of

commitment to the organization (Eliacin, 2013). Cognitive social capital, as opposed to structural social capital, has been shown to be a significant predictor of mental well-being in studies. High amounts of social capital may boost a sense of belonging and so increase collective wellbeing. Individuals who have a poor level of social capital, on the other hand, may feel uneasy and alienated. The relationship between social capital and mental well-being is not completely understood, but some research suggests that having smaller social networks, fewer intimate relationships, and a poorer sense of sufficiency in social support are all connected with depressive symptoms (Stevenson and Rao, 2014; Dein et al., 2013).

1.4: BAME Population in UK

This thesis uses the acronym BAME as it was the most used acronym in both ordinary and academic discourse about people and communities of ethnic backgrounds whilst I was conducting this research in 2017 / 2018. However, BAME as an acronym has been challenged by some researchers and writers. Some writers now argue that the enduring method of racializing and minoritizing people of Black, Asian, and other people of the Global Majority is a form of neo-colonialism (Campbell-Stephens, 2021; dailysabah.com, 2022 in press). The term global majority is therefore currently preferred and used widely in lieu of the acronym BAME in many settings. This is intended to retrieve and reframe discourse that challenges the implicit experiences of being racialized. According to the UK Immigration Law Practitioners' Association (ILPA), the term "Global majority" refers to people of Indigenous, African, Asian, or Latin American descent, who form roughly 85 percent of the worldwide population. The term is being used as an alternative to expressions that are viewed as racialized as "ethnic minority" and "person of colour" (POC), or more regional terms like "visible minority" in Canada and "Black, Asian and Minority Ethnic" (BAME) in the United Kingdom. The term Global majority loosely refers to people whose heritage can be traced back to nations of the Global South (Campbell-Stephens, 2021; ILPA, 2021). As explained earlier, *this thesis* will use the acronym BAME in lieu of the term global majority.

The BAME population in the United Kingdom is diverse and constantly changing. According to the 2021 Census, 18.3 percent of the population of England and Wales is comprised of people

from minority ethnic backgrounds. People who identify as 'Black, Black British, Black Welsh, Caribbean of African: African' increased from 1.8 percent (990,000) in 2011 to 2.5 percent (1.5 million) in 2021. Despite being the majority ethnic group, the proportion of people who identify as White British has declined from 86 percent in 2011 to 81.7 percent in 2021. This can be ascribed in part to the ageing of the White British population, which is predicted to have more people over the age of 60 than people under the age of 16 (Stopforth, Becares, Nazroo and Kapadia, 2021). While international migration may have been a significant driver of this population change in recent years, it is possible to argue that it has been the primary driver in recent years. A variety of causes including historical and commonwealth relationships, legislative changes, as well as personal, economic, and cultural events may explain the changes that have occurred (Becares and Nazroo, 2013; Ochieng and Meetoo, 2015; ONS, 2022).

Recent international migration has also had an impact on the number of births in the United Kingdom, particularly in the last 20 to 30 years. In 2011, a total of 184,529 live births in the United Kingdom were to women who were not born in the country. This figure decreased to 179, 726 live births according to the 2021 census. For women who were born in Eastern Africa, 14, 798 births were recorded in 2011. A decrease to 9751 live births for women who were born in Eastern Africa was recorded in the 2021 census. In my opinion, the decrease can be attributed to factors such as a change in UK law where children born to non- UK residents do not have an automatic right to UK citizenship. Anecdotal stories indicate that some parents (with means) who used to come to UK for antenatal care for purposes of obtaining UK citizenship for their children now prefer to go to other countries like Canada or USA. Also, according to the 2021 census, the average age for the mothers who gave birth in 2021 was 30.9 years. Some of these young mothers although born in UK, may have been identifying as 'UK other'.

In addition, the 2021 Census reported that the number of people who identify as belonging to the 'White Other' category increased from 4.4 percent (2.5 million) in 2011 to 6.2 percent (3.7 million) in 2021. These statistics contained a considerable number of persons who were born in Poland, demonstrating the significant influence that the EU's expansion in 2004 had on the demography of the United Kingdom. It had been speculated that this trend would have changed following the UK's decision to leave the European Community following the Brexit campaign in 2018 but this does not seem to have been the case according to the 2021 Census. In addition to the

increase in migration, those with a dual background are the fastest growing ethnic group in the United Kingdom, with a population of 2.0 million people (8.7 percent) and 2.5 million people (10.1 percent) according to the 2011 and 2021 Census respectively. One of the explanations for the increase that has been advanced is the introduction of the new search-as-you-type functionality in 2021 which made it easier for people to self- define. (Source: Office of National Statistics (ONS) website – https://www.ons.gov.uk.)

Foreign-born individuals living in the UK may be discriminated against for multiple reasons, some of which might be shared with UK-born ethnic minorities (e.g., ethnicity, skin colour or religion) while others are more likely to affect the migrant population (e.g., having foreign qualifications or a foreign accent). It is difficult to disentangle the reasons for discrimination because multiple factors might be at play at the same time. For example, a Somali-born worker might be discriminated against for his/her ethnicity, race, Muslim affiliation, foreign accent, or foreign credentials. The migrant population in the UK is diverse, not only in terms of their national and ethnic origins, but also in regard to their economic and educational backgrounds. These differences will affect their experiences and perceptions of discrimination. Migrant groups who are culturally and ethnically more distant from the local majority population are more likely to experience discrimination than those who are more alike, while migrants from less developed countries are often perceived more negatively than those from developed nations, regardless of their personal characteristics. However, not all discrimination against migrants has an ethno-racial or national component. For example, attitudes towards low-skilled migrants are generally more negative than towards the high skilled, which could in turn affect the experiences of discrimination of high- and low-skilled migrant workers (National Bureau of Statistics, 2021; Smith, 2010; Sewell, 2010).

To understand why people discriminate against others is a difficult task that ultimately entails investigating societal attitudes and preconceptions about specific groups. Even though unfavourable attitudes and prejudices may not always result in discriminatory behaviour, they are more than likely to make discrimination possible or even, acceptable. Negative opinions toward certain minorities are likely to cause not only discriminating attitudes but can also contribute to emotional distress for those that are experiencing discrimination. On the perceptions of care and service provision in African-Caribbean communities, there is a substantial body of literature that suggest that patients, caregivers, their communities, and certain healthcare workers have poor perceptions of the care they receive from the UK National Health Service (NHS). An investigation into the experiences of African

and African Caribbean caregivers of people with learning disabilities discovered that assistance provision was severely inadequate and ineffective (Hubert, 2006). Recently, Islam et al., (2015) called for the development of holistic person-centred therapies that are culturally suitable, acceptable, and easily available to everybody. They claim that this is not the situation at the present time. It has been suggested that cultural stereotypes such as the assumption that Africans are a homogeneous community who readily support one another through their kin and social networks may not be strictly true (Flowers et al., 2006; Pelle, 2013).

It is possible that strong collaborative models that recognise multiple conceptualisations of emotional well-being and distress may be required when investigating service provision in BAME communities. Some collaborative models in East Africa involve working with traditional healers and / or faith-based organisations (Okello & Ssegane Musisi, 2015). Some have argued that referrals for treatment seem to be one-way (i.e., from traditional healers and / or faith-based organisations into 'biomedical services') (Obbo et al, 2015; Green and Colucci, 2020). Collaborative models are recognised by WHO which proposed the following approaches to adopting traditional practices into Primary Care:

1. Tolerant: a select group of traditional practitioners are allowed to practice in some capacity.
2. Inclusive: traditional healers are recognised but not integrated into policy, regulation, or education.
3. Parallel: both traditional and conventional forms of healing are practiced simultaneously in the healthcare system.
4. Integrated: the healthcare and medical education system incorporates both traditional and conventional practices. WHO (2012).

Many NHS Trusts attempt to involve collaborative models with faith-based organisations. These have been mainly with Churches, Muslim clerics, and other faith-based organisations (Dein, 2020; Lloyd, Mengistu and Reid, 2022). They are yet to work collaboratively with traditional healers although individual clinicians such as Littlewood and Lipsedge (1997) and many others have attempted to incorporate traditional healers' views into their clinical formulations. Like health care providers in East Africa, referrals for emotional and mental healthcare in UK seem to be one-way meaning that the NHS does not refer to Faith based organisations or traditional healers (McManus, Bebbington, Jenkins and Brugha, 2016; Nanji, 2022). I would argue that considering WHO (2012)

approaches proposals, the NHS is currently tolerant and inclusive. There is need to work towards the integrated approach to enhance multiple conceptualisations.

1.5: *High rate of Mental Health Problems of people from BAME Background*

A BAME background is represented by roughly 14 percent of the population in England and Wales (Source: Office for National Statistics). Racism, stigma, and inequalities can all have a negative impact on the mental health of persons from BAME groups (Bhatia, 2020; Out, Ahinkorah, Ameyaw et al. 2020). Several BAME populations experience higher rates of mental health problems, misdiagnosis, and possibility of being detained than their Caucasian counterparts. As an illustration: when compared to white counterparts of UK ancestry, African and African Caribbean men are more likely to be diagnosed with a mental illness and to be hospitalised. Conversely, when compared to Caucasian people, African Caribbean individuals are four times more likely to be held under the Mental Health Act (MHA) (Devonport, T.J., Ward, G., Morrissey, H. et al., 2023). This undoubtedly has some impact on the families of the individuals that are held under the MHA (Weich, McBride, Twigg, et al.,2014 Dawn Edge, Anthony Salla and Glicinia Danso, 2018). Older South Asian women are a particularly vulnerable demographic when it comes to suicide (Bhui et al., 2014). Refugees and asylum seekers are more prone than the average population to suffer from mental health problems, including greater rates of depression, anxiety, and post-traumatic stress disorder (PTSD). Irish people living in the United Kingdom, even though they are not classified as a BAME group, have significantly higher rates of hospitalisation for mental health disorders than those from other ethnic groups. They are more likely than the general population to suffer from depression and alcoholism, and they are also more vulnerable to suicide (Rains, Weich, Maddock et al.,2020; Islam et al., 2015; Pelle, 2013). Substance misuse and alcoholism is also reported to be on increase among African and African Caribbean communities, especially men. This is attributed by some studies to issues such as loneliness, poor housing and the UK dispersal policy for migrants that affects many migrants to UK (Sotubo, 2020; Bécares, L., Nazroo, J. and Stafford, M. 2011: Rassool, G.H. 2006).

1.6: *Mental Health Conditions among people of East African Descent in UK*

Charles Darwin (1809-1882) made a pioneering observation that we are one human species, one race, which have a common ancestor. Nonetheless this fundamentally held classical theory is now being challenged by other emerging theories. Attempts to deal with this conundrum and the complexities that are involved have led to people being organised according to their physical

characteristics including colour (Dalal, 2006), and creating sub races- White, Black, Asian etc. This is no doubt an elaborate topic but suffice to say here that people of East African origin residing in UK and other diaspora regions include Black, White and Asian people as well as those of various mixed parentage. This is owing to historical factors including colonialism, slave, and other trade as well as migration. However, whilst Caucasians of East African origin may be the minority group in their respective East African countries (they are usually affluent by African standards), they tend to identify with other White people and the case is similar for Black Africans (also called 'indigenous Africans') and Asian- Africans who belong to minority groups in UK.

The mothers and daughters who took part were members of the BAME community as delineated in the UK. These women possess both similarities and significant differences in some traditional rituals like courting and marriage, preparation of food, tribal languages, and rituals among others. Akyeampong (2015) cautions against presupposing a common African culture that produces a generic African individual. Apart from the DRC, all the other five countries belong to the East African Community, a political and economic bloc where English and Swahili are the two recognised official languages. Owen (2008) reported that more women than men from East Africa have settled in the United Kingdom (UK) over the last 20-year period. Arguably, the available records do not take into consideration the illegal and undocumented migrants.

East African cultures are largely patriarchal. Continuing challenging political and economic conditions in Africa have led to substantial migration abroad. There has been an increasing economic and asylum migration of Africans to UK over the last 20 years (Owen, 2008; Sotubo, 2020; Atta Asiedu, 2020). Experiences of starting a new life can be traumatic and disturbing as it involves a break from familiar surroundings and cognitive comprehension of the world (Bailey, 2012; Smith, Bhui and Cipriani, 2020).

Some studies have reported limited levels of interaction between people from the East African communities and mainstream mental health services. Many are more likely to enter healthcare via less favourable routes, and to report adverse experiences after contact with services (Rains, Weich, Maddock, et al., 2020; Thornicroft, 2011). The trajectory for access to mental health services for many people of East African descent in the UK is marked by delays, mutual suspicion, and non-engagement (Ally and Brennan, 2015). Consequently, patients suffering from untreated illness for a longer length of time are more likely to appear with chronic symptoms when they seek

assistance from mental health services. Other reasons advanced include the stigma linked with seeking or talking about mental health issues. Some individuals have indicated that stigma within many African communities begins in and is perpetuated within ethnic groups and families (Patel and Stein, 2015). The notion of 'appropriated racial oppression' where the effects of oppression can cause some individuals to internalise the values and ideologies of the dominant group, whilst simultaneously providing reasons why someone from a minority group could hold such ideas may at times be unconscious or sub-conscious but nevertheless present in many (Ochieng and Hylton, 2010; Wright, 2021).

1.7: *Mothers of East African descent in the UK*

The encouragement of employed work for single parents is discussed as an anti-dependency strategy in social policy. It is problematic as many single parents are restricted to low-paid 'women's jobs', and childcare costs are high (Ochieng & Meetoo, 2011). The lower the cost of the childcare, the more mothers, whether lone or married, are employed fulltime (Jannesari, Hatch, Prina and Oram, 2020). Pre-school provision is not provided as a universal service in UK but is expensive and dependent on private initiative. Apart from that there is still political-ideological discussion concerning whether mothers should be encouraged to secure their living or whether employment endangers their children's development (Sewell, 2012; Mingot,2020).

Research conducted in the last decade has confirmed that low-income single mothers and their children continue to be vulnerable to a variety of chronic risk factors. In addition to financial insecurity, lack of easy access to primary care health promotion and awareness can hinder good health for the mothers and their families. Job insecurity coupled with the low-income work some are involved in leaves mothers and their children susceptible to food insecurity. Some mothers often hold several jobs to make ends meet and must deal with associated childcare problems. Some mothers are more likely to be homeless or to live in unsafe neighbourhoods in poor quality housing where they and their children confront violence and environmental health risks daily. For some mothers, their own childhoods are likely to have been similar. According to Carney, Boyle, Offord, and Racine (2003), single mothers report earlier childhood adversities, more threatening life events, and more exposure to domestic violence, more periods of unemployment and greater chronic deprivation and stress than other members of the population. Single mothers are more likely than partnered mothers their age to experience poor mental health, such as depression, anxiety, and substance use disorders.

As outlined earlier some studies have indicated that African women, just like many other women from BAME communities, tend to seek medical help only when in crisis and have poorer outcomes when compared to their white counterparts (Becares, Nazroo and Kelly, 2015; Reardon et al., 2017). Some of the elucidated explanations for hospital crisis presentations and poorer health outcomes include racism (real or perceived), a lack of trust in the Western (Eurocentric) medical models and conceptualisations, lack of awareness and cultural incongruence among others (Sotubo, 2020; Thornicroft, 2011).

This study sought to explore the views and experiences of East African women and their daughters in relation to expression of emotional wellbeing and distress. The rationale for this study is the seeming paucity of research concerning African women in general and East Africans in particular, with regards to mental health issues. It sought to explore whether mothers express distress differently in comparison to their daughters. Complex mechanisms of multiple identities and belonging can so often create tensions and anxieties carried by those who have experienced migration and displacement (Owen, 2008; Henry, 2010; Mingot, 2020). The researcher hypothesised that the daughters do not share their mothers' memories and sense of belonging to another land. Curiosity as to how this lack of shared memories informed the attachment stories for the participants in the study also played a part in undertaking this study.

This lack of cultural (and perhaps less emotional) connectedness to another land, it is thought, may be an important factor in emotional expression and help seeking. One wonders whether growing up with a mother who may have a sense of belonging to a different country and culture would impact on the attachment processes. Environmental triggers for mental ill health in those who are predisposed are acknowledged (Sewell, 2012). The study will seek to research two generations of East African women in the United Kingdom (UK) - mothers and their daughters – for two main reasons. It has been suggested that East African daughters' relationships with their mothers in single parent homes is based on both positive, and negative aspects. Thoughts on what happens to the other members of the families of young black daughters who engage in youth offending, and how they express their distress do not seem to have been explored. Similarly, by virtue of group or ethnic density many of these women and their daughters live in communities where they are likely to continue with culturally designated roles as carers in the community. The study will interview women who are UK residents who or their families came from the East African countries of Uganda, Kenya, Tanzania, Rwanda, Burundi, and the Democratic Republic of Congo

(DRC). There are cultural similarities in these countries such as Swahili, a Bantu language that is spoken as a first and national language by many people from these countries. Similarly, religious / spiritual beliefs and the use of traditional healers are themes that are shared by many people from these countries.

However, there are significant differences in some traditional rituals like courting and marriage, preparation of food, tribal languages, and rituals among others. Akyeampong (2015) cautions against presupposing a common African culture that produces a generic African individual. Apart from the DRC, all the other 5 countries belong to the East African Community, a political and economic bloc where English and Swahili are the two recognised official languages. Owen (2008) reported that more women than men from East Africa have settled in the United Kingdom (UK) over the last 20-year period. Arguably, the available records do not take into consideration the illegal and undocumented migrants. Continuing challenging political and economic conditions in Africa have led to substantial migration abroad (Atta-Asiedu, 2020). East African cultures are largely patriarchal. Experiences of starting a new life can be traumatic and disturbing as it involves a break from familiar surroundings and cognitive comprehension of the world (Watters, 2001; Nanji, 2022).

Migration does not simply entail the crossing of territorial boundaries but also a social, cultural, and psychic boundary where one enters new relationships in new spaces (Tastsoglou, 2006). Migrating to UK may require role reversals for women who may have to work long hours whilst taking care of their families including husbands who may at times be experiencing adverse socioeconomic changes. It may also entail taking care of families left behind in home countries for various reasons. Bailey & Harindranath (2006) note that whereas there have been enhancements in levels of involvement of multi-ethnic groups in British society, and a more positive approach to difference and diversity in official policy on race, ethnicity and culture, there has also been an increase of intolerant public discussions and migration policies, particularly regarding asylum seekers. Another source of stress among mothers is parenting. Past research has shown that parenting is stressful and inversely related to adult well-being across social statuses (Nieuwnhuis and Maldonado, 2018). Parenting stress can be more complicated for mothers for several reasons, including inability to complete their education or to make important career decisions coupled with increased financial and time constraints, childcare difficulties, increased household chores, and limited access to health care (Cohen and Samzelius, 2020).

1.8: *Mental Wellbeing among Mothers and their daughters of East African Descent in UK*

East African women are confronted with a variety of difficulties that may result in mental / emotional health distress (Becares, Nazroo & Kelly, 2015). East African mothers and daughters have developed complex expressions in relation to help-seeking behaviours and mental discomfort when compared to the social norms, family system, family dynamic policies, and lifestyle of the United Kingdom (Ochieng, 2011; Atta-Asiedu, 2020). Some East African parents have expressed a strong desire to attempt and embrace UK parenting practices, as they wish for their children to grow up with the ability to succeed in their new country. But some have described fear of being misunderstood, whether by other parents, social workers, other authorities, or their community in UK as well as their relatives back home (Ochieng, 2011; Hylton, 2010).

In terms of the barriers or elements that contribute to the mother's mental health discomfort, it can be argued that certain aspects are related with differences in cultural, social as well as economic status. Additionally, some people in the East African community may not consider mental health services to be relevant to them since they believe they do not suffer from poor emotional /mental health as they consider psychological well-being an inherent element of an East African lifestyle and admission of poor emotional or mental health a weakness. Belief that coping with hardships without the assistance of outside agencies or institutions can at times inform the narratives that help seeking is for lazy or weak people (Akyeampong, Hill and Kleinman, 2015; Linton and Walcott, 2018).

Because some are readjusting to their new environment, East African descendants face difficulties, social complications, and emotional discomfort. To find release from these emotional burdens, the population seeks consolation by forming ties with other immigrants who share their experiences and culture (Butler, 2021). Close familial and community cultural ties, as well as a strong work ethic and spirituality, are among the most significant protective factors for many of these families (Ochieng, 2011; Dein, 2020). East African immigrant community groups tend to dwell in close proximity to one another for the sake of comfort and mutual support, which helps to alleviate the teething challenges associated with new settlement (Eliacin, 2013). Most social engagement and leisure activities are restricted to visiting friends in their own places of residence at this stage. They become the focal point of socialisation on one hand, but their housing also serves as a source of alienation and isolation on the other, particularly when dispersal housing is located in disadvantaged or unfriendly regions. Because of cultural differences and institutional racial prejudices, Black African

families in the United Kingdom are raising their children with the fear of coming into contact with authorities especially the criminal justice system. The structural forces of race, power, and cultural disparities can have a significant impact on mental and emotional wellbeing (Henry, 2010; Reynolds, 2010).

Some of the issues raised included a sense of loss of identity, the stigma associated with their children speaking English with an accent, a lack of understanding of welfare and other laws and the fear of falling foul of authority, as well as the fear that disciplining their children could result in punishment by child welfare agencies or social workers taking their children away. A pilot study by Ally and Brennan (2015) reported that two-thirds of the parents in their study indicated they would consider sending their child back to their East African birthplace to live with a relative if they proved difficult to manage in the UK, with others stating that they would do so with the hope that their children would obtain another cultural or social perspective of their ethnic identities. When it comes to parenting children, there are considerable cultural differences between parenting in the United Kingdom and parenting in East Africa. For instance, in East Africa, responsibility for raising and disciplining children tend to lie mainly with parents and the extended community, with no overt interventions from statutory organisations (Okello and Neema, 2007; Akol et al., 2018). Because children learn by pushing boundaries, parents who have migrated to UK may struggle with child rearing in a country with culture, norms and values that may be different from those that they are accustomed to. Child rearing for most parents, especially those in lower income brackets, is mainly undertaken by the parents rather than neighbours or extended family. For example, in UK it would be considered improper for a neighbour to reprimand the child of another neighbour. Parents of East African descent, on the other hand, have created a variety of parenting methods that are influenced by their upbringing and the present family structures in their homeland. Their previous family system involves a significant amount of involvement from relatives and neighbours when it comes to instructing and directing their children. Conflict between the two parenting styles in two different geographical spaces can create a distressing environment for the East African immigrant mothers living in the UK (Ochieng, 2010).

1.9: *Mental Wellbeing among Daughters of East African Descent in UK*

A considerable influence on immigrants' social circumstances, parental attitudes, and parenting practises, which in turn have an impact on the health, growth, and development of their children, can be exercised in the new culture and environment of the destination country. Parental

and community expectations can overwhelm some children of immigrant families (Hodes, Vila, Kan et al., 2008). There is an expectation, sometimes unconsciously communicated, that the immigrant children will adhere to the values of their native culture, excel in academics, adjust socially, deal positively with discrimination, and learn a new language in their new country of residence (Hylton, 2010; Linton and Walcott, 2018). For some, including some of those that took part in my study, this can cause untold emotional distress and family conflict. For the daughters growing up in UK, there may be differences in cultural understanding of gender roles as understood by their parents and the older members of the community at large. For instance, Mohammed & Loewenthal (2009) found that young female Somalis in their study tended to use derogatory language towards male Somalis and much more favourable language towards older female Somalis. And, as will be discussed later in this paper, some daughters who took part in *this study*, felt that they would not discuss emotional issues with their mothers, for fear of their issues being discussed in the community and / or possibly being gossiped about with extended relatives abroad (whom some had never even met). This phenomenon (of sharing the children's progress with other members of the community or 'prayer partners') would be perfectly acceptable to the older generation but cringeworthy for the younger generation including the some of the daughters in this study. As discussed elsewhere, the East African region continues to be a patriarchal society to a large extent, whereas the UK, on the surface seems to be more liberal. Consequently, for the mothers and their daughters who have been socialised in these different cultural spaces, this can cause considerable personal and familial conflict that may in turn affect their mental / emotional wellbeing (Ally and Brennan, 2015).

1.10: *People of East African Descent adapting to life in UK*

Immigrating for any reason is stressful. For East African immigrants, some of whom had to flee from wars and other political conflict, immigrating poses even more distress and trauma (Akhtar, 1999; Bailey, 2012; Becares and Nazroo, 2013). Acclimatising to new socio-cultural experiences in the new home country, even for those who leave East Africa for economic reasons, can be very challenging. Interesting observations include the difficulties in responding to shifting gender roles and family dynamics (Arnold, 2006). Moreover, individuals who attempt to adjust to this lifestyle and social system are likely to experience stigma and prejudice from both their community as well as the host community (Ochieng and Meetoo, 2015). A study by Owen (2008) discovered that even though many of the East African immigrants to UK were fluent in English and hailed from middle-class families, they were likely to be employed in low-wage positions and more likely to be housed in poor

or dilapidated accommodations. Men were more likely to be marginalised which in patriarchal communities can cause a great deal of suffering, a sense of feeling emasculated and has been blamed for the rise in single parent households among the East African diaspora communities (Henry, 2010; Atta-Asiedu, 2020). However, on a positive note, many other people of East African descent are settled in UK and feel that they have integrated well living as immigrants in a more balanced way.

1:11: Systemic Thinking and research on Emotions / emotional expression

Bertrando (2015:5) argues that "any human system is (also) an emotional system". Earlier systemic theorists and ideas had viewed emotions as essentially extraneous to systemic thinking and therapy. With time, the role of emotions in systemic practice became widely debated and theorized (Dallos & Draper, 2005). For instance, theorists and therapists like Bateson (1972), Minuchin (1974) and Haley (1976) among others began to associate expression of individual emotions with interpersonal events and experiences, which served interpersonal functions.

Furthermore, Palazzoli et al. (1978) offered that in Western culture language is likely to concretize emotions which seemed to imply that emotional states are indeed not transient but intrapsychic. They theorized that emotions emerge as a segment of relationship dynamics. Others have cautioned that when researching 'indigenous' people, using Western research methodologies and concepts, attempts at "developing operational definitions which are reliable and valid" (Tuhiwai Smith, 2021:49) as well as demonstrating "ethically and scientifically sound humanitarian research" (Betancourt, 2015:325) can be a challenge. My research utilised Western Research methodologies and concepts, but I remained open to any possible intersubjective stances. Intersubjectivity, as explained by Benjamin (1998), takes the view that recognition of the other is "built out of the understanding of the other's continuing otherness, maintaining the subjecthood of both participants in the exchange, who are thus both autonomous and yet also exist in relation to one another" (Frosh, 2009:188). This 'cocreation' in systemic research is similar to what takes place in systemic therapy where listening for information and reflecting on what we have heard whilst checking on our first, our second and, our third understanding is key to remaining reflexive and open to outcomes, be it in therapy or in research (Burck, 2005).

Systemic thinking and systemic theory have evolved over time, but context and relationship continue to endure as the parameters that inform systemic research approaches. Systemic practices have changed from behavioural patterns to patterns of language and meaning (Flaskas, 2009).

Meaning-making, language and interactions of this East African group of participants were therefore explored using a systemic lens whilst being careful to take into account my own background (as a Clinician of East African descent and as a researcher).

1.12: *Clinical context and background for research*

1.12:1 *Experiences of Fear and Parental Challenges of Mothers from East African Backgrounds*

Migration is a global movement that is rapidly gaining momentum. Even though migration frequently results in increased economic opportunities, it can also result in increased social vulnerability because immigrant families may lack access to healthcare, fluency in the language of the destination country, secure housing, publicly funded childcare facilities, and adequate support from those in their social network (Ally and Brennan, 2015; Ochieng and Meetoo, 2015). In East African immigrant families, changes in gender role dynamics, as well as power shifts within families, notably between parents and children, pose a challenge to traditional hierarchical family standards. Migration to a new country not only results in cultural shock for many black East African immigrants, but it also creates enormous parenting issues for their children, as previously stated. The lack of social support services and need based programmes for immigrant parents in destination countries frequently makes it more difficult for immigrants with children to fulfil their parenting responsibilities in a new culture because of their immigration status (Mingot, 2020). Some researchers have observed that African immigrants not only have difficulty performing their parental responsibilities in a new culture, but they are also compelled to alter their parenting techniques because of their experiences (Nanji, 2022; Sewell, 2010; Hylton, 2010).

Following the findings of their study, Salami et al. (2017) outlined five key elements that serve as a foundation for distinguishing between the conventional and cultural parenting styles prevalent in East Africa and the United Kingdom. The following themes have been identified: the use of physical discipline, respect as a deeply established value of parenting, integrating cultural values into parenting, integrating religious practises into parenting, and disparities in parenting between male and female parents.

According to most African parents, the use of physical discipline, including spanking, was considered an acceptable practice in most of the African countries. The use of physical chastisement as a disciplinary measure by African parents to maintain control over their children was commonplace in the region. However, child welfare and safety policies and regulations about child

abuse and mistreatment of children in Western countries have interfered with this way of thinking about children. As a result, they expressed dissatisfaction with how difficult it had become for them to discipline their children, given that spanking had previously been a preferred method of discipline. Also reported were incidents in which parents' own children confronted them and threatened to call the police if they were spanked or otherwise physically punished. Some of the mothers in my study also talked about the misinformation and confusion that they had about physical child abuse and reasonable chastisement. Many mothers described the fear and emotional stress that this induced sometimes.

One of the most important values held by African immigrant parents is respect for one's elders. Traditional African belief holds that “children were supposed to be seen and not heard.” As a result, African youngsters are not expected to speak back or quarrel with their parents or elderly family members, according to traditional African belief. Parents have voiced concern that children who are exposed to new Western cultural norms will develop a disregard for their parental authority because of this exposure. Some of the African immigrant parents have been admonished by their extended relatives and community for being too relaxed and failing to educate their children on how to treat others with respect (Salami et al., 2017; Ochieng, 2010). The authors also pointed out that, in Western countries, respect for one's elders is differently expressed and not necessarily through overt expression of respect such as kneeling or bowing every time one meets with their elders. It goes without saying that culture has an impact on childrearing, and in most African cultures, parents are the primary socialisation agents for their children. Because of this, traditional African parenting practises are heavily impacted by the culture in which the family lives. The worry that their children would lose their African cultural heritage because of the overwhelming impact of Western culture was a major source of concern expressed by the African parents (Reardon et al., 2017; Atta-Asiedu, 2020).

Parental explanations included the fact that both children and parents struggle with the difficulty of navigating two cultures. It is possible for youngsters to break the rules of their families when the culture of a new country provides them with too much freedom and allows them to do anything they want with no overt or immediate consequences. The parents of African immigrant children have expressed that it is difficult to enforce religious beliefs without the assistance of their homeland communities and/or the approval of extended family members (Ochieng, 2010). Parents have expressed concern that the conventional ways they used to teach faith to young children are no

longer effective with children who are being raised in a different setting than they were previously. This is a widespread problem among Muslim immigrants from East Africa who have immigrated to North America and Europe. For example, according to Phillips-Mundy (2011), many immigrants from Sudan express concern about their children's behaviour as "un-Islamic," "disrespectful," and "Western." They attribute this to their inability to impose their religious and cultural values on their children through traditional forms of discipline.

Some have also observed that parenting techniques vary depending on the gender of the children. The findings of studies conducted among Sudanese African immigrants revealed a pre-set gender difference in parenting techniques between boys and girls. According to women from Sudanese cultural backgrounds, they want their daughters to work alongside them and other elder female members of their society to carry out domestic tasks such as childrearing, cooking, and cleaning as well as shopping for their families. Compared to girls, boys who have Sudanese parents enjoy greater independence (Mingot, 2020; Cook and Waite, 2016). Boys' hobbies such as travelling, socialising outside the home, and attending sporting events are permitted, however in most Sudanese houses, girls are prohibited from partaking in such activities as sports. These cultural values where boys / males are treated differently from their female counterparts are common across the East African cultures. Families with members who migrated long ago and who have incorporated Western norms into their homes and altered traditional ways of home life and gender roles are less likely to have gender differentiation than other family structures in the community. Migration also had an impact on the interaction between men and women on a gender basis (father and mother). In the face of post-migration economic strain, where a second source of income is required to sustain the family, the traditional role of the father as head of the family is frequently compromised (Leinen, 2020).

1.12:2 *Stigma*

Stigma is both a psychological and social phenomenon that affects people. Power, according to Link and Phelan (2006), is characterised by the following behaviours: labelling, stereotyping, isolation, loss of status, and discrimination. As a result of these conditions, some groups may be undervalued, rejected, or excluded, resulting in social misery and a loss of social standing for those individuals involved. Stigmata may be divided into three categories: personal, societal, and structural, each of which interacts and reinforces the others. The term "self-stigma" refers to the negative

thoughts and feelings experienced by individuals who have characteristics that are stigmatised. Patients suffering from mental illness, for example, are often led to believe that they are low value members of society, which can lead to negative self-perceptions, maladaptive behaviour, and identity alterations such as feelings of guilt and lowered self-efficacy. For Scambler (2009), internalised shame and immobilising anticipation of enacted stigma is defined as a feeling or expectation that one would be discriminated against by others based on one's perceived flaws. Individuals who possess a devalued characteristic are subjected to social stigma when members of their co-social group judge their qualities to be contradictory to community standards and act adversely toward those who possess the devalued feature.

Influential people of society, both individually and collectively, generate social stigma, which defines acceptable ways of behaving toward oppressed groups and is shown in behaviour during interpersonal interactions. It provides an excellent environment for the development of self- and systemic stigma. When it comes to mental illness, for example, some people may be reluctant to befriend anybody who has a mental illness (thereby contributing to self-stigma) and supportive of coercive mental health treatments if they think that all people with mental illness are dangerous (contributing to structural stigma). However, even though the three levels of stigma are closely related, the focus of this study is on personal and social stigmatisation. A significant body of research has been done on the impact of stigma on mental illness (Atta-Asiedu, 2020; Lloyd, 2021; Scambler, 2009). The relationship between stigma and help-seeking among Black and ethnic minority (BAME) groups in the United Kingdom, on the other hand, still needs further exploration. This is especially considering the high prevalence of serious mental disorders such as psychoses and schizophrenia among African-descended people, as well as the considerable stigma associated with mental illness in these communities. It is imperative that this knowledge gap needs to be closed. Some of the findings of studies conducted with African Caribbean communities suggest that religious beliefs and practises may serve to exacerbate the processes of stigma development and repetition (Lloyd and Hutchinson, 2022).

1.12:3 *Help Seeking*

Explanatory models that include racism and a perceived lack of faith in Western (Eurocentric) conceptualizations of mental health and distress, according to some research, are oversimplified. They call for a more in-depth investigation of the elements that influence people's willingness to seek assistance. The findings and ideas of De Maynard et al., (2009), however, show that perceived racism

plays an essential part in the dissociative experiences of black people. Furthermore, sociocultural, and personal limitations such as language and communication barriers, alternative conceptualisations of health and illness, as well as gender and environmental barriers, are among the barriers identified as contributing to challenges to help seeking behaviours and a lack of access to health and social care services for African Caribbean women in the United Kingdom (Sotubo, 2020; Pelle, 2013). Similarly, interestingly, Africans were excluded from a lot of research on the health of African-Caribbean people, which is a first in the field of health (Sisley et al, 2011).

Both political and environmental settings can have an impact on the ability to seek assistance. A study conducted by Adkinson-Bradley et al., (2009) stated that for patients to understand their symptoms of mental distress and treatment concerns, they must be placed in contexts that are easily comprehensible. Both the nations of origin and the host country have political and environmental factors that must be considered (in this case the UK). Even though gender disparities exist in the United Kingdom, they are not as severe as those found in East Africa (Ochieng, 2011). According to Eliacin et al., (2013), African Caribbean men were more likely than other men to be unemployed and disenfranchised. As a result of this, she believes, among other socio-political factors, there has been an increase in the number of single parent households in African-Caribbean communities. As a result, East African women, who are disproportionately descended from patriarchal tribes that consider men as hunters, gatherers, and breadwinners, may experience this significant change in roles as challenging and emotionally distressing. When Whittaker and colleagues studied young Somali women, they discovered that there was some "male bashing" occurring, but that women (mothers) were also acknowledged to be an important emotional support for the young women and other members of the family.

Several researchers, including Okello and Seggane-Musisi (2015), have suggested that cultural and social factors in African settings (and, by extension, in those who have migrated to the diaspora) can both contribute to and mitigate emotional well-being and suffering. In their view, there is frequently a conflict between Western and traditional explanatory theories for mental / emotional wellbeing and distress. Higginbottom et al., (2006), for example, investigated the usage of herbal treatments among people of African and Caribbean heritage in his study. He proposed that the usage of herbal medicine should be taken into consideration throughout the evaluation process. The findings of Whittaker et al., (2005), on the other hand, revealed that Somali women were less likely than other women to disclose their use of herbal treatments to Western doctors. Patients who took

herbal treatments were less likely to report their use to Western healthcare clinicians, according to the findings of another study conducted in London on HIV patients from Zambia, Zimbabwe, and South Africa (Flowers et al., 2006).

It is also necessary to investigate the possibility of getting assistance through religious and traditional beliefs. Dein et al., (2013) believe that the existing literature on the relationship between what they refer to as "religiosity" and mental health focuses mostly on beliefs rather than personal experience and that this is problematic. Others have attempted to distinguish between religious beliefs and religious experiences by introducing notions about the spirituality of persons. Religious belief, according to Jung et al., (1961) in his book titled "Modern Man in Search of His Soul," is crucial in achieving psychological and mental well-being. Dein et al., (2013) appear to argue for a much more diverse yet inclusive extension of gender, socioeconomic class, as well as 'spiritual beliefs' of help-seeking behavioural approaches to mental wellbeing and distress to achieve greater mental wellness and to alleviate distress. Okello and Seggane-Musisi (2015) recognise the difficulties arising from tensions between Eurocentric and established traditional ways of managing emotional health and distress, but they also acknowledge the possibility of multiple conceptualizations of emotional health and distress. Among many people of East African heritage, African Traditional Religions (ATR) and working with traditional healers are important components of their belief systems. Divine healers, priests, and healers (including herbalists) have a long history of healing in Africa, and their practise predates the arrival of European colonial powers (Atta-Asiedu, 2020; Mbiti, 1990).

1.12.4: Aim of the study

The objective of this research study aimed principally to understand expression of distress and wellbeing for mothers who migrated from East Africa to the UK and their adult daughters with a view to address their help seeking behaviours. The daughters may have arrived in UK as children or born in UK. This was in a view to determine whether views regarding mental and emotional health have any influence on how women of East African descent in the United Kingdom perceive care and service provision in their respective areas. It is envisaged that understanding the views of this and other groups who may be holding similar views would help to begin to target key services for this group and to inform current debate relating to accessing health and social care services that are inclusive.

1.12.5: Research Questions

1) A: How do mothers who migrated from East Africa express distress and wellbeing?

B: How does this differ from how their daughters who may have been born or migrated to UK in early childhood express distress and wellbeing?

2) How do mothers of East African descent talk about emotional health or distress? How does this differ for their daughters or the general UK population?

3) A: How do these individuals seek help for their distress?

B: How does the method of seeking help for distress differ between mothers and their daughters?

Chapter Two: Literature Review

The present is the ever- moving shadow that divides yesterday from tomorrow.
In that lies hope.

(Frank Lloyd Wright)

2.1: Summary of the Literature review

The review of the literature aimed at identifying key research papers that address the emotional distress and wellbeing of East African women including their daughters in UK. A narrative review approach was considered the most suitable method for reviewing relevant literature because an extensive literature base on East African women in UK and emotional expression and wellbeing for BAME communities in general did not seem to exist. The narrative review approach can be used for reviews which aim to offer a synopsis of a research area, provide information on a specific topic, and generate references for future research (Hall, Gaved, and Sargent. 2021). Electronic search engines utilised for this review include PsychINFO, CINAHL, Medline and PEP as well as Google scholar. The search terms used were immigration, wellbeing, wellbeing or emotional adjustment or mental health, emotional states, African cultural groups or blacks, England or Ireland or Wales or Scotland or United kingdom or Great Britain, Anxiety or Post traumatic stress or stress or anxiety disorders, emotional states or contentment or pleasure, mental disorders, East African cultural groups or blacks, black and minority ethnic women, African women, BAME or BME, Human females, female attitudes, racial and ethnic differences and cross cultural differences.

To understand the researcher's relationship to the researched, I also searched psychotherapeutic relationships and race and ethnic attitudes. In addition to the accessed papers / journals I also looked at some key textbooks in psychiatry, cultural issues, systemic and psychotherapeutic processes as well as African studies. The literature search and review were conducted between June 2017 and March 2018.

The search utilised a very broad search strategy that identified 318755 papers. A modified critical appraisal skills programme (CASP) by Dixon-Woods et al. (2007) was utilised in a further synthesis that identified 137 papers. The CASP tool is a generic instrument that can be used to evaluate the strengths and limitations of any qualitative research methodology. The tool has ten questions that each concentrate on a different methodological facet of a qualitative study (Please see Figure 1 below). The questions set by the tool request the researcher to deliberate whether the research methods were suitable and whether the findings are credible and presented in an

accessible manner (Long, French and Brooks, 2020). The 137 papers were then grouped into papers that researched African or African-Caribbean women. Another group of papers researched Black British, or African or African Caribbean adolescents. Another group of papers addressed BAME carers of individuals with mental health issues. A few papers addressed the experiences of people of East African origin. No paper addressed my research question specifically. By reading and re-reading several papers, I realised that the six themes that were identified seemed to inform the literature on Black women and African /African Caribbean women's health and wellbeing. 33 papers were chosen although other studies are used to augment the literature review.

Figure 1: The 10 questions of the CASP qualitative checklist tool

1. Was there a clear statement of the aims of the research?

2. Is a qualitative methodology appropriate?

3. Was the research design appropriate to address the aims of the research?

4. Was the recruitment strategy appropriate to the aims of the research?

5. Was the data collected in a way that addressed the research issue?

6. Has the relationship between researcher and participants been adequately considered?

7. Have ethical issues been taken into consideration?

8. Was the data analysis sufficiently rigorous?

9. Is there a clear statement of findings?

10. How valuable is the research?

2.2: *Exclusion criteria*

The exclusion criteria used was any paper that addressed experiences of black / ethnic women outside of the UK. I also excluded papers that were published before 1960.

My literature review identified papers that were published between 2002 and 2017. There was one systematic review, 20 qualitative research papers, four mixed methods research papers, four case studies, two papers that used survey data and one book chapter. All these papers were UK based although none of them was specifically addressing women of East African origin. Following the synthesis of the literature, these themes were used to identify key papers for this study:

1. Social support /group or ethnic density. Four key papers were identified for this theme.
2. Help seeking. Six key papers were identified for this theme.

3. Perceptions of services / care. Three key papers were identified for this theme.

4. Attitudes to mental health / illness. Five key papers were identified for this theme.

5. Treatment Processes (psychoanalytic / systemic). Ten papers were identified for this theme.

6. Therapy / research issues. Four key papers were identified for this theme.

Table 1: Summary of the Literature Review

Author	**Main theme (s)**	**Perspective**	**Method ology**	**Sample**	**Findings**	**Further research / Gaps**
Smith et al. (2015)	Social support / group density	Social Psychiatry	Longitudinal survey /Qualitative	Adolescents from the Olympic regeneration in East London N= 2426	Ethnic differences in social support contribute to positive or negative mental health	Survey did not include parents' views
Eliacin, J. (2013)	Social support / group density	Culture, Medicine & Psychiatry	Ethnographic survey data	African Caribbean adults in North London	Social environment contributes to the emotional tone that impacts mental health	Paper does not specifically address East Africans / women or their daughters.
Becares, L. & Nazroo, J. (2013)	Group density /Social support	Health	Mixed methods	Ethnic minorities in England	Social capital was not found to impact on the association between ethnic density and health	Does not address my research question
Bailey, O.G. (2012)	Social support / Group density	Racial studies	Case studies	Asylum seekers and refugee African women in Nottingham	Social and political empowerment through group participation	Not clinical and addresses a specific group of African women

Arnold, E. (2006)	Immigration / Social support	Attachments & human development	Qualitative Semi structured interviews	Women born in the Caribbean who were left by their mothers in the care of relatives and reunited later	Resilience and broken attachments	Does not address East African women / daughters. Also emphasise need for further research on broken attachments.
Campbell, C. , Cornish, F. & Mclean, C. (2004)	Social capital / attitudes	Ethnicity & Health	Qualitative case studies	African Caribbean lay people in England	Attitudes towards local partnerships to redress health inequalities	Study does not focus on East African women.
van Bergen, D. D. et al (2015)	Help seeking	Epidemiology	N/A	Immigrants and Ethnic minorities in Europe	Suicidal behaviours and gender related stressors	Needs further exploration with UK specific context
Ally, F. & Brennan, T. (2015)	Help seeking	Health & Inclusion	Qualitative Semi structured Interviews	East African Muslims N= 4	Improve on shared conceptualisation of Mental illness and treatment	Views and attitudes of other East Africans not explored
Shefer, G. et al (2013)	Help seeking	Social Psychiatry	Qualitative Interviews	Black & Minority ethnic (BAME) groups in London	Anti-stigma campaigns need to consider the different cultural 'voices'	Mixed methods could help further understanding
Edge, D. (2013)	Help seeking	Public Health	Qualitative	Black British	Role played by the intersections of gender, ethnicity and spirituality	Paper does not specifically address issues for women of East African origin

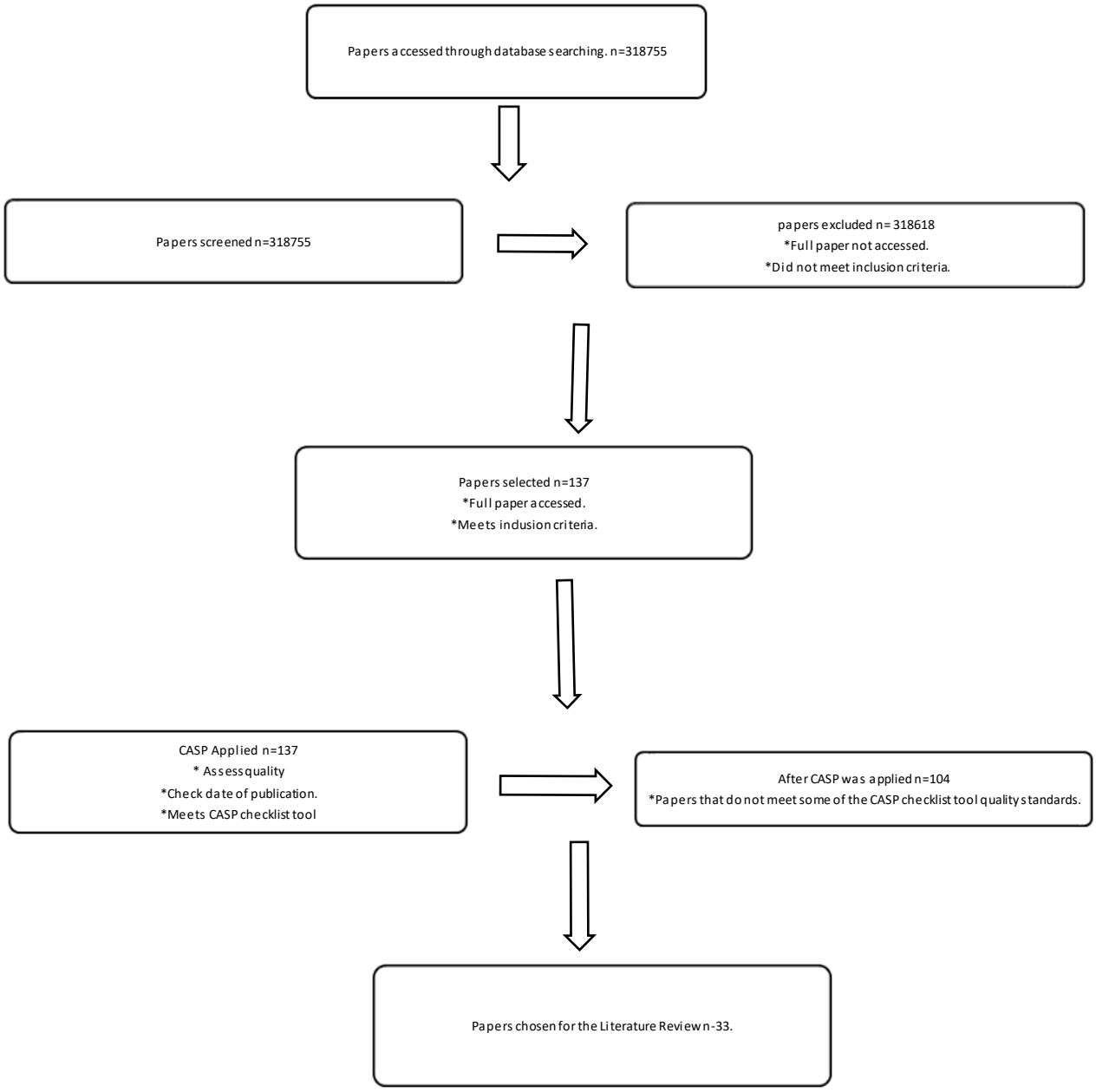
			Interviews	Caribbean women N= 10	need to be explored further.	
Edge, D. & MacKian, S.C. (2010)	Help seeking	Public Health	Qualitative Interviews	Black British Caribbean women N=101	'Reflexive embeddedness' as part of conceptualisation may improve help seeking	A mixed methodology may generate new information
De Maynard, V.A. (2009)	Help seeking	Social Psychiatry	Quantitative Web questionnaire	Black African & Black Caribbean people	Perceived racism has an impact on the dissociative experiences of black people	Qualitative methods to generate more understanding of this concept
Adkinson-Bradley, C. et al.(2009)	Help seeking	Counselling Psychology	Journal article	British African Caribbean women	Symptoms of depression and treatment issues specific to this client group need to be contextualized.	Young African Caribbean women not included in sample.
Hodes, M. et al. (2008)	Help seeking	Adolescent Mental Health	Systematic review	African Caribbean	Reviews available literature on adolescents and young people of African Caribbean origin	Chapter specifically excludes the African community in Britain
Edge, D. (2006)	Help seeking	Midwifery	Mixed methods	Black Caribbean women N=20	Socio-cultural attitudes and personal barriers to help seeking	Cross check with attitudes from East African sample
Higginbottom, G.M.A. & Mathers, N. (2006)	Help seeking	Health & Social Care	Qualitative Semi structured	African Caribbean N=36	Professionals working in primary care need to explore use of herbal remedies with patients	Study excluded people of African origin

			interviews			
Islam, Z. , Rabiee, F. & Singh, S.P. (2015)	Perception of care	Psychology	Qualitative	BAME		
Pelle, J.E. (2013)	Perception of care		Qualitative Ethnography	African & African Caribbean in UK	Improve mental health and social care provision for these communities.	
Hubert, J. (2006)	Perception of care	Psychology	Qualitative	BAME families in South London N=30	Stereotypes of supportive families were unfounded	Mixed methods would help with further exploration
Flowers, P. et al. (2006)	Perception of care	Psychology	Qualitative Semi structured interviews	HIV positive Black Africans in UK N=30	Depression and social isolation reported in this study	Focused on people with a specific illness
Clayton, J. (2012)	Attitudes to Mental health / illness	Psychology	Journal article	Young people in Leicester , UK	Negotiating identity in multicultural settings	
Sisley, E. et al. (2011)	Attitudes to Mental health / illness	Health	Qualitative Interviews	African Caribbean women	Engaging marginalised communities requires a broad knowledge of statutory and non statutory resources	Small sample size

Fawcett, B. & Reynolds, J. (2010)	Attitudes to Mental health / illness	Social Work	Case studies	Older black women in UK & Australia	Argues for a strengths based community capacity building	Need to investigate younger cohorts' views
Koffman, J. et al. (2008)	Attitudes to Mental health / illness	Health	Qualitative Semi structured interviews	BAME and White British patients suffering from cancer	Professionals ought to explore patients' religious and spiritual beliefs during assessments	No focus on East African Women / daughters.
Rassool, G.H. (2006)	Attitudes to Mental health / illness	Addictions (Health)	Qualitative Interviews	BAME communities in UK	BAME substance misusers need to be identified	Need for further exploration
Grilo, C. et al. (2005)	Attitudes to Mental health / illness	Eating disorders	Qualitative Participant observation	Black & White women N= 337 (total) of whom N= 35 (black women)	Little difference in clinical presentations	Explore differences between BAME women who seek help and those that do not
Lowe, F. (2010)	Psychodynamic / systemic processes	Psychoanalysis	Case study	BAME (adolescents) N=1	Understanding and working with ambivalence is key to engaging with BAME adolescents	Need to investigate a larger sample size
Thomas, F. , Aggleton, P. & Anderson, J. (2010)	Psychodynamic / Systemic	Systemic thinking	Qualitative Semi structured	Africans (Zambia, Zimbabwe	Clandestine treatments need to be explored and incorporated	Study does not address East African perspective

	process es		interviews	& South Africa).	in treatment protocols	
Onwumere, J. Smith, B. & Kuipers, E. (2009)	Psychodynamic / Systemic processes	Systemic	Book chapter	Ethnic minorities	Evidence based family interventions	
Maynard, M. et al. (2007)	Psychodynamic / Systemic processes	Social Psychiatry	Quantitative	Black African and White Adolescent young people	Influence of family type seems to operate differently for girls compared to boys in African families	
Tan, R. (2006)	Therapy /Research issues	Psychotherapy	Book chapter	Transference issues	Multicultural practice	
Reis, B. (2005)	Therapy /Research issues	Psychotherapy	Gender & Sexuality	Transference / Counter-transference	Article	
Mandikate, P. (2002)	Therapy /Research issues	Psychotherapy	Multicultural issues	Psychological processes	Diverse cultures	Needs further exploration

2.3: *Prisma flowchart of data selection*



2.4: *Perception of mothers who migrated from East Africa towards emotional distress and wellbeing*

The study conducted by Smith et al. (2015) identified that as an outcome of language and cultural barriers, as well as stressors connected with migration and resettlement, and diagnosing, treating mental health issues among new immigrant mothers in primary care may be difficult for many. In their qualitative survey, Smith et al. (2015) hoped to identify risk factors and solutions for immigrants in primary care who are experiencing mental health issues and need help assessing, preventing, and treating these problems. Although rates of mental illness fluctuate by migrant group, it is possible to argue that these variations may not merely reflect differences in rates in their home countries. While highlighting the ethnic differences in social support and its contribution to positive or negative mental / emotional wellbeing, it has been recognised that the prevalence of specific types of problems and rates of health-care utilisation in specific groups can instead be traced back to migration trajectories in terms of adversity experienced before, during, and after resettlement as well as policies and practises that determine who is admitted to the United Kingdom (Quick, 2015; Stevenson and Rao, 2014). Inadequate relevance, a lack of knowledge, and employment may all influence one's mental health, and all these factors can be assessed in a clinical evaluation (Akhtar, 1999).

Similarly, Bailey, (2012) through his case studies elaborated further that the patient, family, and community outcomes are all affected by these variables, and the impact on society varies considerably depending on the size and significance of the components. To achieve good health outcomes, post-migration treatments that minimise the impacts of pre-migration stress while simultaneously advocating for employment and economic stability are important components of the solution (Dein, 2013; Watters, 2001). On the contrary, Eliacin et al., (2013) demonstrated that among the most significant transitions are the transformation of personal connections and the reconstruction of social networks; the transfer from one socioeconomic structure into a different; and the transfer from one cultural system to another.

2.4.1: *Refugees and asylum-seeking women and daughters from East Africa*

While shedding light on the asylum seekers, and refugee African women, Summerfield (2001) identified that stages of premigration, migration, and post migration resettlement are important in the migration process and need to be considered together in holistically meaningful

clinical contexts. The empirical evidence provided through mixed methods by Becares & Nazroo, (2013) reported that premigration is the first of these processes. Each phase has its own set of risks and possible exposures to be aware of. During the time leading up to migration, normal social roles and networks are often disrupted. During lengthy periods of ambiguity regarding their citizenship status, immigrants may find themselves in potentially hazardous situations. Particularly for those seeking asylum, it is possible that they may be compelled to remain in unsuitable environments with few resources and high levels of violence for long periods of time. Some asylum seekers in UK are kept in terrible circumstances in detention centres, contributing to a feeling of helplessness among some of those that are detained (Calo, Montgomery and Baglioni, 2022; Katwala, Rutter and Ballinger, 2016). This was also supported by Arnold, (2006) following conducting semi-structured interviews with women who were born in the Caribbean and were left by their mothers in the care of relatives and reunited later in certain nations. Many mothers identified barriers with potential to have impacts on their emotional and mental wellbeing.

2.4.2: *Mental and emotional health for women who migrated from East Africa*

Campbell, Cornish, & Mclean (2004) provided some evidence that some groups of migrant mothers are more vulnerable to developing mental disorders after relocating. Several recent meta-analyses have shown that the mean weighted relative risk of schizophrenia among first-generation migrants is just under two percent, whereas the risk of schizophrenia in second-generation migrants is much greater. Similarly, van Bergen et al. (2015) highlighted that being from a poor nation and residing in an area where black people make up the bulk of the population were both associated with increased risk, suggesting that racism and prejudice play a role. However, there has been evidence of an increase in the incidence of psychotic disorders among males (but not females) for Africans and Caribbeans who have moved to the United Kingdom, while there has been no evidence of a similar effect of migration on mood disorders in the UK (Robinson and Gray, 2007; Thornicroft, 2011).

Another primary qualitative study conducted by Ally, & Brennan, (2015) revealed that relocation, after one's future status has been decided, is frequently accompanied with feelings of hope and optimism, which may be good to one's well-being in the short term. A combination of structural hurdles and inequalities, exacerbated by exclusionary policies, racism, and discrimination, means that immigrants and their families face long-term challenges to growth in their new country of residence. Whereas Shefer et al. (2013) claimed that as an outcome of migration-related losses,

disillusionment, demoralisation, and depression can occur early in the process, or later when initial hopes and expectations are not met.

Events that re-activate memories of trauma and loss from the past may induce emotions of anxiety, sorrow, or post-traumatic stress disorder to resurface because of the triggering events. According to a large body of qualitative studies and surveys conducted by Edge, (2013) with clinical and community samples, social and economic hardship, social estrangement, discrimination, loss of social status, and exposure to violence are the most common sources of resettlement stress.

In the United Kingdom, according to some data from primary care, women of black Caribbean heritage are less likely than women of other ethnic groups to seek treatment for pregnancy-related depression than other women. This is not surprising, given the fact that black Caribbean women are disproportionately afflicted by recognised hazards such as lone parenting, poverty, and a lack of social support (Edge and MacKian, 2010). Women appear to be protected against the potentially negative implications of psychological stressors by the ethnic density effect and, to a lesser extent, by peer support (Eliacin, 2013). It is estimated that immigrant mothers have postpartum depression at a rate of two to three times higher than that of mothers born in the UK (Edge and MacKian, 2010). Through a quantitative web questionnaire, De Maynard, (2009) identified that most women do not seek therapy for postpartum depression on their own initiative; instead, they are referred by their doctor. Secondly, Adkinson-Bradley et al. (2009) suggested that postpartum depression and treatment options are not well understood or available to migrant women.

Some women are also reluctant to seek medical treatment for what they perceive to be a psychosocial problem. In his systematic review, Hodes et al. (2008) mothers reported the fear that maternal mental illness will burden or stigmatise the family which created barriers to seeking help. This was reported to be more prevalent or have a greater impact on migrant women than among non-migrant women. Refugee women who seek treatment at specialised clinics have often been subjected to violence and suffer from posttraumatic stress disorder (Cook and Waite, 2015). Some mothers also reported feeling that they had not been typically treated in a kind and professional way (Edge, 2006). Possible history of migration PTSD or effects of sexual assault, according to Edge, (2006), must be probed with great caution. Nevertheless, they also believe that the inquiry should always be led by the needs and comfort levels of those who are being examined.

There is need for studies on prenatal depression and other maternal health issues in African Caribbean women in the United Kingdom to improve the evidence base in this key population. A serious oversight, considering the accumulating evidence of prenatal depression's harmful effects on women's long-term mental health, in addition to their children's growth and well-being in the areas of physical and cognitive development as well as emotional and psychological well-being (Edge, 2010). Similarly, It is both necessary and timely to conduct research on perinatal mental health in underserved communities, given the current policy emphasis on reducing health inequalities, increasing access to psychological therapy in primary care, achieving race equality in mental health care, and improving the psychosocial wellbeing of mothers and their children, among other thing (Duveau, Demoulin, Dauvrin et al., 2022).

2.4.3: *Migrant Women and Work*

Some immigrant mothers who work are reported to have difficulty having their credentials recognised, making it difficult for them to find employment that is compatible with their educational background (Ochieng, 2010). Social and economic hardship are identified as the most common sources of distress. When cultural change happens, it has an impact on both an individual's identity and the lives of their family. As an example, men's employment and, consequently, their mental health is more influenced by language proficiency than women's employment, according to (Edge, & MacKian, 2010). Mothers in this study felt that organisations they worked for often provided them with better safety and protection when compared to male counterparts in the same groups. According to De Maynard, (2009) the many responsibilities and commitments that immigrant mothers have at home and at work may also act as a hindrance to their ability to seek mental health care.

2.4.4: *Children, young people from East African backgrounds and mental / emotional health issues*

In contrast to the trauma and well-being experienced by moms who migrated to the United Kingdom from East Africa as adults, Higginbottom & Mathers (2006) suggested that the well-being of their daughters who arrived as children is more likely to be prioritised than that of their mothers. Some research on the mental health of teenagers who are immigrants or refugees have shown a broad range of outcomes in terms of mental health (Hubert, 2006; Hodes et al.,2008). Despite some evidence from treatment centres and small community samples that migrant youth are more likely to develop psychopathologic disorders such as posttraumatic stress disorder (PTSD), depressive disorders, conduct disorders (juvenile delinquency), and substance abuse issues, findings from a few

large-scale community surveys suggest that the rate of psychiatric disorders among immigrant youth is lower (Islam, Rabiee, and Singh, 2015). Following their study, Islam, Rabiee, & Singh (2015) argued that in terms of ambition and intellectual performance, many immigrant children far outperform their native-born classmates, and some even outperform their native-born peers. They similarly asserted that many children who have been exposed to war and political violence had excellent psychological health. Nonetheless, there are reports that young refugees and asylum seekers including some in United Kingdom present with depression and other common mental disorders (Mingot, 2020).

While still in the pre-migration period, many young refugees particularly girls suffer social instability and a halt in their social and intellectual development as noted by (Pelle, 2013). During migration, many young women are separated from their parents and no longer get emotional, physical, or financial support from their family, which may be devastating. Unaccompanied minors and children who grow up in dangerous settings are more prone than other youngsters to develop mental / emotional ill-health (Katwala et al, 2016; Mingot, 2020). According to Hubert, (2006) youth in the post-migration period often suffer from acculturative stress as well as poverty in their families. The quality of the asylum seekers reception and support are significant determinants of long-term outcomes. For some young people, in addition to learning a new language and re-negotiating their cultural identities, children and adolescents must also cope with social isolation, racism, prejudice, and discrimination after being reunited with their family. Many young people suffer disputes with their parents and relatives when they acculturate because their parents' and relatives' perspectives and beliefs vary from those of their children (Flowers, 2006).

Clayton (2012) observed that school structure and routine help refugee and asylum-seeking families to maintain a sense of normalcy. These are critical factors in promoting emotional, physical, educational, and social development in daughters who migrated from East Africa during their childhood or were born in the United Kingdom after their parents' migration (Fawcett & Reynolds, 2010). In deciding how quickly and effectively children integrate into society, the qualitative perspective offered by Koffman et al. (2008) reflected that the quality of their early school experiences is critical to their success. Indeed, education is important to young children and teenagers and can be a predictor for positive mental and emotional wellbeing. There is some evidence that newly arrived migrant children are at high risk for developing mental and psychosocial problems, particularly internalising disorders such as post-traumatic stress disorder (PTSD),

depression, and anxiety, all of which have been linked to exposure to organised violence (OV) and migration stress (Calo, Montgomery and Baglioni, 2022). On the other hand, Sisley et al. (2011) argued that symptoms of externalising disorder do not seem to be more prevalent among migrant girls than in children from the host communities. Some have reported that because of traumatic experiences and migration stress, some migrant daughters have often had to take care of parents who are suffering from stress-related illnesses resulting into them becoming young carers (Sawyerr, Hylton, and Moore, 2010).

Meanwhile, those daughters who are born in the United Kingdom after their mothers have moved from East Africa are more likely to face the same stressful circumstances, although to a lesser extent. Several important social and health indices suggest that African-descended individuals in the United Kingdom (mainly from Africa and the Caribbean) perform below the national average in education (Hodes et al., 2005). However, some other researchers have challenged notions that underachievement for African Caribbean young people is attributable to other factors, suggesting that it is mainly the institutional racism in UK that makes it difficult for young people to thrive in British schools. (Gillborn, 2020; Crozier, 2005). Similarly, others have asserted that people from BAME communities are exposed to prejudice and discrimination due primarily to their race or ethnic backgrounds (Bhui & Bhugra, 2005; Fernando, 2010). Nevertheless, some have reported that young people of African descent are more prone than other groups to be diagnosed with psychotic disorders and to be committed to a mental facility (Schierenbeck, Johansson, Andersson et al., 2016; Singh, Islam, Brown, et al.,2013).

2.4.5: *Women, daughters of East African descent and multiple identities*

The number of women migrating has increased significantly in recent decades. Women constitute 47 percent of all international migrants that arrive in the United Kingdom (UK). Female immigrants make up 51.7 percent of all entrants to the United Kingdom, according to official figures. Between 1990 and 2017, female migration grew in almost every region of the world, except for East Asia and the Pacific, which may be attributable to rising demand for male-dominated occupations in the developing world (UK Parliament: House of Commons Library, 2022). Arguably, the official figures do not take into consideration those who are undocumented and live in UK illegally. Among other issues, female migration trends appear to differ between countries because of a variety of economic and political factors, as well as the shift in gender roles of labour globally. My study has not looked at

UK statistics for mothers who have had their children removed from them by Social Care services as the main aim was to study mothers and their daughters.

Attitudes influence ideas, which, in turn, impact on compliance and adherence to treatment methods and procedures. For instance, Clayton (2012) found that African-Caribbean young people negotiate different identities while growing up in multicultural environments. It is plausible to suggest that East African women, like young people from these communities, may be required to establish numerous identities depending on their views toward the expression of emotional wellbeing and suffering in different situations. Women, just like the young people in Clayton (2012) study may feel the need to negotiate multiple identities to manage both their emotions and to defend against difficult possible prejudices (whether real or imagined). It can therefore be argued that to effectively engage BAME communities, it is necessary to incorporate their religious and spiritual beliefs into assessments (Koffman et al., 2008). Sisley et al., (2011) advocates for the acquisition of broad knowledge about both statutory and non-statutory organisations to engage BAME communities.

2.5: *Barriers of help seeking behaviours & distress by mothers & daughter of East African descent in UK*

Compared to the white population in the United Kingdom, the research conducted by Rassool, (2006) revealed that mothers from ethnic minority groups have greater incidence of common mental health problems, and these illnesses are less likely to be recognised or treated, particularly during pregnancy. There is a link between minority ethnicity and psychological stress, which includes poverty and social isolation as well as discrimination, being a migrant or refugee as well as inequalities in health care access and assistance. But the causes for these discrepancies remain unclear. From the empirical data provided by Grilo et al. (2005) it has been highlighted that it is essential to remember that the term “minority ethnicity” refers to a group of people who are exposed to the same dangers in different ways depending on their race or ethnicity.

2.5.1: Stigma

According to the implications suggested by Thomas, Aggleton and Anderson, (2010) it has been reported that even though women of all races and ethnic backgrounds fear or experience stigma if their mental illness is revealed, people of ethnic minority backgrounds are disproportionately affected by stigma, which can include "double stigma," or the intersectionality of

prejudice and discrimination in healthcare settings. This adds to the public (social) and overt as well as internal stigma of mental illness. Lowe (2010) suggested that women in his study reported that prejudice influences equal access to healthcare services in the United Kingdom including mental and psychological healthcare services. According to the 2010 Equality Act, treatment and care provided by the NHS, including perinatal mental health care, should be equal, and no one should be treated unjustly because of their race, ethnicity, gender, or origin (Equality Act, 2010).

Stigma is primarily a psychological and social phenomenon that affects people. Stigma, according to Link and Phelan (2006), is defined as the process of labelling, stereotyping, isolation, loss of status, and discrimination that takes place within a framework of authority. As a result of these conditions, some groups may be undervalued, rejected, or excluded, resulting in social misery and a loss of social standing for those individuals involved. Many studies on the effect of stigma on those who suffer from mental illnesses have been conducted. As noted by Maynard et al., (2007) the connection between stigma and seeking help among the Black and ethnic minority (BAME) communities of the United Kingdom is not well understood. Considering the high incidences of severe mental illnesses such as psychoses and schizophrenia among African-descended peoples, as well as the significant stigma associated with mental illness in these communities, it is imperative that this knowledge gap be closed to provide better understanding of this phenomenon.

On the other hand, some research that has been carried out with African and Caribbean people, religious beliefs and practises may aggravate the processes of stigma formation and recurrence among the communities studied (Tan, 2006; Lloyd and Waller, 2020). But Turner (2020) has suggested that stigma will often occur in any environment that involves othering. Onwumere, Smith, & Kuipers, (2009) asserted that though African-descended populations in the United Kingdom have a disproportionately high prevalence of serious mental illness, such as psychosis, when diagnosed continue to underutilise mental health services. This group is often described as "hard-to reach" and will likely present to healthcare services in crisis or via the criminal justice system (Thornicroft, 2011). It is possible to argue that all this serves to perpetuate stigma within some members of the BAME groups. Similarly, religious practises, the expectation/experience of negative repercussions, familial kinship/relational structure, and the desire to remain anonymous were all factors that contributed to stigma and acted as barriers to seeking mental health care. Many individuals in African communities have strong negative views about mental illness, which leads them to seek help from religious leaders or participate in religious coping rather than seeking

psychiatric or psychological treatment for their mental health issues (Lloyd, Mengistu and Reid, 2022). Others prefer to seek help for mental / emotional distress from traditional healers both in UK and back in their respective East African countries of origin (Dein and Littlewood, 2020; Akol et al, 2018).

2.5.2: *Financial Vulnerability*

When it comes to welfare assistance, both parents and young people have highlighted reluctance to receive government 'handouts' due partly to the negative connotations that accompany these handouts as well as the public perceptions that portray people on welfare benefits as 'spongers'. Some have expressed pride in doing menial jobs rather than receive handouts in form of welfare benefits. However, there are some sections of people from migrant groups who would not mind receiving benefits, but government policies prevent this (Younge, 2017 in Press; Leinen, 2022). Some migrants who arrive in UK from countries where healthcare is paid for at source and are not yet conversant with NHS care provision structures may presume that they would need to incur expenses of visiting a healthcare specialist. This can be an additional barrier to help seeking. Having access to experts was seen as a symbol of affluence in Sub-Saharan Africa since specialised treatments were frequently only available via private health facilities that were out of reach for the bulk of the population (Tan, 2006). Some participants felt that prohibitive costs for private therapy for instance, would prevent them from seeking help. This is in addition to the constraints of having to be placed on long waiting lists for psychological therapies in the NHS. Although financial constraints were a barrier to obtaining specialised treatment in certain cases, some young people reported that they were able to overcome this obstacle in some situations. Similarly, whereas possessing refugee or asylum status does not prevent people from accessing healthcare services in UK, some of the participants reported that they had believed that to be the case when they first arrived in UK.

Additionally, variables such as asylum/immigration status, family circumstances, job opportunities, education opportunities, social participation opportunities, contribute to the help seeking behaviours and disparities in mental health treatment that women from these groups experience. As the stories demonstrate, a variety of socio-cultural variables seem to have had a role in the development of mental and emotional distress. Topics included racism, views toward women and their genderised roles, problems resulting from their African ancestry and migratory situations, conflicts with negotiating cultures, and attitudes about race and culture within mental health

services. As reported by East African immigrants, the loss of self-worth and pride in one's own person as a direct consequence of growing up society that promotes both internal and external othering (Turner, 2020) were major issues that continued inform their co-constructed histories and permeated their accounts. For some, experiences of being othered has resulted in the internalisation of negative self-images. That has led some to argue that people of African descent both in UK as well as elsewhere in the diaspora experience poorer outcomes against several key social and health indicators (Leinen, 2022; Lloyd and Hutchinson, 2022; Bhatia, 2020; Out, Ahinkorah, Ameyaw et al., 2020).

2.5.3: *Cultural Competency*

Cultural competence or the perceived lack of has a significant role to play in clinical outcomes (Lee, 2021; Krause, 2009; Bhui, Warfa, Edonya et al, 2007). A systematic review that was undertaken by Bhui et al. (2007) proposed that Cultural competence entails a set of skills or actions that enable mental health professionals to provide services that are culturally relevant for the diverse populations that they serve. Cultural competency is now an essential requirement for mental health professionals working with culturally diversified patient categories (Lee, 2021; Cowan, 2009). But Cowan (2009) cautions that there is a lack of consensus when defining cultural competence as well as the sequence of when elements should be obtained, and some of the labels can at times be used interchangeably. Regarding cultural competence, systemic thinking recognises that to mitigate the risk of privileging the therapist's notions and ideas, the perceptions, and orientations of individual clients whether explicit or hidden and therefore not easily accessible, must be acknowledged (Krause, 2009; Dallos and Vetere, 2009). Cultural competency training may enhance the standard of mental health care for ethnic groups (Bhui et al, 2007).

Despite the completion of the UK government's 5-year "Delivering Race Equality in Mental Health Treatment" initiative, the "Five Year Forward View for Mental Health" research showed that racial inequalities in mental health treatment access and experience continue to exist in the United Kingdom (Lau, 2008). This has led to the realisation that addressing the human rights elements of equitable mental health care access is critical. To enable the delivery of culturally appropriate healthcare and reduce healthcare disparities and inequalities in healthcare interactions, cultural competence training has been proposed as a strategy to increase cultural knowledge, skills, and attitudes through formalised classroom instruction. While shedding light on the African communities, Onwumere, Smith, and Kuipers, (2009) stated that several professional standards and regulations

currently promote or require this approach; nevertheless, cultural competency training varies widely throughout the United Kingdom, and has been hampered by a lack of conceptual clarity, rigorous assessment, and institutional buy-in, among other issues. As a result, more study is required to determine whether attitudes and behaviours toward women from ethnic minority groups who present with mental / emotional health problems can be improved upon by health-care providers.

It has been suggested that therapists who are mindful of their cultural competence tend to exhibit increased sense of self-awareness, an expanded cultural knowledge base and a willingness to utilising their skills in a culturally responsive manner (Lee, 2021; Cowan, 2009). This also applies to organisational policies hence further work that places cultural competence principles and practices at all levels of the organisation, for example, by establishing tracking systems that enable organisations to gauge service delivery outcomes as a culturally capable organisation (Adamson, Warfa and Bhui, 2011).

Many participants in this study expressed fears that they would either be misunderstood at best or poorly judged by healthcare professionals. Some participants were of the view that they do not trust people in official positions and would therefore conceal some information that would be essential in formulating effective treatment plans and/ or facilitating concordance. Perhaps not surprisingly, there were those who do not feel that cultural competence has any role to play. Those who subscribe to this notion argue that almost all East African countries were colonised by Britain and are therefore, by design, Anglicised, therefore technically culturally congruent in UK. Many others would point to neo-colonialism, 'brainwashing', globalisation, and many other suppositions to argue against those who prefer East African political and socio-economic structures as essentially 'Anglicised' (Mbiti, 1990; Gureja et al., 2008; Atta-Asiedu, 2020).

2.5.4: *Poverty*

Some available literature suggests that, over the long term, chronic emotional distress and other poverty-related stressors among low-income households, especially single parent households can negatively impact their physical health (Nieuwenhuis and Maldonado, 2018). It is also important to recognise that there is a complicated connection between illness burden and socioeconomic status (SES), especially considering the substantial evidence of SES disparity across ethnic groups and

the continuing effect of interpersonal and institutional discrimination (Smith, 2007). Low-income single mothers, for example, are more prone than other women to suffer from diabetes, hypertension, and obesity, and many other non-communicable diseases (NCDs) due to multifactorial issues, some of which have been enumerated in this thesis (Cohen and Samzelius, 2020; Link and Phelan, 2006). Some women have been reported to lower their nutritional intake to ensure that their children receive adequate nourishment, a behaviour that increases the morbidity of some mothers over time because of the stress associated with household food shortages and concern about their children's health. There is a reported link between the development of NCDs and mental / emotional distress (White, Adams, and Heywood, 2009). Some studies have also indicated that younger single mothers and grandmothers who are raising their grandchildren are more vulnerable to age-related disorders than older single mothers. Younger mothers who are less likely to receive adequate prenatal care and may therefore have a higher risk of mental and emotional distress during pregnancy and postpartum (Lund, Alison, Flisher, et al.,2010; Edge and MacKian, 2010).

2.6: *Limitations of this Narrative Literature Review*

Whilst undertaking this literature review, I considered the potential limitations that I encountered comprising possible bias where I would instinctively choose studies that seem to support the hypothesis (Creswell, 2014). However, due to the paucity of papers addressing my research study, the potential for bias was reasonably managed. Also, this review was conducted between June 2017 and March 2018 highlighting the sensitivity to time due to the evolving nature of the various research fields. This was mitigated by my further reading of more recent research and other publications (Riessman, 2015). There was also restricted access to some journals as well as some language constraints e.g. some publications were in other languages (Swedish, Spanish, German etc) rendering them difficult for me to access for this review. Other limitations such as quality assessment and subjectivity were mitigated using the modified CASP tool.

The paucity of research on African women including those from East Africa presented me with a challenge due to the inability to cover a wide-ranging body of literature broadly which may have led to missing relevant studies and gaps in the discussion. Transparency about the review process, critical evaluation of the literature, and a laborious search strategy helped to address some of these limitations (Weatherhead, 2011). Similarly, Mitchell and Egudo (2003) have argued that narrative reviews offer the potential to address uncertainty, difficulties and vigour of individual, group, and organisational phenomena. Different viewpoints and interpretation of the accumulated

data can assist in identifying similarities and differences in actions and experiences (Phoenix, 2013; McAlpine, 2016).

2.7: *Implications for future research*

Future research could examine how East African mothers and daughters navigate their cultural and multiple identities within the context of the UK. Research into how disparities in the health and wellbeing of East African mothers and daughters including access to healthcare, cultural influences, acculturation and their impact on mental health and resilience would offer further insights (Sotubo, 2020; Bhatia, 2020). Similarly, understanding the unique parenting practices of East African mothers in the UK, including how they incorporate traditional parenting styles that suit the cultural context of their daughters' realities, as well as the challenges they face could be another focus for further research (Atta-asiedu, 2020). Further exploration of gender roles and expectations, community and social support, inter-generational factors, intersectionality, and multiple identities within the East African diaspora in UK could enhance our understanding of how factors such as religion, ethnicity, socioeconomic status, and immigration status interrelate with gender in determining the experiences of mothers and daughters (Dein, 2020; Folbre, 2021). By studying these and other areas of analysis, future literature reviews can contribute to a more nuanced understanding of the challenges, experiences, and resilience of mothers and daughters of East African descent in the UK. This could inform how future interventions, policies, and services can be developed and improved.

2.8: *Conclusion*

This narrative literature review has examined various notions and theory traversing various disciplines and fields. The pertinent ideas identified here will be situated in the analysis and discussion chapters. I hope that this study will begin to address some of the identified gaps in the review and help to further understand how mothers and daughters of East African descent in UK express emotions as well as seek help when in distress.

Chapter Three: Methodology

Study Overview

> *Ours is a field characterized by extreme diversity and complexity. There is no single way to do narrative research, just as there is no single definition of narrative.*
>
> (Riessman, 2008b :155).

3.1: Research Design

Mixed methods

This study utilised a mixed methods approach. Quantitative and qualitative methods were used at different phases of the study. The decision to use mixed methods for this research was borne out of the need to have a wider understanding and to address the research questions more succinctly. Ochieng and Meetoo (2015) suggest that mixed method approaches have a potential to grapple with limitations of individual methods by drawing on the robustness of each at distinct phases of research. By jointly integrating the methods, I hoped to gain more understanding of the participants experiences. Whilst administering the survey for instance, participants were interacting with various notions around mental / emotional wellbeing for individuals, their communities, and the wider UK population. Using quantitative and qualitative methods for this research study helped to enhance my grasp of the connection between wellbeing and the experiences of the East African communities in UK. Mixed methods were also helpful in exploring the socio-cultural factors and experiences of health and healthcare practice more effectively to inform future practice.

Quantitative study

The study utilised a UK Department of Health (DoH) questionnaire (please see appendix 2). I administered a questionnaire that had been previously offered to other UK samples. A total of 400 questionnaires were sent out. These were distributed to the four 'recruitment centres' and at various 'party in the park' gatherings. This was a huge effort and costly on my part but very ably supported by the community 'recruiters' to whom I am very grateful. I had intended to survey at least 200 participants from the various East African communities but in the end 50 participants were able to return their completed questionnaires. The survey intended to elicit views concerning various mental

/ emotional health issues and to compare these with wider UK narratives. The survey also purposed to address one of the research questions: *How do mothers of East African descent talk about emotional health or distress? How does this differ for their daughters or the general UK population?* Data that was generated from the quantitative survey was analysed using Statistical Package for Social Sciences (SPSS) software.

Reliability, Validity values and Power calculation:

This study used the Cronbach's alpha reliability value of 0.8 and a content validity index (CVI) of 0.9. These two values were the same as the values used during the DoH (2011) survey. I performed a power calculation using a sample size (n=200), Type 1 error rate = 0.05 and power of = 0.80 or 80% which resulted into a standard deviation (SD) = 0.349. These values suggest that my sample size was both valid and reliable.

Qualitative study

The qualitative study utilised four focus groups and three mother – daughter dyad interviews. This was aimed at understanding and attempting to answer all the three research questions as outlined in the next section in this chapter. Data that was generated from the qualitative study was analysed using narrative analysis.

Narrative Analysis

A narrative analysis approach was used for this study because of its reported appropriateness for various types of data, ranging from archival documents to interview segments as well as life stories (Weatherhead, 2011; Tamboukou, 2010; Riessman, 2008; Burck, 2005; Mishler, 1999). Riessman (2008:76) asserts that in narrative analysis, researchers 'make connections between the life worlds depicted in personal narratives and larger social structures – power relations, hidden inequalities, and historical contingencies. Here, emphasis seems to be on 'the told' – the events and cognitions to which language refers (the content of speech)'. The analysis involved reading the transcripts so many times (as well as revisiting the data after a very long period of being and feeling disconnected due to researcher health and other personal issues), inductive coding, developing themes and sub themes, and seeking to identify core narrative elements associated with each theme (Bryman, 2016).

I used narrative and systemic theory lenses to interpret the themes paying particular attention to continuity and coherence, in addition to identifying characteristic narratives and narrative resources. I endeavoured to be reflexive in my interaction with the data in order not to subdue the participants' knowing "as opposed to applying foundational 'set in stone' rules that ensure trustworthiness and truth" (Schinke, McGammon, Battochio & Wells, 2013).

3.2: Alternative methodological considerations (FANI, Discourse Analysis and Grounded Theory)

I initially considered Free Association Narrative Interview (FANI) for this project. FANI uses ethical principles of honesty, respect, and empathy to recognize and be open to the participant's story whilst being attentive to the defences that may be applied for protection against any vulnerability. By so doing, FANI recognises that what we experience at emotional and intellectual levels is limited by our subjective knowledge that must concede the position of the other which may be open to change (Woodcock, 2009). Morris-King (2009) study used FANI after conducting a focus group. Although Holloway & Jefferson (2013) suggested that FANI offers biographical uniqueness, I eventually recognised that my research was not to enquire into defences and therefore FANI would not adequately address my research questions.

I also considered Discourse Analysis (DA) and Grounded theory (GT). Although DA has many versions, it portrays language as a producer and generator of the social world. DA tends to explore how groups explore meaning rather than individual meaning making and is not merely a process of understanding the social world (Bryman, 2016). GT is inductive, just like narrative analysis, but I felt from the onset that my research was going to collect data that was to be gathered at different times in terms of when the focus groups, mother-daughter dyad interviews and questionnaire would be accessed. GT just like DA and narrative analysis has many variations however it is recommended that with GT data collection and analysis processes run comparably (Glaser & Strauss, 1967; Braun & Clarke, 2006). I therefore considered that Narrative Analysis would be the most suitable for this research project.

3.3: Aims and Research questions:

I conducted four focus groups; two groups with mothers who were born in one of the East African Countries (Uganda, Kenya, Tanzania, Rwanda, Burundi, and Democratic Republic of Congo – DRC*) and later migrated to UK. Two groups with their daughters who may have been born in UK or migrated to UK at a very young age. I also held three mother – daughter dyad interviews who

volunteered to be interviewed following the focus groups. A fourth mother-daughter dyad was unfortunately unable to be interviewed as the mother was hospitalised at the time although they had individually taken part in the focus groups. Additionally, a survey was completed by 50 participants at various sites in London and Essex. All the participants in the focus groups also completed the survey.

The study aimed to understand expression of distress and wellbeing for mothers who migrated from East Africa to the UK and their adult daughters with a view to address their help seeking behaviours. It aims to determine whether views regarding mental and emotional health have any influence on how women of East African descent in the UK perceive care and service provision in their respective areas. It is also aimed at beginning to target key services for this group and to inform current debate relating to accessing health and social care services that are inclusive.

The following research questions informed the focus groups and mother-daughter dyad discussions:

1) a: How do mothers who migrated from East Africa express distress and wellbeing?

b: How does this differ from how their daughters who may have been born or migrated to UK in early childhood express distress and wellbeing?

2) How do mothers of East African descent talk about emotional health or distress? How does this differ for their daughters or the general UK population? (this will also draw from data that was generated from the UK attitude survey by the Department of Health (DoH)- (Please see appendix 2 for the survey)

3) a: How do these individuals seek help for their distress?

b: How does the method of seeking help for distress differ between mothers and their daughters?

3.4: Research Process

Glogowska (2011) argues that health care researchers are facing increasing complexities due to the rise in complications within the health care systems because of an aging population, a surge in chronic and complex diseases as well as limited budgets. Hence, addressing the multidimensional features of health and other issues may require exploring alternative methodologies that may not necessarily be 'pure' (Creswell & Plano Clark, 2011; Halcomb and Hickman, 2015). Although a

quantitative methodology was utilised for part of this project, the bulk of my enquiry was qualitative and interpretivist. Further, Elliot (2009) proposes that narratives can utilise quantitative, qualitative, or mixed methods to research and analyse data from various perspectives. The basic assumption made by the social constructionist approach is that reality is socially constructed by and between the individuals who experience it (Gergen, 1999). In essence, reality is totally subjective "and need not be anything that can be shared by anyone else but at the same time is independent of the person living it" (Darlston-Jones, 2007:19).

Identities can be assigned and constructed through narratives that are shaped within a social constructionist approach, (Riessman, 2008; Semino et al., 2014). Postmodernist thinking or social constructionism tends to counter positivist or modernist thinking by forming a basis for the application and understanding of narratives (Gergen, 1999). Furthermore, social constructionism summons for a grounding of knowledge in the circumstances of its social functioning with emphasis on the social and cultural nature of narrative discourse (Mitchell and Egudo, 2003; Elliot, 2005; McAlpine, 2016). Unlike other qualitative research methods, narrative analysis does not advance rules for suitable resources or approaches of investigation, or the highest level at which to explore stories (Squire, Andrews and Tamboukou, 2013). Further, narrative analysis portrays personal meaning of experience (Reissman, 2015). Narratives can provide powerful means through which integrating past experiences into meaningful learning, locating oneself and others in the story, and foreshadowing of the future (Coulter and Smith, 2009; McAlpine, 2016). Furthermore, narrative analysis provides the capacity to address ambivalence, variability, complexity and vigour of individual, group, and organisational dynamism (Mitchell and Egudo, 2003; Reissman, 2008). While arguing for the use of narrative analysis, Riessman (2008:53) proposes that this method is 'the most straightforward and appealing in applied settings'.

I chose narrative analysis for this research project as it not only suited a wide range of narrative texts but also, I considered Bertrando (2015) view that whilst attempting to study emotional expressions, there is need for one to remain open to the multiple stances and opinions that may emerge. A social constructionist perspective (Gergen, 2015) and narrative analysis approach informed a large chunk of my research (Riessman, 2008). Social constructionist perspectives and narrative meaning making are some of the assumptions that underpin systemic theory and thinking (Flaskas, 2009; Dallos and Draper, 2009; Walsh, 2016). As Mitchell and Egudo (2003) whilst affirming Gergen (1999) suppositions that narratives are best suited to make inquiries into subjectivity and the

impact of culture and identity on human circumstances proposed, stories are fundamentally individual constructs that leave constraints that may influence objectivity in presentation. However, as with other methodologies, narrative analysis has some limitations (Elliot, 2005; Riessman, 2015). One of them is that participant narratives grasp only a constricted number of experiences, which we then, as researchers, utilise to weigh up a coherent story. Therefore, researchers need to be careful about what is left out of an individual's accounts, as well as contradictions across accounts, or the meaning of uncertainties or defences in the accounts (McAlpine, 2016). For this study it was difficult to heed Elliot (2005) advice to recruit a large sample to overcome the limitation above.

3.5: Epistemology

Burr (2003: 202) defines epistemology as "the study of the nature of knowledge and the methods of obtaining it". Identifying the connection between epistemological underpinning of research and the methods that are used in conducting it is fundamental for research to be truly meaningful (Darlaston-Jones, 2007). Epistemology is mainly concerned with how we construct, validate, and understand the world, as Langridghe and Hagger-Johnson (2009) suggest more succinctly. I used pragmatism as a philosophical underpinning for my study (Maarouf, 2019; McAlpine, 2016). Research starts with a compelling idea or a question and a final goal to respond to this question to add valuable knowledge to the study and pertinent area of research (Creswell, 2014; Maarouf, 2019). I began my study with a goal to explore how mothers and their daughters of East African descent express their mental / emotional wellbeing and whether this was either similar or different between mothers and their daughters. By using a questionnaire for the quantitative part of my study as well as focus groups and mother-daughter dyad semi-structured interviews for the qualitative part of the study, I sought to be 'intersubjective' by simultaneously being objective and subjective, bearing in mind both one reality and that the participants have diverse expositions of this reality (Denscombe, 2008; Morgan, 2007). Although there are arguments for and against using pragmatic epistemological underpinnings, I found this stance more suited to my mixed methods choice of enquiry (Creswell, 2014; Glogowska, 2011). As a result, I focused on my research objective of listening to participants' narratives whilst utilising my ethics and experiences both as a member of the East African community, clinician, and researcher to enhance my research outcomes (Maarouf, 2019). In other words, I would argue that I was 'biased only by the necessary degree to meet the research requirements' (Maarouf, 2019:6).

This research process and analysis was essentially embedded in "the empathic understanding of human action rather than with the forces that are deemed to act on it" which is a social science realm (Bryman 2016:26). According to Halcomb and Hickman (2015:4), "Research problems that are best suited to mixed methods designs are those in which multiple perspectives of the research problem will provide detailed understanding than could be gleaned from a single perspective".

3.6: Merging a Systemic Approach with Narrative Analysis

Narrative inquiry has advanced as a research methodology over the last 30 years. It offers a mode of collecting, exploring, and reviewing stories of experiences and events. Webster and Mertova (2007) have argued that storytelling is the most common form of human communication. Storytelling can be used to weave and make sense of the elements of experience that have affected an individual or a larger group of people (Andrews, Squire & Tamboukou, 2013). Contemporary systemic theory and research places emphasis on meaning-making and language in the analysis of narratives. Social constructivism can generically explore the power of construction by persistently negotiating the social world through addressing the processes by which we make sense of the social world (Flaskas, 2009). Further, it has been suggested that reality has multiple perspectives and in systemic theory, thinking can be viewed as an interpretive act (Coulter and Smith, 2009; Mitchell and Egudo, 2003).

3.7: Researcher Position and Ethics

3.7.1: *The Researcher*

"There is more of ourselves, of our relationships, of our experiences and our feelings which are culturally constructed than we know or realize" (Krauss pp. xxvii.). My interest in this study confirms the above observation by Krauss. I am a British citizen of Ugandan ancestry. I believe that the people who took part in this study would have had this information about me prior to taking part in the research. What is less known though, and I very rarely talk about, even within family settings, is that my mother left Rwanda as a refugee in her childhood. She became a Ugandan citizen on the eve of Uganda's independence in 1962. I was made to understand from various sources including my parents that anyone who was in Uganda on the eve of Uganda's independence from Britain on 9th October 1962 automatically became a citizen. Many years later, I went to Rwanda to work, after the Rwandan genocide of 1994. During this time, I was stationed near the Rwanda /DRC border and

regularly crossed to the DRC. My father on the other hand, ran businesses between Kenya and Tanzania and our home was as a result, a busy hub of multinationals whose lingua franca was Swahili.

We, as a family, obtained (bought) our British citizenship courtesy of my paternal grandfather who was recruited into the First World War and was stationed in Burma. Recently the Ugandan government introduced a law that requires dual nationals, like me, to pay 400 US dollars or face losing the Ugandan nationality. This new law is causing a great deal of consternation and distress for Ugandans with dual nationality, especially the children who were born outside Uganda.
Many parents express fear that their adult children who are not as emotionally connected to Uganda (the motherland) may refuse to pay to be registered as Ugandans thereby losing their rights to aspects such as land and property acquisition in Uganda. This is important for my study as both mothers and their daughters who took part in my study were comparing the different policies across East Africa that impacted on their attachment to home countries. All the other East African Countries except Uganda accept dual citizenship without any encumbrances. I am a mother and a clinical nurse therapist who has worked with both children and adults within the NHS. In addition to the information sheet that identifies me as an NHS clinician, I introduced myself to all the participants as an NHS Nurse Therapist of Ugandan descent. Some of the younger participants were curious about my role within the NHS structure. Whilst some of the mothers were interested in how, as a clinician of East African descent, I was able to navigate the perceived or real bureaucracy within the NHS. This posited me as 'an insider' both within the NHS and the diaspora community. It is these experiences, conscious and perhaps some unconscious, that inform my curiosity about emotional distress and expression for people of East African descent. As a female researcher of East African descent, I reflected and remained aware of my position and how this may or may not influence the shaping of the narratives throughout the research process. I am a self-financing student and paid for most of the logistics involved with this research.

3.7.2: *'Doing curiosity' as a social constructionist.*

Burck (2005) suggests the idea of 'doing curiosity' without being encumbered by the responsibility for change that can facilitate discussions of a distinct structure. This enables researchers to follow the research participants' responses more intently and being more probing. As my research progressed, I found myself moving from a clinician and East African woman to

researcher position. Burck (2005) describes how this stance can open new areas of investigations which was my experience in this project.

3.8: Research Strategy and Design

3.8.1: **Recruitment**

Since embarking on the doctorate programme, I intentionally interacted with various East African groups living in London and Essex. This included attending churches and mosques that are known to host people from East Africa. Where possible, I attended funerals, weddings, fundraisings and in the summers before COVID-19, various summer parties (Uganda in the Park, Kenya in the Park, East Africa in the Park etc…) in the said communities. One of my intentions was to identify community leaders and potential participants for my research. For this study I had an intention of recruiting a sample size of 20 to 30 mother – daughter dyads. A possible total of 60 participants.

I identified three 'recruiting centres'. In East London, I approached a prominent vendor ("Paskali's" – 'ewa Paskali' in Luganda language) who imports food and other paraphernalia from East Africa. Paskali's opened in the 1980's in Forest Gate (East London) selling food and artifacts from East Africa. During the weekends / evenings, Paskali's also doubles as a restaurant and meeting point with the upstairs room offering a dance / community hall. Over the years, Paskali's has expanded to West and South London with branches in Wembley and Croydon respectively. In North London, I approached another prominent food vendor in Tottenham's West Green Road. West Green Road is well known as a hub and meeting point for people of African descent from all walks of life. In Essex I approached the recruitment process differently because I live in this area and happen to know many of the families from the BAME communities who live here. I approached the Essex BAME community leader who is very active in the various communities and of Ghanaian origin. This was done to enable any prospective participants not to feel pressured to take part but decide willingly without any sense of feeling coerced by me. There were no overt differences between the participants that were recruited from London and those that were recruited from Essex. This may be because most members of the BAME community in Essex relocated from London Boroughs and many continue to work and have friends and family in various London Boroughs.

After explaining my research project to the 'recruiting teams' in East, North London and Essex, I left copies of the information sheet (Appendix 3) and consent form (appendix 4) with them. We agreed that I would contact them weekly to answer any further questions and check in on the recruitment process.

I was able to recruit 10 mother – daughter dyads from Essex and 15 mother daughter dyads in London (East London & North London). When I had recruited 25 mother-daughter dyads from the 3 centres, I distributed the questionnaire and focus group topic guide to all the prospective participants. Of the 25 mother- daughter dyads that indicated willingness to participate, only 14 of them finally took part in the focus groups. 28 participants took part in the focus groups. The age range for mothers was not determined as they may, for various reasons, not be willing to state their actual age. Their daughters however had to be 18 years of age and above. They also needed to have spent a reasonable period of their childhoods in the UK.

3.9: Data collection

3.9.1: *Materials*

I purchased two digital audio recorders to enable the recording of the focus group and mother – daughter dyad interviews. I bought some iCloud data storage to ensure the safe storage of the audio recorded interviews and the transcribed interviews. I also purchased a small lockable cabinet to safely store the paper transcripts and any other material that was being used for this research project. I booked space in North London at a cost where the two focus group interviews took place. For the other two focus groups in Essex, as a local Council taxpayer, I was provided with space at one of the public libraries in Essex at no cost for which I was very grateful. The three mother-daughter dyad interviews took place in the participants' respective homes at no cost. Furthermore, I approached Makerere University's Language department who helped with translating the questionnaire and interview schedule into Luganda, Runyakitara, Swahili, Kinyarwanda, and Luo at a cost. As will be discussed later, all the participants opted to use the English version.

3.9.2: *Participants*

I held the first three focus groups on three successive Saturdays in September 2019. Seven participants who live or have family in Essex were the first group. Their ages ranged from 18 to 26 (see table 1).

Table 1: FG 1 (Girls – Essex –Harlow Public Library - 14/9/2019)

Participant (Pseudonym)	**Age**	**Origin**	**Religion**	**Occupation**

Wambui	18 - 20	Kenya	Catholic	Student
Kasongo	25 - 30	DRC	Pentecostal	Midwife
Zalwango	21 - 25	Uganda	Muslim	Dental Nurse
Otieno	18 - 20	Kenya	Anglican	Student
Uwase	18 - 20	Rwanda	Catholic	Student
Nakku	21 - 25	Uganda	Anglican	Social Worker
Ngala	21 - 25	DRC	Catholic	Lawyer

The second group comprised of daughters who live or have family in London with age ranges from 19 to 26 (see table 2).

Table 2: FG 2 (Girls – Tottenham - London 21/9/2019)

Participant (Pseudonym)	**Age**	**Origin**	**Religion**	**Occupation**
Wanyana	21 - 25	Uganda	Anglican	Public Relations
Kamau	26 - 30	Kenya	Christian	Metropolitan Police
Wafula	18 - 20	Kenya	Catholic	Student
Nyerere	26 - 30	Tanzania	Muslim	Doctor
Malembe	18 - 20	DRC	Pentecostal	Student
Mutesi	21 - 25	Rwanda	Anglican	Chef
Kagame	21 - 25	Rwanda	Catholic	Accountant

The third focus group was for mothers who live in Essex. It took some time to get the fourth group together which created some worry and anxiety in me (See table 3 and 4 for all the mothers who took part).

Table 3: FG3 (Mothers – Essex – Harlow Public Library - 21/9/2019)

Participant (Pseudonym)	**Years in UK**	**Origin**	**Religion**	**Occupation before coming to UK**	**Current Occupation in UK**
Muigai	22	Kenya	Catholic	Journalist	Childminder
Kabila	16	DRC	Pentecostal	Businesswoman	Unemployed
Kongwa	24	Uganda	Muslim	Student	Pharmacist
Uhuru	20	Kenya	Anglican	Teacher	Paralympian / Disabled Activist
Mobutu	16	DRC	Catholic	Housewife	Social Worker
Munyakazi	13	Rwanda	Catholic	Student	Healthcare Assistant
Namubiru	28	Uganda	Anglican	Nurse	Nurse

Table 4: FG4 (Mothers – Tottenham - London- 18/10/2019

Participant (Pseudonym)	Years in UK	Origin	Religion	Occupation before coming to UK	Current occupation in UK
Mugizi	18	Rwanda	Anglican	Midwife	Midwife
Mirembe	10	Uganda	Anglican	Hair Stylist	Healthcare Assistant
Matope	15	DRC	Pentecostal	Worked in Government	Youth Worker
Kiprotich	23	Kenya	Christian	Housewife	Nurse
Wekesa	22	Kenya	Catholic	Student	Public Health
Mujomba		Tanzania	Muslim	Teacher	Lecturer
Ingabire	20	Rwanda	Catholic	Tailor	Nurse

3.10: Ethical considerations and consent

Ethics need to be central to all research since any valuable research must be ethical (Betancourt, 2015). In this regard, informed consent from every participant (taking care to ensure that daughters are not coerced by their mothers and vice versa) was sought and clarified at every stage of the study. I obtained approval from the Psychology Research Ethics Committee (PREC) at the University of Exeter (appendix 5).

Krueger & Casey (2015:35) suggest that when conducting research using focus groups, every effort should be made to create a 'permissive and nonthreatening environment'. I made every effort to create a permissive and nonthreatening environment by utilising some suggestions that were offered by Krueger & Casey (2015) such as ensuring that the information sheets, consent forms and interview schedule were sent to the participants before the day of the focus group interviews.

Minimizing harm, especially when exploring issues that have potential for being emotive, is very significant (Harper & Chambers, 2012). I ensured that all the participants were made aware of their right to withdraw from the study at any stage. I also made sure that any questions about the study were answered as truthfully as possible. I ensured that any useful telephone numbers for any participants that would wish to seek further professional support were available for the duration of the study. A follow up de-brief session was offered at the beginning of the study. But, not surprisingly perhaps, the de-brief usually took on an informal stance where participants just talked amongst themselves at the end of the study while I learned to keep quiet and listen without interrupting. The signed ethical forms were safely and confidentially kept as part of the information governance.

3.11: Reflexivity

3.11.1: *Introduction*

Karl Tomm (1987a cited by Donovan, 2009:158) describes reflexivity as 'a process in which one is performing and, at the same time, audience to one's performance'. Reflexivity is key to qualitative psychosocial research that engages in first person enquiry. It serves as a significant element of the research process. Undertaking research in an area that has personal reverberation with one can invoke powerful feelings and risk the researcher losing objectivity. The researcher can make undue rights to authority. Reflecting on one's identity, their relationship with the research topic, as well as the area of inquiry, through the process called reflexivity is key to maintaining researcher objectivity. The researcher continually weighs how their subjectivity, identity, and role might impact on the study through reflexivity (Spencer and Ritchie, 2012).

I am of Ugandan descent but my mother was born in Rwanda so I could claim Rwandan citizenship if I wished to do so (according to Rwandan Law). I am also a British citizen. I am a Registered Mental Health Nurse practitioner with systemic and cognitive behaviour therapy training and practice. I am a mother of two adult children who were born in the UK, and they identify, largely, as Black British as opposed to Black British (African of East African descent). My interest in this research project was borne out of my professional and personal experiences. It was drawn from my curiosity arising from the many conversations that I have held both within the UK East African community and the wider diaspora as well as my observations from my various interactions with numerous multi-disciplinary / multi agency professional networks within mental health settings. My personal and professional identities bear proximity to the researched participants and subject, hence

requiring me to continually apply reflexivity and awareness of any suppositions that I may hold. Being reflexive helped me to remain mindful of personal opinions, preconceptions, and biases throughout the research process. Dodgson (2019) suggested that outlining the contextual intersecting relationships between the participants and the researcher not only improves the reliability of the findings but also intensifies the understanding of the work.

Furthermore, Pazella, Pettigrew, and Miller-Day (2012) argued strongly that reflexivity must be central to the research process with a view to curtail bias, since research is a co-creation of knowledge by the researcher and the participants. When it comes to narrative analysis as a methodology, it has been suggested that being actively reflexive can bolster the validity and 'trustworthiness' of the collected narratives (Riessman, 2008; Phoenix, 2013).

I was able to use reflexivity with a view to create a "third space" and help to develop a comprehensive grasp between myself and the study (Patton, 1999). Creating a third space allowed me to be able to examine what Squire (2013:62) refers to as 'the social and cultural character of personal narratives'. Systemic therapy, much like many other psychosocial interventions recommend use of third spaces or otherwise referred to as reflexive think space to make sense of the meanings and narratives that may emerge either consciously or unconsciously (Flaskas & Pocock, 2009). Some researchers who have engaged with narrative analysis suggest further that reflexivity is crucial since the narratives we gather and interpret have a potential to shift meanings over time (Riessman, 2008; Tambouku, 2013).

Reflexivity has the potential to enhance a self-development process for the researcher. This may in turn augment how meticulous and attentive the researcher manages the entire research process from the beginning to the end of the study and beyond.

Whilst undertaking qualitative research, it is suggested that reflexivity as a notion can be approached in three different ways; to minimise bias in research, as a primary methodological mode of enquiry, and as a method of straddling the gap between research and practice (Etherington 2004; Riessman, 2008; Squire, 2013).

3.12: Research Reflexive Account

One of the mothers who took part in this study described her journey of getting to UK, navigating the immigration system, and maintaining professional, social, and cultural spaces as a rollercoaster. At the time, I did not consider my journey to bear any resemblance to hers. I later

realised that this was a befitting description of my personal experience throughout this academic journey. I had not foreseen the challenges that awaited me in both my work and personal life that have had a significant impact on my research candidature. What I did not envisage in the early years was that breaks can elicit a sense of disconnection from your research, and it can take a while to refocus and become re-motivated after each break. I have encountered the challenge of regaining momentum after each break and maintaining reflexivity has helped me to view 'my rollercoaster' with more clarity to remain engaged and focused.

Reflexivity also enabled me to record some of the anecdotes and stories that people shared when dropping off their survey responses or after a focus group or mother-daughter interviews sometimes around issues that had not been addressed in the study. This rich source of information promised to potentiality provide insight for further interrogation and exploration. From the onset of the academic study, I was encouraged to use a reflective log. As stated elsewhere, the entire academic journey has been disjointed for many reasons, some personal while others were institutional as well as a global pandemic that has impacted everyone worldwide. Maintaining a reflective log has been key in helping to remember some of the issues that I probably would have forgotten had I not documented them as they happened.

The reflective log has not only been helpful as part of the reflexive process, but it has also helped me to recall some of the experiences and how I felt at the time in comparison to how I now look back at some of those incidents. This has been a very important process for me and helpful in keeping me mindful about my initial quest to undertake doctoral studies. In addition to the reflexive log, I have also engaged in various Doctoral Learning sets both in Exeter and in London. With the advent of the global pandemic, most of learning sets have taken place online. Whilst reflecting on how the Doctoral learning sets changed over the years, I feel very privileged to have met clinicians and researchers from different professional disciplines that I probably would not have been able to meet, had I not made the decision to go to Exeter.

Other modes of maintaining reflexivity and rigor were provided by my Doctoral supervisors. I have also utilised other forums such as talking to friends, family, and colleagues at work. Similarly, comments from the two pilot projects were very helpful in shaping my thought process whilst ensuring that the study is rigorous and meaningful.

This chapter summarises the process that I undertook to plan, organise, recruit, and eventually collect data for my study. It addresses my research position and ethics. The chapter also looks at the merging of my systemic approach with the narrative analysis method as well as how these two were utilised during the entire process of data collection. The chapter has looked at other methodological considerations as well as reiterating the research design, process, aims and objectives. It was a very important process that has a huge bearing to the eventual success of the study. The process was aided by meticulously keeping a reflexive diary, especially given the extended period between undertaking the study and eventually synthesising the data and writing up my findings. The study process has undoubtedly played a huge role in both personal and academic implications for me as a researcher in terms of how I view data collection and participant involvement.

The following two chapters; chapter four and chapter five, will elaborate on the quantitative and qualitative data analysis and findings. The quantitative data by way of a questionnaire, sought to inquire into my research question number two. The qualitative analysis in chapter five, collected through focus groups and mother-daughter dyad interviews, seeks to address research question one and three although it also partly addressed research question number two. Quantitative and qualitative data analysis are addressed separately to be clearer with my findings and to gain more understanding of the research questions for this study.

Chapter Four: Quantitative Data Analysis and Findings

The use of qualitative and quantitative methods is likely to enrich our understanding of the interrelationship between wellbeing and the experiences of communities. This should help researchers to explore socio-cultural factors and experiences of health and healthcare practice more effectively.

(Ochieng, B.M.N & Meetoo, D., 2015:16)

4.1: Quantitative Analysis

This chapter presents the findings of the quantitative analysis of the study. A Department of Health (DoH) questionnaire that was devised and utilised in 2014 to survey different communities concerning their attitudes to mental health / wellbeing was applied. This questionnaire with 41 questions on attitudes to mental illness was administered to prospective consenting mother and daughter participants. Some of these mothers and daughters, as will be discussed in the next chapter, took part in my focus groups and mother-daughter dyad interactions. My rationale for applying this questionnaire was to compare my participants responses against the UK national responses. The questionnaires were left in four recruiting centres. Two recruiting centres in East London, one recruiting centre in North London and one centre in Essex. Additionally, I attended two 'Party in the park' – in East and North London. Party in the Park are gatherings for families (mainly younger) in UK. Afro Caribbean music, food and other Afrocentric interactions take place. Lately, mainstream politicians from UK and East African countries feature at such parties.

The questionnaire was designed and validated by the DoH, (2014) and administered to other samples in UK (see appendix 3 for questionnaire). The idea for administering this questionnaire to my recruited sample was to compare it with other UK communities that have been surveyed in the past. Depending on the languages spoken by the participants, the questionnaire was translated into the main languages spoken by Makerere University – Department of Languages at a fee. (i.e., Luo, Swahili, Luganda, Runyakitara, Kinyarwanda/ Kirundi, Lingala). This was intended to facilitate easy understanding of the questions by those that may not readily express any difficulties in comprehension of the English language. The questionnaire used close ended questions (Please see

Appendix 3). 50 respondents completed the questionnaires that were utilised for this quantitative analysis.

Prior to conducting the quantitative study part of this project, my hypothesis was that mothers' perceptions of mental illness would be different to those of their daughters. I was basing my hypothesis purely on the assumption that the daughters were more exposed to literature on mental wellbeing through various information routes. My second assumption was generated from the awareness as a healthcare professional, of the numerous health promotion and health protection projects that are run by schools from a very early age onwards. However, the data analysis of this question revealed that the value of the F-statistic was not statistically significant (F statistic= 0.098, p=0.7). Hence the variance between a mother and their daughter may be deemed equivalent. The analysis showed that mothers and their daughters do not substantially differ from one another regarding how they perceive the elements that lead to the development of mental illness.

4.2: Demographics of Respondents for the survey.

Figure 1:

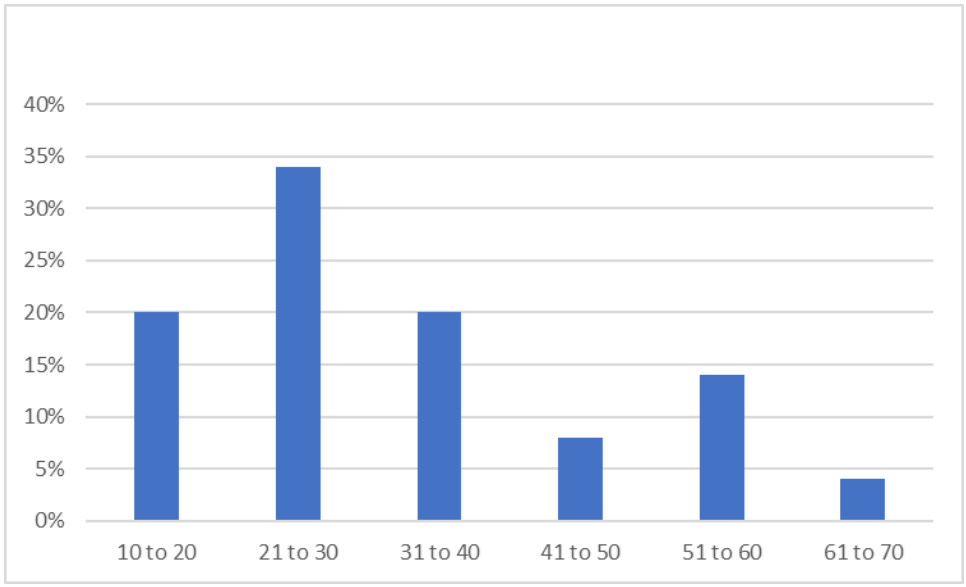


Figure 1 presents age of respondents including both mothers and daughters that took part in the study. 34% of the respondents fall within the age group of 20-30, 20% respondents fall within the age 10 to 20. Another 20% of respondents fall into the age group of 30 to 40, 14% respondents were

in 50 to 60 age group, 8 respondents in 40 to 50 age group and 4% respondents were in the 60 to 70 age group.

Figure 2:

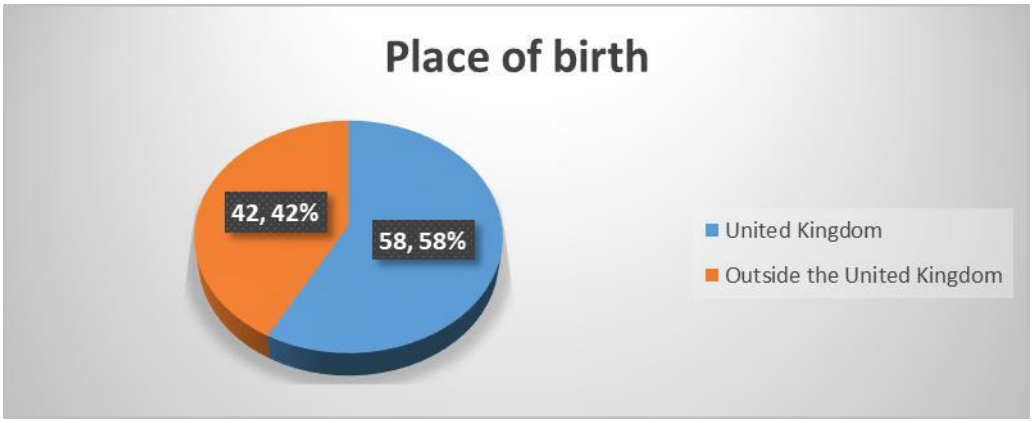


Figure 2 shows that 58 % respondents were born within the UK whereas; 42 % of respondents were born outside of the UK.

4.3: *Opinions of both mothers and Daughters which other people hold about mental illness*

Question 1 to 27 related to opinions which other people hold about mental illness.

Respondents were asked to answer the questions using a five-point Likert scale. T-test is one kind of inferential statistics which is used to determine if there is significant difference between the means of two groups which may be related to certain characteristics. It is a widely common test which is used for the purpose of hypothesis testing. For using the statistics for unequal and equal variance, the test of Leneve for equality of variances is used which assumes that variance of two groups is equal. If the value of F statistics is significant this proves that variance is not equal.

4.3.1: One of the main causes of mental illness is a lack of self-discipline and will-power.

This question generated the following values. 50 participants answered this question. It was revealed from the analysis that the value of F-statistic is insignificant (F statistic= 0.098, p=0.7) hence, variance between mother and daughter can be treated as equal. The t-test related to "equal variances are assumed" has been used to test the mean difference between mother and daughter related to "cause of mental illness". There is no statistical difference for the value of mother

(M=4.04; SD=1.2), and daughter (M=3.5; SD=1.26) with respect to cause of illness (t=1.4; p=0.14). Please see Table 1 in appendix 7 for details of the analysis.

4.3.2: There is something about people with mental illness that makes it easy to tell them from normal people.

This question was answered by all the 50 participants. The value of F-statistic is insignificant (F statistic= 1.01, p=0.2) hence, variance between mother and daughter can be treated as equal. There is statistical difference for the value of mother (M=3.71.04; SD=1.26), and daughter (M=2.7; SD=1.48) with respect to opinion about this question (t=2.49; p=0.016). (see Table 2 in appendix 6).

I related the two questions and findings above to theme 2 of my research questions where sub theme (a) examines participants *awareness*. The findings above reveal no significant difference between mothers and their daughters regarding their views about causes of mental illness. Views on whether mothers and their daughters were able to identify people with mental illness from 'normal' people were statistically significant. This may indicate that daughters are exposed to more awareness about mental illness / distress.

4.3.3: "People with mental illness should not be given any responsibility".

The value of F-statistic for this question is insignificant (F statistic= 4.9, p= 0.03) hence, variance between mother and daughter can be treated as equal. There is no statistical difference for the value of mother (M=4.08; SD=0.9), and daughter (M=3.5; SD=1.2) with respect to this opinion (t= 1.6; p=0.09). (See Table 3 in Appendix 6).

The findings from this question can relate to both theme 1 (sub theme - b) *resilience* and theme 2 (sub theme - a) *awareness*. It seems that both mothers and their daughters believe that having a mental illness does not deter individuals from taking on responsibilities or being responsible members of society.

4.3.4: **A woman would be foolish to marry a man who has suffered from mental illness, even though he seems fully recovered.**

The value of F-statistic in relation to the statement in Table 4 is significant (F statistic= 4.6, p= 0.03) hence, variance between mother and daughter cannot be treated as equal. The t-test related to "equal variances are not assumed" has been used to test the mean difference between mothers and

daughters. There is no statistical difference for the value of mother (M=4.28; SD=1.17), and daughter (M=3.6; SD=1.55) with respect to this opinion (t= 1.5; p=0.12).
(see Table 4 in Appendix 6).

Using my coding themes of the 6 research questions, the findings based on this statement seem to pertain to theme 1 (sub theme b – *resilience*) and theme 2 (sub theme a – *awareness*). Mothers answered negatively to this statement when compared to their daughters hence the variance could not be treated as equal.

4.3.5: **The best therapy for many people with mental illness is to be part of a normal community.**

The value of F-statistic for this statement is insignificant (F statistic= 2.7, p= 0.10) hence, variance between mothers and daughters can be treated as equal. The t-test related to "equal variances are assumed" has been used to test the mean difference between mothers and daughters related to this statement. There is no statistical difference for the value of mother (M=1.3; SD=0.49), and daughter (M=1.5; SD=0.9) with respect to the opinion above (t= -0.9; p=0.3). (see Table 5 in appendix 6).

This statement seems to address various aspects of the 3 themes that I generated from my research questions. Theme 1 (*Difference / other & Resilience)*, theme 2 (*Awareness & Help seeking*) and theme 3 (*Treatment modalities & Systemic / attachment issues)*.

4.3.6: **Most women who were once patients in a mental hospital can be trusted as babysitters.**

Findings using the above statement indicate that the value of F-statistic is not significant (F statistic= 2.7, p= 0.10) hence, variance between mothers and daughters can be treated as equal. When using these findings to test the mean difference between mother and daughter in relation to this statement, there is no statistical difference for the value of mother (M=1.3; SD=0.49), and daughter (M=1.5; SD=0.9) with respect to the opinion above (t= -0.9; p=0.3). (Table 6 - appendix 6).

4.3.7: **People with mental health problems should have the same rights to a job as anyone else.**

The value of F-statistic for this statement is insignificant (F statistic= 0.005, p= 0.94) hence, variance between mother and daughter can be treated as equal. With regards to the t-test, there is no statistical difference for the value of mother (M= 3.8; SD=1.14), and daughter (M=1.5; SD=0.86) with respect to this opinion (t= 1.7; p=0.95).

The two statements (4.3.6 and 4.3.7) and expressed opinions by the participants seem to fit easily into theme 1 (sub theme b – *resilience)*, theme 2 (sub theme a – *awareness)* and theme 3 (sub theme b – *systemic / attachment issues*).

4.3.8: Mother – daughter experiences and views on various mental health issues.

Four questions were asked that explored respondents (mother and daughter) experiences and views.

Table 8

"Are you currently living with, or have you ever lived with, someone with a mental health problem?"					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	13	26.0	28.3	28.3
	No	26	52.0	56.5	84.8
	Don't know	7	14.0	15.2	100.0
	Total	46	92.0	100.0	
Missing	System	4	8.0		
Total		50	100.0		

As Table 8 above illustrates, respondents were asked questions relating to living with someone who has mental health issues. 52% of the respondents were not currently living with someone who has mental health issues whereas 26 % of the respondents disclosed that they are currently living with someone with a mental health issue. Furthermore; 14 % respondents answered that they don't know whether they live or have ever lived with someone with a mental health problem and 8 % of the respondents did not answer this question.

In relation to the question concerning whether respondents in this study were currently or have ever worked with someone with a mental health problem, 58% respondents were currently working with or have worked with someone who has mental health issues or problem. 16% respondents are not working or have not worked with someone with a mental health issue.

Furthermore; 18 % respondents don't know that they have ever worked, or if they are currently working with someone who has mental health issues whereas; 8 % respondents did not respond to this question. 18 % respondents don't know that they have ever worked, or if they are currently working with someone who has mental health issues whereas; 8 % respondents did not respond to this question. (see tables 9,10 and 11).

Table 9

"Are you currently working, or have you ever worked, with someone with a mental health problem?"					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	29	58.0	63.0	63.0
	No	8	16.0	17.4	80.4
	Don't know	9	18.0	19.6	100.0
	Total	46	92.0	100.0	
Missing	System	4	8.0		
Total		50	100.0		

Regarding the question relating to having a neighbour with mental health problems, 28 % respondents said yes, they have or had a neighbour with mental health problem whereas; 28 % respondents said no to the same question. A slightly higher percentage of 36% responded that they don't know whereas 8% did not answer the question.

Table 10

"Do you currently, or have you ever, had a neighbor with mental health problem?"					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	14	28.0	30.4	30.4
	No	14	28.0	30.4	60.9
	Don't know	18	36.0	39.1	100.0
	Total	46	92.0	100.0	
Missing	System	4	8.0		
Total		50	100.0		

Table 11

"Do you currently have, or have you ever had, a close friend with a mental health problem?"					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes	33	66.0	71.7	71.7
	No	12	24.0	26.1	97.8
	Don't know	1	2.0	2.2	100.0
	Total	46	92.0	100.0	
Missing	System	4	8.0		
Total		50	100.0		

4.3.9: Future relationships

Four statements were asked about future relationships that the respondents may experience with people with mental health problems. There is no statistical difference in the mean value of mother (M=2.3; SD=0.8) and daughter (M=2.5; SD=0.8), with respect to the future oriented statements. The t-test for equality of means for various statements ranged between (t= 1.07; p=0.2), (t=-0.7; p=0.4) and (t=-03; p=0.7). (see Table 12 - Appendix 6)

4.3.10: Views on various aspects regarding mental / emotional wellbeing

According to the findings from the various questions that were posed, there is no statistical difference in the mean value of mother (M=2.1; SD=1.0) and daughter (M=1.7; SD=0.9), with respect to the statement "most people with mental health problems want to have paid employment". (t=1.4; p=0.16). Equally, there is no statistical difference in the mean value of mother (M=1.8; SD=0.9) and daughter (M=2.1; SD=1.04), with respect to the statement "if a friend had a mental health problem, I know what advice to give them to get professional help" (t=-0.6; p=0.5). On the other hand, no statistical difference in the mean value of mother (M=1.7; SD=1.01) and daughter (M=1.6; SD=0.7), with respect to the statement "medication can be an effective treatment for people with mental health problems" was registered (t=-0.3; p=0.7). Moreover, there is no statistical difference in the mean value of mother (M=1.8; SD=0.9) and daughter (M=1.8; SD=0.9), with respect to the statement "psychotherapy (e.g., talking therapy or counselling) can be an effective treatment for people with mental health problems". (t=-0.1; p=0.8). No statistical difference in the mean value of mother (M=2.07; SD=0.9) and daughter (M=2.3; SD=1.06), with respect to the statement "people with severe mental health problems can fully recover" was found (t=-0.7; p=0.4). Lastly, there is statistical difference in the mean value of mother (M=3.43; SD=1.08) and daughter (M=2.4; SD=1.2), with

respect to the statement "most people with mental health problems go to a health care professional to get help". (t= 2.4; p=0.01). (see Table 13 in appendix 6 for various statements).

Respondents seemed to cover the 3 themes using various statements under theme 1 (*difference / other & resilience),* theme 2 (*awareness & help seeking*) and theme 3 (*treatment modalities & systemic / attachment issues*).

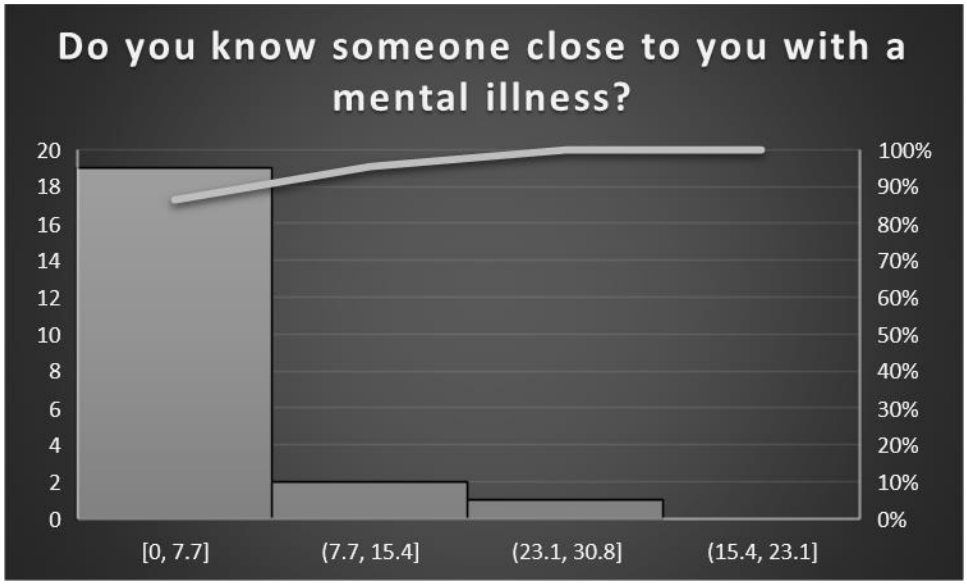
4.3.11: Understanding of various mental health issues

Respondents were asked to comment on their understanding of various mental health issues. The findings indicate that there is no statistical difference in the mean value of mother (M=1.79; SD=1.13) and daughter (M=1.5; SD=0.7), with respect to depression (t=0.9; p=0.3). Similarly, there is no statistical difference in the mean value of mother (M=2.9; SD=1.4) and daughter (M=2.6; SD=1.3), with respect to stress (t= 0.5; p=0.58). No statistical difference in the mean value of mother (M=1.3; SD=0.8) and daughter (M=2.6; SD=1.3) was found, with respect to the statement "Schizophrenia" (t= -0.8; p=0.3). There is no statistical difference in the mean value of mother (M=1.2; SD= 0.5) and daughter (M=1.6; SD=0.9), with respect to the statement "bipolar disorder (manic depression) (t=1.6; p= 0.11). No statistical difference in the mean value of mother (M=2.3; SD=1.5) and daughter (M=2.3; SD=1.2), with respect to the statement drug addiction was indicated (t=0.05; p=0.9). Finally, in relation to grief, there is no statistical difference in the mean value of mother (M=.2; SD=1.5) and daughter (M=2.9; SD=1.5), (t=0.6; p=0.5). (see Table 14 in Appendix 6).

Awareness – sub theme (a) under theme 2 seems to cover the statements in Table 14. And, as will be explained in the discussion chapter, I have included this table due to the many comments that were made by various participants who took part in the qualitative study.

4.3.12: Do you know someone close to you with a mental illness?

Figure 15



Respondents were invited to indicate whether a person who was / used to be closest to them has or had some kind of mental illness from a list of 10 statements. Figure 15 above highlights the responses and percentages by the participants who took part in the survey. A friend was selected 24 times and was the closest person to most of the respondents to be selected. This seems to indicate that most of the respondents played significant roles during times when their friends were encountering mental health illness or distress. Work colleagues and family members other than partners were the second closest groups in this survey. Findings from the survey highlighted that five respondents did not know anyone close to them who has ever suffered from mental or emotional distress. On the other hand, three respondents self-reported as having experienced emotional or mental distress. (Table 15 and Figure 15 are included in appendix 6).

4.3.13: Views on mental health awareness, stigma, and discrimination in UK.

Questions concerning mental health awareness, stigma and discrimination in UK were addressed using various statements (Table 16, Table 17 and Table 18 for details). Respondents from both groups (mothers and daughters) expressed their views on how they think about mental health issues, discrimination, and stigma. According to 22 % respondents, one in four people might have a mental health issue at some point in their lives, 18 % respondents think that one in 50 people might have a mental health problem at some point in their lives; 16 % respondents think that one in three people might have a mental health problem at some point in their lives; 14 % respondents think that

one in 100 people might have a mental health problem at some point in their lives; 12 % respondents think that one in ten people might have a mental health problem at some point in their lives; and 10 % respondents think that one in 1000 people might have a mental health problem at some point in their lives.

Table 16:

"What proportion of people in the UK do you think might have a mental health problem at some point in their lives?"					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1 in 1000	5	10.0	10.9	10.9
	1 in 100	7	14.0	15.2	26.1
	1 in 50	9	18.0	19.6	45.7
	1 in 10	6	12.0	13.0	58.7
	1 in 4	11	22.0	23.9	82.6
	1 in 3	8	16.0	17.4	100.0
	Total	46	92.0	100.0	
Missing	System	4	8.0		
Total		50	100.0		

Similarly, whilst 56% believe that there is a lot of discrimination and stigma for people because of their mental health problems, 32% of the respondents believe that the stigma has increased in the last year. 34% respondents think that there is little discrimination and stigma for people with mental illness while 50% respondents are of the view that stigma and discrimination has decreased. 2% of respondents think that there is no discrimination or stigma for people with mental health issues. Equally, 10% think that mental health related stigma has not changed at all during the year (note: survey was carried out in 2019).

Table 17

"Do you think that people with mental illness experience stigma and discrimination nowadays, because of their mental health problems?"					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes - a lot of stigma and discrimination	28	56.0	60.9	60.9
	Yes - a little stigma and discrimination	17	34.0	37.0	97.8
	No	1	2.0	2.2	100.0
	Total	46	92.0	100.0	
Missing	System	4	8.0		
Total		50	100.0		

Table 18

"Do you think mental health-related stigma and discrimination has changed in the past year?"					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Yes - increased	16	32.0	34.8	34.8
	Yes - decreased	25	50.0	54.3	89.1
	No	5	10.0	10.9	100.0
	Total	46	92.0	100.0	
Missing	System	4	8.0		
Total		50	100.0		

Looking at the themes that I generated using the 6 research questions I would place the findings from the above responses under theme 1 (sub theme a – *difference / other* and sub theme b – *resilience*) and theme 2 (sub theme a – *awareness*).

4.3.14: How likely are you to go to your GP if you had a mental health problem?

The value of F-statistic is not significant (F statistic= 2.0, p= 0.15) hence, variance between mother and daughter can be treated as equal. The findings of t-test show that there is no statistical difference in the mean value of mother (M=2.09; SD=1.3) and daughter (M=2.0; SD=0.9) related to this statement (t=-0.08; p=0.9). (Table 19 - appendix 6).

This survey question addresses respondents' views about their *awareness* and *help seeking* (theme 2, sub-themes a & b).

4.3.15: Talking to members of the family, a friend, or your employer about your mental health.

The value of F-statistic is not significant (F statistic= 0.06, p= 0.7) hence, variance between mother and daughter can be treated as equal. The t-test related to "equal variances are assumed" has been used to test the mean difference between mother and daughter. The findings of the t-test show that there is no statistical difference in the mean value of mother (M=2.9; SD=1.7) and daughter (M=2.9; SD=1.5) relating to the statement "In general, how comfortable would you feel talking to a current or prospective employer about your mental health, for example telling them you have a mental health diagnosis and how it affects you?" (t=-0.08; p=0.9). The value of F-statistic relating to the question about talking to an employer was not significant (F statistic = 0.08, P= 0.7) therefore, variance between mother and daughter can be treated as equal. The findings of the t-test show that there is no statistical difference in the mean value of mother (M=2,9; SD- 1.7) and daughter (M=2.9; SD= 1.5) in relation to the statement above. (see Tables 20 and 21 in appendix 6).

The findings from the two statements above can address some of the questions that were generated from my research questions using the various statements under theme 1 (*difference / other & resilience*), theme 2 (*awareness & help seeking*) and theme 3 (*treatment modalities & systemic / attachment issues).*

Conclusion

This chapter has covered the quantitative data analysis component of my study. The survey covered the three themes that I utilise in this study using various statements. Theme one looks at difference / other and resilience. Theme two addresses questions around awareness and help seeking. Theme three looks at treatment modalities and systemic / attachment issues. The analysis indicates that mothers and daughters who took part in the survey did not significantly differ in their views concerning various mental / emotional wellbeing issues. The findings from this analysis did not differ significantly from those that were generated from the various samples in different areas in England who were surveyed using the validated DoH (2014) survey. It is possible to argue that the views that were expressed by the participants who took part in my study would not differ significantly from the national sample because those who took part in this study have completed the assimilation process and are acculturated (Akhtar, 1999; Hylton, 2010). Others may argue that this is due to "appropriated racial oppression' - a result of the impact of oppression in causing individuals to internalise dominant group values and ideology" (Wright, 2021, pp .38). Findings from the survey were helpful towards reflecting on my research questions and preparing for the focus groups and mother – daughter interviews.

Chapter Five: Qualitative analysis of the focus groups and mother- daughter interviews.

"Key themes may, but need not, be stories of events" - Phoenix, A. (2013, pp. 75)

Having completed the analysis of the data that was generated from the survey, I embarked on analysing qualitative data from the focus groups and mother -daughter dyad interviews. Using thematic narrative analysis, I divided the research data into three themes that seemed to emerge as I coded and re-coded the generated data. I relied on the aims and the six research questions for my study whilst coding, re-reading, and re-coding the data. Under each theme, I assigned two sub-themes that I eventually used to organise the data.

Theme one:

Expression of mental distress or wellbeing:

a) *Difference / Other:*

When thinking about difference, there is need to identify that people often have more than one perception of being the other. Turner (2021, pp.38) cites Crenshaw (2013) work which "recognises double, or even triple jeopardies of difference, and studies showing these additional layers of otherness compounding the experiences of otherness, isolation and invisibility, it seems challenging to propose that whilst we are all the other, we all also simultaneously hold some type of privilege that we often are unaware of." Turner (2021) further suggests that otherness can be both individual as well as systemic. Mothers and daughters in this study demonstrated many ways in which they have been 'othered'. Gender, religion, language / tribe (some within the same country of birth) were among the examples that were offered. Being made the other can have a deep unconscious impact on an individual and their systems.

b) *Resilience:*

It is suggested that the term 'resilience' comes from the Latin word *resilire* - 'to spring back or to rebound'. The term gives an impression of one experiencing an adverse or traumatic event(s) but rather than being devastated by the adverse effects, the individual or system possesses enough mastery to cope with the crisis (Holmes and Slade, 2018). According to Walsh (2017, pp. 39), 'belief systems are at the heart of all family functioning and are powerful forces for resilience'. All the mothers in this study admitted to belonging to an organised religion or belief. Some of their daughters, on the other hand, admitted to not being interested in belonging to an organised belief

system. Interestingly, all the daughters in the study had been brought up either in Church or Muslim communities.

***Theme two**:*

Emotional health and distress

a) Awareness:

This sub-theme addresses my first research question regarding how mothers and their daughters who took part in the study expressed awareness of their own and other people's emotional / mental health and / or distress.

Help seeking:

Research question three (a) of this study was enquiring about how the participants seek help for their distress if at all. This question was pertinent in many aspects as my hypothesis prior to undertaking the study was that mothers would seek help differently when compared to their daughters. I based my hypothesis on some published evidence that women from BAME communities seek help mainly when in crisis *(*Ayón, Ojeda and Ruano, 2018; Linton and Walcott, 2018; Read, Duko and De-Graft Aikins, 2015).

Theme three:

Help seeking behaviours:

a) Treatment modalities:

The sub-theme on treatment modalities explores research question two – how mothers and their daughters in this study talk about emotional health / distress as well as research question three (b); the participants' preferred methods of seeking help for distress.

b) Systemic / Attachment theories:

This sub-theme considers the participants knowledge of their systems and attachment stories that emerged during the focus groups and mother-daughter interviews. All the three themes including the sub-themes address my research aims of understanding expression of distress and wellbeing for mothers who migrated to UK and their adult daughters who may have come to UK in childhood or were born in UK. The other aim is to utilise this study to begin to target key services to people of East African descent living in UK.

Table 2 – Summary of key findings from the qualitative data.

Theme / Sub-theme	Key Findings
Theme one	Expression of mental distress or wellbeing.
Sub theme (a) – Difference / Other	• Difference in age and gender in perception of mental / emotional illness. • Language people use to describe mental / emotional wellbeing. • Mother – daughter interactional / generational differences. • Meaning making regarding the notion of the other.
Sub theme (b) - Resilience	• Intersectionality of gender, ethnicity, and other markers e.g. disability. • Relationship between fear, trust, and resilience.
	• Resilience is not a choice that individuals make. It is a survival strategy.
Theme Two	Emotional Health and Distress
Sub theme (a) Awareness	• Pre-migration knowledge about mental / emotional wellbeing and illness. • Awareness of mental emotional wellbeing issues via various means especially social media for younger participants. • Ignorance or dismissal of mental health issues as things that happen to other ethnicities.

Sub theme (b) Help seeking	• Mistrust of GPs and other healthcare professionals. • Community gatherings perceived by some as a form of group therapy. • Talking to family and friends viewed as a form of help seeking. • Alcohol and substance misuse concealed but prevalent within the East African communities.
Theme 3	Help seeking behaviours
Sub theme (a) Treatment modalities	• Prayer seen as the easiest and cost-free treatment modality. • GPs and medical model viewed by some participants as discriminatory. • Fear of being judged by healthcare professionals as a barrier. • Bureaucracy, red tape, and cost of private therapy perceived as barriers. • Use of witchcraft, herbal remedies, and African traditional religion (ATR).
Sub theme (b) Systemic / Attachment theories	• Generational attachment narratives. • Dissonance in cultural / spiritual / gender issues. • Need for systemic work that is specific to people from Ethnic minority backgrounds.

Theme one (a)

Difference / Other – Please tell me what mental health / wellbeing means to you:

The notion of the 'other' and difference was identified within focus groups and in mother daughter interviews. Notions such as age and how daughters and their mothers discussed their views on various issues indicated some differences and 'othering'.

It has been suggested e.g. (Turner, 2021; Walsh, 2017) that difference can be unconscious to the individual and their social systems. Difference and othering were found both within focus groups and between some mothers and their daughters regarding how they thought about how they would talk about mental / emotional health and wellbeing. Similarly, even within the closer age groups,

some participants differed on how they talked about experiences from their countries of origin and how emotional wellbeing was regarded in those countries.

Whilst exploring the notion of 'difference', daughters in their focus groups, focus on the language that other people use to describe mental illness. Focus group participants did not differentiate between emotional wellbeing and mental wellbeing. To them this was one and the same. Language that describes mental ill-health was perceived as derogatory but used in closed spaces. The daughters in the two focus groups refer quite often to what their mums or other members of their families have said about mental / emotional wellbeing. Nakku and Zalwango who come from the same country talked about how both their mothers use derogatory words for mental illness - 'zonto' and 'kuku' - whenever they were referring to anyone they did not like. Nakku said, "*Come on (…) Being mental is when you are completely kuku. My mother calls them zontos. 'oyo zonto' – That one is mad*". Zalwango replies almost immediately, "*Yeah. My mother says that too. Zonto (laughs). My mother calls everyone she does not agree with zonto. The President is a zonto (…) Some people at her workplace are zontos*". Whilst talking about emotional or mental wellbeing, the daughters seem to describe symptoms with more clarity when compared to their parents. Kasongo reported the view that "*Wellbeing is when we are free of disease, I guess. So mental health is health that has to do with our wellbeing*". And Wambui felt that mental or emotional wellbeing were one and the same. She said that "*It is trauma (…) yes, it is trauma alright*". During one of the mother-daughter interviews, Zalwango (daughter) observed that "*I think mental wellbeing is very much to do…erm…with your mental state…and could be affected by things like stress…anxiety…which in turn can affect your physical state of being…*".

The mothers on the other hand, talk about mental health as *dangerous*, for *weak* people or differentiate between how genders *accept* this phenomenon even if it means having to keep up appearances. In this regard, Mirembe expressed that "*I think with women…I feel that it is more accepted…we accept it more…I feel like…with men…there is this persona that they have to maintain…keep up with appearances so to speak…*". Another mother, Matope, talked about men finding difficulty in accepting that they may struggle with mental or emotional challenges. She said, "*Some say that mental health is for weak people…no one wants to be weak…*". Mental / emotional illness and dangerousness being synonymous was a theme that many mothers discussed during the two focus groups as well as mother-daughter dyads. Uhuru stated that "*Mental health separates us…Even in hospitals, people with mental health problems are separated from others… yes,*

discriminated…". Kabila, another mother informed that "*They are seen as dangerous ...*". Muigai seemed to be convinced that indeed people with mental illness are dangerous. She said, "*But they are erm…very dangerous …some can even attack you if you are not careful…*"

Another difference was noted during mother-daughter dyad interviews. Daughters tended to let their mothers speak first even when the mothers had indicated that it would be ok for their daughters to speak first. Matope overtly tells her daughter that she should speak first because "*You know this better than me*". The daughter (Ngala) seems to reassure her mother by letting her know that her views are valid, but mum insists that her daughter should go first. "*Mum, they are asking you about your views*...". Mum tells daughter – "*ok, you go first".* The mother-daughter interviews revealed that to some extent, mothers expected their daughters to know more and gave them space to express their views more succinctly. For instance, Otieno (daughter) after mother (Wekesa) has offered her personal views says, "*LOL, trust my mum to dive in at the deep end…* Wekesa replies "*It is true Otieno…it is true now…".* Otieno retorts, "*Anyway…there is a difference between mental, emotional and physical wellbeing…".* Otieno continues, "*...mental ill-health is the real deal…like going kukuz (laughs)…I know my mother hates that word…kukuz…yeah…I know why mother…and I understand…I am only pulling your leg…*". Wekesa replies "*but this is an interview…".*

There is a way that Namubiru appears to attribute emotional or mental wellbeing to personal or genetic factors such as taking drugs or being born with it. She informed that "*...some people are born with mental issues or call it mental illness...*". Namubiru also added that "*some may use drugs and have no effect...and others use drugs, and it affects their mental capacity...*". But her daughter (Zalwango) seems to locate her arguments in environmental factors. Otieno (Wekesa's daughter) talks about how she perceives difference between how young people are 'assigned' diagnosis. She says for instance, "*White kids are diagnosed with Attention Deficiency Hyperactive Disorder (ADHD) whilst black kids especially boys are diagnosed with Conduct Disorder*". Her mother seems to dispute that there is such a diagnosis like ADHD and views it purely as rudeness or lack of parental /societal control. Difference/ othering was elicited during this study in terms of age, gender, generational/cultural as well as racial/ethnic stories.

Theme one (b)

Resilience - <u>How can a person who is experiencing worry or difficult emotions express them?</u>

This theme explored participants resilience. Resilience is an often talked about phenomenon both clinically and in general discourse but possibly individually understood and experienced. As a researcher, I was interested in understanding how participants not only viewed resilience as a concept, but also how they had experienced this idea of going through traumatic experiences. I was also interested in how they had coped with any traumatic experiences (if at all).

Resilience was a theme that seeped through the entire study. This theme addressed all my research questions and aims in several ways. In addition to issues relating to migrating, mothers and their daughters talked about how they have variously coped with many aspects in relation to living as black, minority ethnic women. Many recounted how they have dealt with the intersectionality of being black African, women and for some, disabled in UK. Through these stories the participants were able to answer some of my questions in relation to how they expressed distress as well as how they individually sought help for any distress. Fear permeates most of the stories that participants narrated. There is a recognition that emotional wellbeing can vary for many reasons but being '*mental'* is scary or even super scary. Uwase said in relation to fear and resilience; "*Huh, Mental illness is super scary, I swear down. Imagine being sectioned for no reason… The Feds picked him up from some party…yeah…then, the next thing yeah…He is sectioned…mad…The feds are so racist I swear down…".* Uwase whilst explaining what happened to her cousin who was picked up by the 'Feds' (Police) and taken to a Psychiatric hospital, keeps on emphasising how being 'mental' is super scary by underscoring her story with a phrase '*I swear down'*. In UK Black urban slang, Uwase is inviting her audience to believe what she is telling them, but she also seems to be re-living this episode in this group. Kasongo also agrees with the idea of feeling scared by mentioning that "*I think being emotional is temporary. Like getting angry, fear… crying, you get me...I swear down everyone gets emotional sometimes. Everyone, yeah…yeah…but being mental? That is huge. It scares me…" Fear* is expressed for many reasons by various participants. Fear of being judged. Fear of being misdiagnosed. Fear of becoming the conversation both in the diaspora and 'back home' in Africa. Fear of loss of home, culture, role, or status. Fear seems also to be an important factor that inform how participants experience shame, guilt, worry and at times denial.

Some participants felt that talking, especially to family or friends, would be helpful. Younger participants more so than older ones. *Trust* or the lack of, seem to determine whether people would be willing to share their distress. For instance, Wanyana expressed a view that "*…There have been so many times when I have gone through crap, and I don't even know who to tell or how to tell…Hello…people just judge you and talk about you behind your back…".* Then another daughter, Kagame, whilst agreeing with other participants added, "oh yes…people talk…*that is my fear too*…erm…*they even make your situation to sound worse*…but now I *talk to a few people that I trust*…*but it is long*…" Trust also seems to be key in determining whether these participants would be willing to seek professional help. One mother in the study, Uhuru, said that her lack of trust was a result of fear that she would be judged by healthcare professionals. She said, "*It is difficult to trust them…very difficult…I mean, how do I tell them about the Home Office? They will just judge me… I am a refugee…I am poor…I have too many problems…That is how they see me…No, I don't trust them…*". Mobutu another mother added, "*I would never tell…I fear to become the conversation… that is why I do not talk…".*

On the other hand, there is a sense that some participants feel that talking to others about their distress would be burdening to others. Mujomba, one of the mothers, reported that she finds difficulty talking to others when in distress. She said, "*Some of us just get on with it…what is the point of expressing your worries…what will it serve...but going to a friend to worry them as well…I don't think that is a good thing…*". Malembe, her daughter asked her mum, "*…in other words…erm…you do not trust anyone…erm…with your secrets?*" Mujomba replies, "*No, not secrets…I just don't see the point of running around telling people…eh…I have this problem…help me…that is what I am saying…*". Some participants felt that they were strong enough to cope with any adversity. Munyakazi, one of the mothers, whilst seemingly joking with her daughter, Uwase, quipped, "*What is that they say? Erm…Black don't what?".* The daughter replies; *"Don't crack…yeah…".*

Deciding whether to talk about distress also seems to be impacted by how women perceive themselves in their families and the community. Muigai, a mother, talks about women needing 'to get on with it' and Wambui, a daughter, talks about women being 'the backbone'. Kiprotich expressed the view that, "*There is a fear about how mental or emotional wellbeing is perceived in our communities…yes, fear of how the other person might think of you…may be think that I am mad…you know…some people may even say…er…you are being silly…you are not depressed…"*.

Namubiru replied, "*oh sister…the conversation goes all the way to Africa…after it has made rounds here and in other countries…can you imagine?... the shame…oh my sister, the shame…I would prefer to die first…".* Some participants thought though that they did not have issues with expressing their distress. Ingabire, a mother, expressed surprise by saying, *"Seriously? …Me, I don't care…they can talk…I don't care…what do I lose?...My mother always used to say that a problem shared…No, I fear no one…".* One other participant, Matope said to Ingabire, *"You are lucky sis…Most of us are not as brave as you are…It is not easy at all…"*

Whilst thinking about how and who these participants talk to, it is worth noting that the participants who took part in mother-daughter interviews tended to express themselves more explicitly without much censoring. It was not clear whether this had to do with time, number of people taking part in the focus group or simply undertaking the interviews in their own homes (which would supposedly render this a very safe space). Mirembe, one of the mothers who took part, reported that, "*Mental illness is something to be ashamed of…Living in England…maybe not so much…but back home…I do not think so…I really think it is taboo…that topic is taboo…*". Her daughter, replied, "*Exactly… Back home…some people might write you off…*". Mirembe goes on to say, "*There is no middle ground…you are either mad…or you are normal…Yes…*" I wanted to clarify what Mirembe meant so I asked, *"Why do you think that is the case?".* Mirembe replies, "*...it is the stigma…Mental illness affects the whole family…sometimes the whole clan…*". Wanyana, her daughter, then says, "*Can you imagine?... That is unbelievable"*.

There were some participants who viewed resilience as something that they had no choice but to evoke. Ngala, one of the daughters who took part explained that "*I do not know how to explain it…but it feels at times like someone is putting on a mask. Acting like…yeah…everything is ok…but you can tell…erm…that they are not…".* Kabila (mother) in what sounded like a reassuring tone replied to her daughter*," Women are strong…You know that now…We are the backbone…*". Ngala goes on to express "*erm…women are emotional (laughs). But then again…because of the world that we live in …we are told to just deal with things…so even with emotional things that may be going on…you just push through…you just get on with it…you know…". Ngala's mother then says, "You kind of do not want to have a pity party…So if your mind is not on it…you do not have to deal with it…".* Others talked about how having found themselves in adverse situations, they had no alternative but to find ways to deal with those situations the best way they could. One of the participants recalled the turmoil she experienced after coming to UK with her English husband thus, "*Losing my home, my*

culture, status, everything was scary. I was not a refugee. I came here to join my English husband…We met in Kenya…We were both teachers there…Here, I was told that I did not qualify to teach…oh, I cried…". Resilience as a theme enabled participant views on issues such as fear, trust and coping strategies to be explored in the context of how the participants talked about distress and how they seek help if at all.

Theme Two – Emotional health or distress

(a) - Awareness

Participants awareness of the various mental and emotional issues was addressing my research question on how they understand and communicate distress. I felt that participants awareness of these issues would subsequently inform my third research question on their help seeking behaviours.

Younger participants seemed to be open to the existence of ignorance within their communities around mental / emotional health awareness. For some it was due to people *snitching* on others but some thought that their communities were suspicious of how they would be treated by services. For instance, Zalwango and Nakku whose parents hail from the same country in East Africa disagree on how they perceive the Psychiatric hospital in their East African country (Butabika). Zalwango perceives this hospital as a place to go when one 'is completely gone' meaning that the person must be severely unwell mentally. On the other hand, Nakku contends that the same hospital can generate denigrating phrases or connotations that may imply that a person is stupid or a fool. Zalwango says, when talking about her understanding of emotional health and distress observed that "*In my country they send you to Butabika if you are completely kuku…If they call you a Butabika case…erm…it means you are a gone case…*". However, Nakku observed that the same hospital conjures up denigrating images and can serve to put others down. She observed that "*That is not completely true. Butabika case is also used as an insult… If someone wants to say that you are stupid…they can call you a Butabika case…yeah…sometimes they point to their heads…*". Otieno observed that prejudice and lack of understanding of 'our ways' by UK host communities may contribute to how people in the East African community communicate their awareness of distress. She said, "*… My mother says it is pointless talking to people here…they do not understand our ways…They are always judging us. When I tell her that we judge others too…erm…she gives me that look…*". However, other younger participants in the two focus groups agreed that there was a lot of

ignorance and lack of knowledge regarding mental/ emotional wellbeing issues within the East African community in UK. Wambui submitted that "*I agree…there is so little awareness in our community…we are so biased…*" while Kasango felt that this was purely due to ignorance by adding that *"...biased?... no way…We are just so ignorant…and super scared…".*

Other participants acknowledged some degree of awareness while others admitted to not paying as much attention to issues concerning mental / emotional wellbeing. Mutesi observed that "*I never give it much thought…I mean…erm…erm…I see all these posters saying 1 in 5 people suffer from a mental health problem…but…I do not really take time to think about it…".* Some participants acknowledge that they have come across various campaigns around mental / emotional wellbeing. Some mention social media, Television adverts and posters. Another young participant, Kamau, acknowledged that she had some idea of what mental health is via her social media handles. She said "*...Kinda…I saw a meme on insta…yeah…that said… erm… there is a thin line between mental health and illness…Did not make much sense to me…*". Nyerere, a medical doctor by profession, was of the view that there was sufficient help in the East African community. She appeared to be agreeing with the other participants who expressed that fear and lack of trust contributes to lack of awareness of mental health concerns within the community. Nyerere expressed that "*There is a lot of help in the community…just that…we snitch a lot…The excuse is…erm…let us talk to this prayer group…but hohoho…they are just snitching…*".

There is a sense though, that many of the participants in this study do not pay as much attention to the various campaigns because mental / emotional issues happen to people of other races or communities. Some talk of being advised to 'throw away medication' with the understanding that use of prescribed medication for mental health issues is a Westen concept that would not apply to people in this community. According to Kongwa, one of the mothers, "*if you are taking medicine…they will tell you to throw it away…they will tell you…us Africans…we do not get depressed…"*. Uhuru adds, "*They say…people like to say…oh us Africans…we do not get those things…whatever…so they seem to think that those mental health issues happen to people of other races…*". Kiprotich clearly views ADHD as a Western problem. Wafula (Kiprotich's daughter) said to her mother "*But mum…there is a problem too…where some African people do not want to educate themselves…on things like autism…there is a lot of ignorance out there…*". Kiprotich replies, "*I agree to some extent …erm…yes…some ignorance…but let me tell you…here…everything is given a medical diagnosis…why...Attention Deficiency Hyperactive Disorder (ADHD)? what is that really?... This is a*

Western problem…". Some participants talked about depression as a concept they only encountered after coming to the UK. According to Mirembe (a mother) "*Many people will say to you…depression…what is that...nothing…they will not really understand…*". Mujomba, another mother, observes that "*Sometimes it is a lack of awareness…You know…when I first came to this country…we used to hear that people are depressed…and…we would laugh about it…there is no such thing as depression…but as you live in the country for some time… you start hearing about what causes depression…oh my god…*". She continues, "*...you learn to differentiate what is happening to people…if it ever happens to you… you are more aware now…*"

Mixed views regarding whether there is enough awareness and who is responsible for the dissemination seem to be expressed by various participants. Mirembe, one of the mothers, mentions that they used to laugh when others talked about depression but having learnt later about the causes of depression, she feels able to spread the awareness and be helpful to others. Mirembe says, "*I guess the information is there…hmmnn…if you look for it…but our people like to be spoon-fed…erm…don't get me wrong…we came here to get away…er…er…er…from our old ways…why then don't we make the effort to look for useful tools that can help us?...it beats me…*". Wanyana, one of the daughters, argues on the other hand, that many people in her community prefer to be mollycoddled. She also expresses a view that some adults in her community engage in habits that may be harmful. Wanyana says "*I mean…let us face it…there is a great deal of alcoholism in our community…some men drink openly…but women drink too…all those house parties we grew up going to…people were always drinking too much…looking back now…I think those house parties…erm…a form of group therapy…I do…*". Although gathering in their communities may be interpreted by some as a form of 'group therapy'. Mobutu observed that "*I don't drink alcohol…in Africa…I probably would not attend these parties…but I would be going to duwas…mikutano…so I would still be engaging with other people…here…I go to work…I come home…I cannot go to their pubs…no way…".*

Negotiating focus group and at some points, mother-daughter dynamics in terms of how issues were being articulated, was another factor in terms of understanding how individuals and families understand and communicate distress. It was important for me to remain aware of my own position as a researcher (Smithson, 2000). Whilst coding and re-coding the generated data, I listened to the contradictions within specific focus groups as well as the three mother – daughter dyad interviews. Some of the contradictions had to do with how participants thought about their

individual countries compared to other East African countries. How younger participants and their mothers used language to communicate various issues was viewed as another source of contradiction. Kongwa, one of the mothers, said "*It is difficult… Here, you hear a lot about counselling…they say it is expensive…they don't tell where to find them…everything is depression this…erm…depression that…very difficult…*". Mobutu was of the view that many in their community did not like to learn new ideas but prefer to blame government. This view was challenged by other participants. Munyakazi laughed at Mobutu and said "*Hahaha…Mobutu thinks we want to be spoon-fed…what did I say about judging? No, madam. Here everything is meant for British people…when you come here…everything is confusing…I mean, they tell you to go to a GP…where I come from everyone is in a hospital…erm, we call them musawo / Mganga / doctor…even witchdoctors are called musawo / mganga / doctor. It is not that we want to be spoon-fed…*". Uhuru agreed with Munyakazi by saying "*I agree Munyakazi…Everyone assumes that we know…or worse…they ignore you…stereotyping is worse…*".

Similarly, for some participants awareness about mental / emotional wellbeing were explained from past experiences of how other people described these concepts. Ingabire explained that "*Our people don't talk about these things…when we struggle…it is because of the devil…witchcraft…jealousy…racism…but not mental health…*". Mujomba decided to tell fellow participants one of her experiences thus "*I don't entertain that nonsense…even when I was in Africa…I am a rebel eh…my father used to say…He was a polygamist…He and his friends…one minute they are praying swalah…the next erm…they are talking about djini…I used to ask my father…what is the truth? Even here…I don't entertain that nonsense…*". This seemed to excite the group. Matope says to Mujomba "*Huh? …You are a woman and a half… Standing up to those polygamists? …my sister…you are brave…Me…I don't believe in mental health so much, but I believe…er…in prayer you know…Prayer works…prayer works…*". Others were forthcoming about beginning to think about emotions as a concept after arriving in UK. Mugizi admits "*...to be honest…I did not know about emotions…sijui…mental health…For me you are either mad…or you are not…The rest …me…I learned when I came here…Even then…I do not know a lot…*".

Sub theme (b) -Help seeking

Help seeking was one of my research questions. I wanted to understand how individuals and families within East African communities seek help if at all, for their emotional wellbeing. Most participants seemed to agree that seeking help for emotional / mental health distress may be

helpful, but they did not agree much on how or where to seek help from. Younger participants seemed to be open to the idea of talking to other people when compared to the mothers who took part. While some expressed that family and friends would be easier to access, others were not agreeable. Ideas such as whether the family and friends would understand the causes of distress and how this information would be handled were offered. Otieno said, "*...me? I talk to my bedrens. No point talking to my mother…she will just tell me to pray about it…talk to Jesus…*". Another daughter (Mutesi) also felt that "*…I rarely tell my mother…because I hate her lectures…Then, erm…she rings all her sisters…and it becomes a circus…*". Kamau was also of the same view. She said, "*oh no…that is my life…my mother tells all the aunts on planet earth…to dissect my problems…it starts off so small…(laughs)… by the time she finishes…the problem is so big, and it is no longer my problem…but hers…*".

For others, talking to religious leaders or older males in their families was not a good idea. Some felt that although they were being encouraged by their respective religions to speak to their religious leaders, they did not find this helpful. Zalwango mentioned that "*In Islam…women can talk to their fathers, brothers, or the Imam…I asked my mother how that can work for me. My father lives in Africa. I don't even talk to him that much… I only go to the mosque for special occasions…My mother is not a practicing Muslim…She drinks alcohol…I think if we lived in Africa…it would be different…But I do not know how…*". Ngala agrees with Zalwango by saying, "*I think it is the same for most of us…In the Catholic Church we are supposed to go to the priest bossman…yeah…erm…to repent our sins…We go to church most Sundays… but…erm…I have never done the penitence crap…*".

Some participants expressed that seeking help for distress whether through talking to people in the community or professional services was a waste of time and / or another way of burdening others unnecessarily. Some informed that they were aware of people in their communities who relied on alcohol and other illicit substances when experiencing emotional distress. Malembe observed that "*Yes…but others use expressive ways…use drugs, alcohol, become sexually promiscuous…I think us black people sometimes pretend…we do not want to face the facts…call a spade a spade…*". And Wambui had observed in a different focus group that "*Alcohol helps…just get drunk…and blurt out everything…*". Although some of the daughters disclosed that there was a problem with alcohol misuse in their respective communities, especially with male members, mothers who took part did not say much about this subject.

Many of the participants seemed to mistrust professionals and felt that therapists were mainly motivated by monetary gains, would not understand *their* problems and were quite judgemental towards people from *their* communities. Some admitted having gradually understood that seeking professional help for emotional / mental distress was not harmful and had some positive benefits. Mirembe observed, "*...and really Psychiatrists and other doctors are there for a reason…They have studied these illnesses…they will find ways to help you…rather than saying God help me and they will believe…it is all about you…yes…I don't think it would work…"*. Another participant identified that they could perhaps speak to people like me. Otieno said "*Talk to people like you I guess…What are you again aunt?...What do you do*?". *Moderator: That is interesting…A good question actually…I am a Nurse Therapist…I have worked with both young people and adults…erm…in Mental Health Settings and General Hospitals…*Otieno seemed to be satisfied with my reply by saying "*cool*". This was not the first time during the research study that I had been addressed as "aunt" by younger participants or "sister" by their mothers. Mothers also tended to address one another as 'my sister' from time to time.

All the participants identified GPs as a first port of call although most of them, especially younger participants, decried the time that it takes before one gets to access their GP. Others expressed concerns that their GPs would judge them negatively if they were to disclose their mental / emotional difficulties. Kabila said that "*...here they tell you to go to your GP…to do what there?...I talk to my sisters…here and back home…"*. Some participants recognised that the UK healthcare system was different compared to the various East African healthcare systems. Namubiru observed that "*But that is how this country operates… It makes life easier…although…I have never taken my troubles to the GP…I mean…I wouldn't know how to start even…".* However, some of the participants expressed the view that the UK healthcare system was difficult to navigate when compared to those in their home countries of East Africa. Muigai said for instance, "*Aha, my sister… understanding how the system works…erm…and the truth…are two different topics…but me…I thank God…I have my family and friends to rely on…"*. Other participants on the other hand, expressed their fears that GPs were more likely to prescribe medication than refer people from ethnic groups for therapy / counselling. Kiprotich told of her experience of when she had just arrived in UK thus, "*When I first came here…I heard that everything is recorded…I said…me…never…I do not trust the system… then you hear all those stories about how black people are given strong medication…our sons and husbands become impotent…not good at all…".*

Seeking help through prayer seem to be preferred by many of the older participants than their younger counterparts. Matope, one of the mothers, like many other mothers who participated in the study expressed the view that "*Some of us just get on with it…What is the point of expressing your worries…what will it serve…Maybe prayer…talk to God about my worries…but going to a friend to worry them as well…I don't think that is a good thing…*". Malembe, her daughter jokingly interjects, "*...but mother…according to BT, it is good to talk*…(laughs). Many participants felt that they would be able to talk to their community leaders (Priests, Pastors, Imams etc). Others, on the other hand, were of the view that many of their community leaders were as ignorant about emotional / mental health issues as they are, and some could be exploitative by gaining monetarily from vulnerable individuals / families. Kongwa, a mother, expressed that "*...instead of seeking help from a doctor…they would prefer to go to church…to be prayed for…I am not saying it won't work…but I would prefer to do both…erm…going to church to be prayed for…but also seeking medical help…".* Her daughter agreed by stating, "*Yeah I believe that as well…you know God said…erm…you know…God helps those who help themselves…so…if you are just sitting there waiting for an answer…I don't think so…".*

With regards to help seeking for emotional needs, many mothers in this study felt that they would either not seek any help at all or wait until the issue has been resolved before talking about it. Uhuru for instance, was of the view that, "*Yes…I will talk after my problem has been resolved…but not before…in my language there is a saying that means…there is no secret between two people…you tell someone your problem…they run to the next person…and make it worse…or they begin to judge you…*". Wambui, her daughter, seeks some clarification from her mother by saying, "*In other words…you do not trust anyone…erm…with your secrets…*". Uhuru clarifies by saying "*no. not secrets…I just don't see the point of running around telling people…erm…I have this problem…help me…help me…that is what I am saying…*". For some participants in this study, it was felt that they would seek help from others with similar experiences. Mugizi agreed with other participants in the focus group by saying *"Yes…when I know a sister that has gone through…erm... what I am going through…erm…then I can speak …*". Some, on the other hand, expressed the view that it was easier not to deal with their emotional issues or avoiding seeking help. Wekesa said for instance that, "*…you don't have to deal with it…sometimes…I just push things to the back of my mind…yeah…that is the truth…*".

Theme 3: **Help seeking behaviours**

Sub theme (a)Treatment modalities

This sub theme links with all the three broad research questions for my study as well as the study aim, mainly how to target key services to people of East African descent in UK and other BAME communities.

Praying when in distress was the most preferred treatment modality although some seemed to intimate that this modality was imposed upon them by others. To this regard, Ngala observed that "*...to be honest? …I would pray first…I am a Christian you know…so I would pray…*". Some expressed a view that prayer was costless. Many participants felt that praying was not only free but was easily accessible as participants stated that they are able to pray at any time. Most of the older participants talked about belonging to various prayer groups. The prayer groups could be seen as places where some of the participants expressed and shared their distress. It was interesting to note that prayer would still be preferred even when the individuals did not trust their religious leaders. Mirembe reports "*... but if you tell your pastor…that you have been to a witch doctor…oh…they will start talking about demons… sijui bad spirits…We are so fake…*". Ngala adds later, "*at Uni everyone kept on banging on about seeking counselling if needed…erm…and I used to think…why?...I always imagine counsellors laughing at me afterwards…I would probably talk to my pastor or his wife instead…*". Many participants felt that they can combine prayers with other treatment modalities. Mobutu, one of the mothers said, "*...for me I use everything…I will go to the GP…Pray…Talk to my sisters…*". She adds, "*...because… I have come to realise…that as long as I get my problems solved…it does not matter whether others judge me or not…*".

For some of the participants, talking to family, friends or community leaders can be augmented with herbal remedies, witchcraft or visiting their GPs. Nakku asked fellow participants, "*Hands up those who would go to their GP?*". Uwase answered almost immediately, "*What for? You would have to wait for a month at least…*". Matope, a mother, expressed in another focus group that "*...going to the GP…aha…that depends,*". This indicated that some of the participants would have been willing to consult their GPs, if the appointments were to be expedited. In a way, this explains some of the crisis presentations to the Emergency departments in various hospitals. As an example, Kabila said, "*...the problem in this country…erm…is the bureaucracy…back home…if I have money, I don't have to wait…here it takes so long…even to see your GP…*". Mujomba talked about going private but did not feel that she would be able to afford the consultation fees. Mujomba said "*I guess you*

can go private…but huh…can I afford their fees? ...for me it is my sisters and prayers…My Imam will only judge my life…I don't bother with him…".

Other participants were of the view that initiating a conversation about mental or emotional illness might be difficult for them. Uhuru said, "*It is difficult you know…even having that conversation with a trained person is not easy… I find it easier to speak to my pastor…*". Use of herbal remedies was also discussed. Some participants expressed their lack of clarity. Munyakazi asked fellow participants, "*...talk about it…Herbalists too…by the way…are herbalists witchdoctors too?...*". Muigai answers, "*Witchdoctors are different…they are like some pastors…they are extortionists…but then again…this may be Western propaganda…*". (laughs).

Conversations around witchdoctors and herbalists were interesting in the sense that no one owned up to have actively participated. One participant observed this. Namubiru, one of the mothers asked, "*No one is talking about witch doctors here…are you saying you have never heard of them...My people can pretend…*". Muigai, in the same group said, "*... witchdoctors get a bad press…especially here…some are very good…they can tell your future…*". Kongwa replies, "*My sister…you are right…I would probably be like you…I only draw a line…erm…with witchdoctors…No way…never in my life…*". Negative connotations seemed to be attributed to use of witchcraft and herbal remedies by some participants. Some blamed Western propaganda, Colonialism, and religious dogma for this. Again, during mother-daughter dyad interviews where participants seemed to feel safest while expressing themselves, they demonstrated more knowledge about the practice of witchcraft and use of herbal remedies and various other modes of African Traditional Religious (ATR) interventions in African spaces.

There also seemed to be agreement within all the focus groups that people from ethnic groups are treated differently compared to their white counterparts. Some who had experience of seeking help from their GPs expressed that use of medications was more common and they rarely offered counselling or therapy even when they would have preferred this treatment modality. Matope told her experience thus, "*Many years ago…when I struggled with so many issues…family separation…Home Office…work…so many things…*". She continued, "*I went to see the GP…I said I am having trouble sleeping…without even asking me any other questions…he gave me sleeping tablets…*". Another participant, Mirembe, also said, "*Oh dear…that happened to me too…Every time I went to the GP…I came back with different tablets…I stopped going…*".

Equally, there were some participants who expressed sceptism about the existence of mental or emotional illness. This was a basis on which they disregarded any known treatment modality. Mutesi observed, "*Raa, you guys are extra…go to the pastor…talk to GP…it is all a con…there is no such thing as mental illness…there. I said it…that is what you are all thinking, no?*".

Some younger participants felt that talking to family members was at times counterproductive. Wanyana expressed that "*in this country there are so many places and ways to find help if you need it… I rarely tell my mother because I hate her lectures…then, erm…she rings all her sisters…and it turns into a circus…*". Kagame said that she has had the same experience. She said, "*Oh no…that is my life…My mother rings every aunt on planet earth to dissect my problems…*". Others talked of not being sure who to talk to exactly. Kamau expressed, "*I dunno…Talk to people like you I guess…What are you again aunt?".* While there was a view that some may be seeking help from people that have more problems than themselves. Matope asked cryptically*, "May be …the person you are asking to help you has more problems than yours…*".

Sub theme (b) - Systemic / Attachment issues

All the focus groups and mother-daughter dyads told stories that had systemic and attachment narratives. Culture, race, ethnicity, and religion (faith / spirituality) seemed to play major roles in many of the stories. Although I did not ask specific questions about culture, race, ethnicity, or religion, these seemed to be woven into individual experiences and observational narratives. Here below is a conversation that took place between one mother – daughter interviews.

Namubiru (mother): "*They are perceived to be strong (women)…and believing that something has gone mentally wrong with me and I cannot cope…with caring for my family…would be a bit difficult to accept…*".

Zalwango: (daughter): "*To accept…yeah*".

Zalwango: "*I feel like…they just feel like…I have to go on…I have to do this for my family…"*.

Namubiru: "*Yeah… It is just like other illness…a mother will be very ill but they have to carry on…you know…*".

Zalwango: "*Caring for their children…*".

Namubiru: "*They have to carry on…or even thinking it cannot happen to me… sometimes we do it unknowingly…*".

Namubiru: "*Back home I would employ some house help but here this is almost impossible…too expensive…too many challenges here…*".

A common theme for the mothers was the need to tell their stories from before they came to the UK, how they managed the early years in the UK and how their experiences were different from those of their daughters. Mothers also seemed to feel that their roles were very crucial for their families to survive. In essence, mothers in this study considered themselves to be the 'backbones' for their families. The following conversation between a mother and her daughter offers an example of some of the narratives that ensued during focus groups and mother – daughter interviews.

Malembe: (daughter) – *"I know mum will not agree…but I believe all black kids should go to therapy at a young age…"*.

Moderator*: "that is interesting. Why?".*

Malembe: "*Aunt…I am not playing…you know…black children are traumatised…by so many things…I can think of a few…dealing with the transferred anger from parents…". "…our parents feel marginalised outside the family home...so they get home...how can I put it?..."."…erm…and transfer all their frustrations...on to their children...". "I mean…there are threats…both from outside…and at home…"*.

Matope: (mother)- "*No. I actually agree with you…I don't know about sending all black children to therapy…". "May be…eh…eh…send all UK kids to therapy… but…yes…house parties for us Africans…was the only way we could meet…". "Transferred anger from parents?...child…please…how about transferred anger from children…(laughs)". "Seriously though…we as a community have so many things to deal with…me…I can give me as an example…". "When the troubles started back home…erm…I was in Russia". "I was in Russia". "I was sent there by the Government…I was a senior Government officer then…". "…so I called your father…and asked him what I should do…he advised me to come to UK…". "I did not know anyone here…although my husband had come here for his master's degree…in Reading…". "I did not know anyone…I remember spending the first week crying…then I ran out of money…". "oh oh...my sister…this was a terrible time…then the phones got cut off…so I did not know where my family was.".*

Malembe: "*Yeah…erm…this is true…we as children were not really focused on this… we were living in Usiago"*.

Malembe: "*…playing with other children…eating fresh mangoes…*".

Matope: "*Now me?...oh Lord…I was going out of my mind…*".

Daughters, on the other hand, seemed to communicate an understanding that their mothers and by extension other older members of their communities may have experienced adverse life stories. They however seemed to offer the same narratives as their mothers that

were anchored in race, culture, ethnicity, and spirituality. Here below is an excerpt from a conversation between a daughter and her mother.

> Kamau: (daughter) - "*…oh gosh…I doubt it…I did not grow up back home…but I know my culture…*" (laughs).
>
> Wekesa: (mother) -"*What do you know about your culture?*".
>
> Kamau: "*What don't I know mum?...I think our culture is very much…". "…so that you do not show what you are going through…erm…you do not ask for help… ". "…it is a bit of a paradox that one…because we always ask for help…erm…in our community…". "But when it comes to asking for help to enhance our mental wellbeing…we act like…we do not need it…". "So yeah…when it comes to mental wellbeing…it is almost like it does not exist.".*
>
> Wekesa*: "You act like you are ok…you are not struggling…you are not going crazy…". "Yes, my sister…some of us are married singles…". "I mean…we are married…but we might as well be single…".*
>
> Kamau*: "…mum …you have too much drama…".*

Similarly, systemic thought recognises that families are complex systems that are interconnected and interdependent. In the case of mothers and daughters of East African descent living in UK, intergenerational transmission of beliefs, values, and cultural practices from one generation to another, can have a significant impact on the relationship dynamics and overall wellbeing. Take for instance, when Namubiru(mother) and her daughter (Zalwango) talk about the role of women in this interview:

> Namubiru: *They are perceived to be strong (women)…and believing that something has gone mentally wrong with me and I cannot cope…with caring for my family…would be a bit difficult to accept…*
>
> Zalwango: *To accept…yeah.*
>
> Zalwango: *I feel like…they just feel like…I have to go on…I have to do this for my family…*
>
> Namubiru: *Yeah…*
>
> Namubiru: *It is just like other illness…a mother will be very ill but they have to carry on…you know…*
>
> Zalwango: *Caring for their children…*
>
> Namubiru: *They have to carry on…or even thinking it cannot happen to me…sometimes we do it unknowingly…*

Namubiru: *Back home I would employ some house help but here this is almost impossible…too expensive…too many challenges here…*

Conclusion:

Qualitative data that was collected from the four focus groups and three mother-daughter dyad interviews helped to address the aims of my study. The study aims were to begin to understand how women of East African descent express their emotional / mental distress. It also aimed at beginning to understand how to target key services for this community and other BAME communities. The three themes that I used to organise the data helped to address key research questions for this study. Each theme generated two sub themes which were used to organise the data more coherently. Theme one- expression of mental distress or wellbeing – generated two sub themes: the notions of difference/ other and resilience. Theme two – Emotional health and distress – generated two sub themes: awareness and help seeking. The third theme – Help seeking behaviours- has two sub themes: treatment modalities and systemic / attachment theories. Findings from the analysis will inform how distress among this community is understood, not only amongst the concerned individuals but also by various healthcare providers.

Both quantitative and qualitative data in this study helped to deepen my understanding of the research aims and questions. The analyses helped to address the various generational differences and contradictions within the East African communities and other BAME communities living in UK and the diaspora at large. One of the interesting contradictions is the realisation that there were differences between quantitative and qualitative findings. Quantitative findings in this study revealed no major differences between mothers and daughters whereas the qualitative component of this study suggested some differences between mothers and daughters. I would argue that the difference in findings may have been due to the different methods utilised in data collection (i.e. survey vs semi-structured interviews).

Chapter Six: Discussion

We live in turbulent times, on the edge of uncertainty. As the world around us has changed so dramatically in recent years, we yearn for strong and enduring family bonds, yet we are unsure how to shape and sustain them to weather the storms of life.

- *Froma Walsh (2016:3)*

6.1: Introduction

This study focused on aiming to understand expression of distress and wellbeing for mothers and their daughters of East African descent living in UK with a view to address their help seeking behaviours. It also aimed at beginning to target key services for this group and to inform current debate relating to accessing health and social care services that are inclusive. I conducted four focus groups; two groups with mothers who were born in one of the East African Countries (Uganda, Kenya, Tanzania, Rwanda, Burundi, and Democratic Republic of Congo – DRC) and later migrated to UK. Two groups with their daughters who may have been born in UK or migrated to UK at a very young age also took part. Three mother-daughter dyad interviews were held following the focus groups.

Similarly, a survey consisting of 42 questions was completed by fifty (50) participants at various sites in London and Essex. All the participants in the focus groups also completed the survey. Survey data that was generated from the questionnaires was analysed using the Statistical Package for the Social Sciences (SPSS). Some of the questions on the questionnaire helped to provide anecdotal talking points by some participants in the focus groups. For the focus groups and mother-daughter interviews, I utilised narrative analysis for the purpose of conducting the qualitative analysis that eventually generated three distinct themes.

Reflecting on the methodology used in this study:

This research utilised a mixed methods design with the anticipation that this would generate numerous viewpoints of the research topic and therefore provide more in-depth insight that could not be gathered from a single perspective (Ochieng, 2014). I was able to hear people's first-hand views on either personal experiences or those of people they know with regards to mental and emotional wellbeing. This provided a deeper understanding of some of the concerns in these communities as well as how they perceive the healthcare industry both in UK and their various East African countries. I felt

that the mixed methods research approach was best suited for my project as I was able to generate multiple viewpoints especially with regards to how people of East African descent experience mental and emotional wellbeing in UK in comparison to how they understand or experience mental / emotional wellbeing from East African perspectives. Interacting with both quantitative and qualitative data enabled me to gain an in-depth understanding of some of the barriers to seeking help for people from the East African communities and possibly for other BAME communities. I was also able to recognise some taboo subjects such as talking about witchcraft or traditional healing in open spaces for many of the participants. On the other hand, I found using mixed methods very time, labour, and resource intensive. For instance, printing and circulating the questionnaires to the four 'recruitment' centres was quite expensive in time and money. Nevertheless, on completing the study, I feel that using mixed methods provided me with enough data that has helped me to draw some conclusions about my research questions and aims of the study.

6.2: Do the mothers differ from their daughters in how they express distress and wellbeing? (Quantitative Surveys)

I would argue that this seeming convergence in views may have been because the mothers in this study have lived in UK for a considerable period which may have had an impact on their current views on how mental illness develops. It could also be because of the mothers' education and enlightenment levels which may have exposed them to other perspectives that may differ from other people in East Africa who may not have necessarily been exposed to the experiences of their counterparts who migrated to UK / diaspora. Many of the people that I approached during the process of completing the survey that declined to take part, more than often talked about their views that mental health / illness was a Western concept and form of indoctrination. Some would even express that mental health and by extension the overrepresentation of people from minority ethnic groups in mental health services was a form of social and political control.

Harrison et al (2017) have highlighted that women from East Africa are faced with a plethora of obstacles, each of which has the potential to have a detrimental impact on their mental health. Although the research by Harrison et al (2017) focused mainly on physical health and treatment, they suggested that socio-cultural factors such as poor incomes and poor support networks were key indicators for poor physical health which also impacted on mental and emotional wellbeing. Another study by Holmes et al (2020) revealed that minority communities (including people of East African

descent) in the UK experience crucial difficulties in both their wellbeing and socio-economic status which inadvertently impacts on mental wellbeing. Nevertheless, this study focused mainly on those women of East African descent and their adult daughters.

Bowlby (1944) underscored the significance of the subtleties of the emotional atmosphere in the environments where children are brought up. Many of the women that I interviewed have had to adjust to living in UK whilst bringing up their children. Bowlby's concept of the internal working model as a representation of the self-in-relation-to-others that influences the individual's emotional life was one of the pertinent ideas that informed my curiosity whilst undertaking this study. I was, for instance, interested in the attachment stories for those that volunteered to take part in this study in comparison to those that declined (regardless of the reasons offered for not taking part or dropping out after agreeing to take part). This is another study that would perhaps be of interest to deepen the understanding of help seeking behaviours of the East African community in UK.

Many people within East African cultures possess different values, beliefs and attitudes towards mental and emotional wellbeing compared to their Western counterparts (Okello et al., 2012). Seeking help for mental / emotional issues from professionals may be viewed as a weakness and can lead to feelings of being stigmatised. This study found that this continues to be the case for most of the mothers who took part. Their daughters were more willing to seek professional help. Some of the daughters also tended to be mistrusting of the community route of seeking help (i.e.: through talking to community leaders / elders / traditional healers).

Although ethnic density tends to provide both health and social protection to communities, women from ethnic minority groups including those from East Africa tend to bear the additional responsibilities of taking care of other members of their community (both young and old). Many of the people that took part in this study talked about the additional strain that ethnic density brings to women. Some who choose not to conform are portrayed as '*sell outs*' or '*coconuts*'. Both these terms are derogatory and may drive some people into isolation from their communities. Women that choose to conform to pre-existing socio-cultural expectations may have additional roles to play in the community in addition to working in paid employment and taking care of their families.
This is inevitably strenuous and emotionally draining for some (Egziabher, 2014).

Social and self-stigma can be formed when communities generate acceptable ways of behaviour in specific social groups. Those that do not conform can feel stigmatised. According to Craig and Richeson (2016) influential people in society such as community leaders, employers etc. tend to

generate and perpetuate social stigma during interpersonal interactions. Social stigma can further broaden the parameters of what constitutes acceptable behaviour or ways of being in a particular community and society beyond. In other words, how these women are perceived by the community can induce both social and/or self-stigma and may influence how they perceive or talk about mental / emotional health issues as a way of preserving themselves or for fear of being discriminated against or shunned by their community. For women of East African descent who have migrated to the UK, social stigma can create many barriers. Culturally, East Africa is a patriarchal society. Many women who have migrated to the diaspora from East Africa have not only had to at times become the sole bread winners, but some have ended in single parenthood. In patriarchal societies, women who are sole breadwinners or those that are single parents are deemed to be poor in character at best or immoral and a bad influence in the community. These ideas that may be held by the community are very conducive to the formation of both self-stigma and systemic stigma (Tyler and Slater, 2018).

Social stigma for these women can also originate from the country of origin due to any changes that may have taken place since relocating to UK. Some women may live in fear of the relatives they left behind learning that they were not living according to the previously held cultural norms and values. This also seemed to apply to the daughters where some felt that they at times feel uneasy when interacting with extended relatives, both in UK and in their respective East African countries. This can create a double-edged sword of sorts where some women feel uncomfortable both by the new changes and trying to hold on to previously held cultural / social values. The women in this study talked about how social stigma has shaped some of their perceptions about mental / emotional wellbeing.

6.2.1: People with mental illness should not be given any responsibility.

Historically, women in East African settings have had to play the role of carers in their families and communities at large. This would be the case where members of the family with mental illness required support (Okello & Ssegane Musisi, 2015; Eliacin et al, 2013). This phenomenon is not unique to women of East African origin. In the UK, majority of the workforce in the NHS in lower and middle management, for example, are female. Coincidentally, a study by Lee et al., (2019) reported an alarmingly high occurrence of mental and emotional health difficulties among women in UK. There are numerous explanations for the high occurrences of mental / emotional difficulties among women when compared to their male counterparts (Edge and MacKian, 2010). Some studies suggest that women find it easier to talk about their health issues (Liew, 2012; Dein, 2020). Others report that

women tend to seek help from healthcare professionals more easily (Sotubo, 2020; Ally and Brennan, 2015**)**. It is possible to argue that this finding is in keeping with what would be expected of mother-daughter dyads that exhibit more secure attachments as these participants seemed to be. Their shared belief systems which are usually at the core of family functioning seem to generally embody values, convictions, attitudes, assumptions, and biases which may have coalesced to inform decision making, guide actions and trigger emotional responses (Walsh, 2016). Similarly, shared belief systems can also foster resilience in families especially regarding communication, organisational and problem-solving processes according to Dallos & Draper (2005). Also, these mothers who have experienced adversity both pre and post migration may have utilised their resilience to guide their daughters (families) in enhancing their problem-solving, mutual support, and meaning making. Exploring whether the participants in this study would feel comfortable employing or working with individuals who disclose a history of mental illness would have been interesting.

6.3: **Marry someone who has suffered from mental illness.**

Mothers and daughters differed in their views when it came to whether they would marry someone who has suffered from a mental illness; (F statistic = 4.6, p = 0.03). Several explanations can help in understanding this difference. The mothers who grew up in East Africa would probably have been socialised with ideas that mental illness is a Western concept. Or, as Collignon (2015:163) suggests, Western imagination had already conjured the African as primitive, "making it difficult to conceive of a mad African", rendering the very nature of colonial relations in helping to explain the erring traditions of colonial psychiatry. On the other hand, social and cultural stigmatization of people (and by extension, their families) with a history of mental illness by many people of East African descent may also have informed the mothers' views in comparison to those of their daughters. Fear of being ostracized and gossiped about both in the diaspora and back in the home countries may also have informed some of the participants views. The daughters who may not have experienced such ostracization may not necessarily hold similar views to those of their mothers when thinking about who they would marry. It is also possible to suggest that the younger generation (of daughters) is more open to new ideas about causes of mental / emotional ill-health and how these can be treated.

6.4: 'Normalising' taking care of people with mental /emotional illness in the community.

According to the World Bank (1998/1999) healthcare in general in most African countries is poorly funded. Mental health care services and policies for many of these African countries, including all the East African countries, are less developed and poorly funded of all health services (WHO, 2020;

Okasha & Karam, 1998). This has traditionally created a necessity for communities to take care of their sick relatives within their settings as opposed to seeking help from professional healthcare settings (Ayón, Ojeda and Ruano, 2018). Traditional healers who share a history, culture as well as environment with those who consult them are widely dispersed in all the East African countries (Okello & Ssegane Musisi, 2015). During a study of the people who live in Kilungu Hills (Kenya), Good (1980) identified several specialities within traditional healing that comprised of herbalists, diviners, midwives, and circumcisers. Traditional healers are more culturally acceptable in most African settings and are distinguished from the practice of witchcraft and sorcery which can be believed by some to be a cause of both mental and emotional illness.

Caring for the sick or where necessary, seeking the help of traditional healers seems to be ingrained in people who have grown up in East Africa that the women in this study did not seem to find caring for people with mental or emotional illness in the community cumbersome or out of the norm. Some of the participants also talked about the thinking that taking those who are unwell to be cared for in hospitals would be a form of abandonment. This may hinder some from accessing help from professional healthcare settings due to the fear that they may be hospitalised. Previous practices from home countries such as consulting with herbalists (traditional healers) may also contribute to the reluctance to seek help from Western trained healthcare professionals. For most of the daughters that took part in this study, treating people with mental illness in the communities was mainly preferred due to convenience as well as being the norm in UK Mental Health care policy.

6.5: Visiting General Practitioners (GPs) to seek help for a mental / emotional health problem

Fear of being judged or misunderstood by GPs was the most proffered explanation for many participants reluctance to talk to their GPs about their emotional issues. Many participants felt that Western trained GPs may not be aware of pre-migration and post migration challenges that they encounter. Some participants explained that their GPs did not know enough about their culture, norms and beliefs and were quick to locate every issue within the medical model. Others expressed worry that they would be judged by their GPs if they were to tell them the truth about the real challenges that were causing them distress. Many participants cited their challenges with various immigration issues as very emotionally disturbing, but they would find difficulty in telling their GPs that this was the underlying issue. Instead, they would talk about symptoms such as lack of sleep for which GPs would respond by prescribing sleeping tablets.

Younger participants generally felt that red tape and the bureaucracy involved in accessing their GPs was a barrier for them. They also agreed largely with their mothers, that GPs tend to prefer the medical model of treatment and rarely suggest talking therapies to their patients as a first step. All the participants in this study understood how healthcare is organised in the UK where GPs form the core of Primary healthcare. Some participants drew a difference between how UK healthcare is organised and how healthcare in their respective 'home' countries is organised. They offered that in their respective countries they would have been able to access healthcare services quicker, as they would be paying privately. Although challenged by some about those who cannot afford to pay, some said they did not know how to solve that problem.

6.6.1: How mothers and their daughters talk about emotional health or distress

The second and larger part of this study utilised four focus groups and three mother – daughter dyad interviews. Within the focus groups and the mother dyad interviews, compelling discussions about what constitutes mental / emotional distress were explored. My initial hypothesis was that mothers hold different perspectives about mental / emotional health and wellbeing when compared to their daughters. What I was not sure of was how the different perspectives between mothers and their daughters would manifest. The results support my initial hypothesis and may help to address how to enhance timely access to mental health care and wellbeing for this community and many other communities like those of East African descent.

The daughters in the two focus groups seemed to be more open to the idea of talking about mental and emotional health in a more personalised way when compared to their mothers in the same study. Where mothers tended to speak in a more general way, the daughters in this study were able to give examples of themes and people known to them. Similarly, younger participants seemed more open to conversations around some 'taboo' issues like criticising community leaders, racism, and witchcraft among other things. Equally, the younger participants were open to talking about issues within their families although, I was not able to find out whether such openness was only meant for the interviews. The interactions within the focus groups seemed to agree with the observations by Ochieng (2005; 2010) where she argued that black children in UK grow up in the ambiguity as well as the marginality of living simultaneously in two worlds – the world of the mainstream White population and the world of their black community.

6.6.2: Expression of mental distress or wellbeing

The notion of difference / Otherness as perceived by the participants in this study.

According to Harkness and Super (2014), when it comes to the way in which parents in East Africa and parents in the UK bring up their children, there are substantial cultural disparities between the two groups of parents. Interactions and relationships within a family system are interconnected and interdependent hence any changes in one part of the system can affect the emotional wellbeing of all members (Holmes & Slade, 2018; Dallos & Draper, 2005). According to McPherson (1999), for black families in UK, parenting occurs within the uncertainties of a social system which accentuates democratic equality for all citizens and institutional racism for its minority citizens. Parents from East Africa tend to have a greater propensity towards establishing a structured hierarchical family structure with the assistance of members of their extended families as well as the community (Owiny, Mehta and Maretzki, 2014). Nonetheless, most Black families in the UK have complex relationships with people in the same ethnic group, discovering common ties or alliances and it is not uncommon for black children to refer to people who are not blood relatives as mother, aunt, uncle, or brother (Ochieng, 2010). It can be argued that it is these complex family relationships that mitigate the absence of the extended family system.

On the other hand, Owiny, Mehta and Maretzki (2014) have highlighted that parents of East African descent have created a variety of parenting methods that are influenced both by their upbringing and the present family structures in their homeland. When it came to instructing and guiding their children, Okello and Novelli (2014) have shed light on the fact that the previous structure of their family featured significant contributions from a variety of members of the extended family in addition to feedback from neighbours. When there is a conflict between two distinct parenting styles that are practised in two different geographical regions, it may create some tension for East African immigrant mothers who live in the UK and their families (Akhtar,1999; Ochieng & Hylton, 2010).

The most prevalent cause of stress associated with relocation is deprivation on a social and economic level. A shift in cultural norms has the potential to affect not just an individual's sense of self but also the way their family lives. De Maynard (2009) argues that the numerous responsibilities and commitments that immigrant mothers have both at home and at work may also act as a barrier to their capacity to receive mental health treatment for either themselves or their children. It is estimated that the risk of postpartum depression for mothers who were not born in the UK is two to three times

higher for immigrant mothers than it is for mothers who were born in the UK. Country development and income inequalities are among some of the explanations for postpartum depression epidemiology. However, lack of social support was reported as the most influential factor for postpartum epidemiology regardless of whether research was conducted in a developed or developing country (Wang Z, Liu J, Shuai H, et al., 2021). There is a growing body of evidence that suggests that parental beliefs, warmth, availability, and support can contribute to their children's healthy emotional wellbeing (Kilroy, Egan, Maliszewska, and Sarma, 2014; Walsh, 2016).

Smith & Tang (2006) identified that apart from race and culture, there are other complex subjective and objective factors which are based not just on the visible external differences, but other non-visible differences such as class, ethnicity, and religion which also play a role in subjectivity, identity formation and 'otherness'. Frosh (2009:186) argues that whilst "addressing issues of racialized oppression and conflict, family systems theorists and therapists – overwhelmingly white and western – have had to think through what it might mean to be confronted with 'otherness', including how they are incorporated into it and also how they might face the limits of understanding and of the appropriateness of their methods." The women in my study reported their experiences of 'otherness' in a racialized and culturally different space in UK as an important factor in how they express and seek help for their mental and emotional wellbeing. Although, with systemic thinking – and indeed with other psychological theories, otherness and difference can be bridged when all human encounters are construed as relationships that take on multiple stances from which all social and relational phenomena can be articulated and understood (Bertrando. 2015; Frosh, 2009).

In systemic thinking, the notion of the 'other' refers to the idea that individuals and groups define themselves in relation to those who are different or outside of their own group. The other can be seen as an opposing force, a source of threat or danger, or as an opportunity for growth and learning (Dallos & Draper, 2005). According to systemic theory, the other is a crucial factor in shaping the dynamics of relationships and communication. It is through interaction with the other that groups as well as individuals can establish their own identity, values, and beliefs. The systemic perspective views the other as simply not a passive object or target of observation, but an active participant in the process of communication and interaction. Thus, the other is seen as having agency and autonomy, and as capable of influencing and shaping the dynamics of relationships and communication. The concept of the other is particularly relevant in contexts of social and cultural diversity, where individuals and groups with different backgrounds and experiences interact and negotiate their

differences. In such contexts, the other can be seen as a source of richness and diversity, but also as a source of conflict and tension. Systemic thinking encourages individuals and groups to engage in dialogue and negotiation with the other, to build mutual understanding, respect, and collaboration (Walsh, 2016; Bertrando,2015; Frosh, 2009).

Dalal (1997) has placed emphasis on how skin colour as a component of race not only influences one's external world, but also the internal world. This creates colour coded psyches. Dalal (1997) underscores how important it is for therapists to recognise the external realities of their clients relating to race, for the therapists to enable the client to begin working with the racial other, by addressing the internal world through the transference. Dalal (1997) seems to be highlighting the intricacies of the multiplicity of identities which merge into each other when we try to categorise people. Jessica Benjamin, a Feminist scholar, explains this seeming intersubjective stance as a particular shift within a broad realm of relational theorising. She refers to the intersubjectivity as a 'subject – subject psychology' (Benjamin, 1998). Systemic work and thinking recognise Benjamin (1998) stance on intersubjectivity as 'co-creation' which point to the mutual notions with relational psychoanalysis that subjects actively engage with one another in 'world building' (Frosh, 2009). It is further argued by Frosh (2009) that intersubjectivity helps in the recognition that the self should not be absorbed into the other. Benjamin offers an unambiguous distinction between omnipotence and recognition thus:

> "The tension between recognising the other and wanting the self to be absolute (omnipotence) is, to my mind, an internal conflict inherent in the psyche; it exists independent of any given interaction – even in the most favourable conditions. It is not interpersonally generated but is, rather, a psychic structure that conditions the interpersonal. The problem of whether we can recognise the other person as outside, not the sum of, our projections or the mere object of need, and still feel recognised by her or him, is defining for intersubjectivity" (Benjamin, 2000: 294).

Recognising intersubjectivity whilst working with others whether in therapy or in research, requires an ongoing reflective process. This would help people such as those that took part in my study to trust the processes and to possibly open themselves to possibilities of seeking help for their emotional and / or mental wellbeing.

6.6.3: The notion of being resilient for people of East African descent

The Oxford dictionary defines Resilience as the term used to describe the ability of an individual or a community to cope with stress, adversity, and trauma. The term resilience originates from the Latin word *resilire*, meaning 'to rebound or spring back'. Rutter (2012:335) offers that Resilience is 'patterns of positive adaptation in the context of significant risk and adversity'. Indeed, many in the field of mental / psychological and other health sectors regard resilience as a hot topic currently (Rutter, 2012; Southwick et al., 2014).

Women of African descent especially those from sub-Saharan Africa have a long history of resilience in their mental and emotional wellbeing. Some of these women have faced numerous challenges, including war, famine, displacement, and discrimination, yet they have managed to maintain their mental and emotional wellbeing without necessarily coming to the attention of Healthcare Services (Akyeampong, Hill & Kleinman,2015; Patel & Stein,2015). Systemic therapy / thinking, as an approach, recognises the interconnectedness between individuals, families, and communities. This perspective emphasises the importance of understanding the context in which individuals live and how this context can affect their emotional and mental wellbeing (Walsh, 2016). Most of the earlier research on resilience focused on individual resilience, with emphasis being placed on prevention and early intervention to mitigate risk and increase protective factors (Masten, 2014). A sense of coherence, that is, one's belief that life challenges are understandable, important to confront and manageable, enable proficiency and can improve one's quality of life (Antonovsky, 1998). Other researchers such as Seligman (1990) have advanced that possessing an inner locus of control – a belief in the ability to shape events or 'learned optimism' – informs our understanding of resilience. According to Rutter (1987), whilst most early resilience research tended to emphasise individual qualities and temperament such as easy temperament, high intelligence as beneficial, these are helpful assets but not vital for resilience.

Research on resilience has expanded to wider social and psychological contexts that consider risk and resilience under overwhelming psychosocial conditions such as poverty, domestic and community violence (Rutter, 1987; Rutter, 2012; Walsh, 2016; Holmes & Slade, 2018). The women in this study demonstrated their resilience in many aspects of their lives and relationships. The women also demonstrated strong and deep connections to their culture and traditions as key to their ability to be resilient. Maintaining cultural practices from home countries such as wake keeping, in person for weeks, with a family that has lost a loved one (whether the person who has passed is in UK or

back in the home country), music, dance and storytelling are key contributors to how some participants in the study felt that they were able to maintain their resilience. However, some of the women in the study felt that maintaining these practices in UK placed them under more strain as women due to their roles as 'carers in the community'. Cultural practices such as communal wake keeping are said to be blamed for the high rates of Covid-19 sufferers and deaths in the African communities in London during the first wave. Nevertheless, these practices also help to pass on their cultural heritage, traditions, and values to the next generation (of their daughters and beyond). They demonstrated a strong sense of community and family support although this was also described as a source of tension and contributing to some of their stress. The women in this study talked of the tensions within their families not only as stressors but also a necessary component to family settings and the eventual development of their individual and group resilience (Abbo, 2011; Watson, 2021).

The women in the study also felt that a reliance on God or a higher spiritual being during difficult times can help to maintain a positive outlook on life, even in the face of adversity and to effectively boost one's resilience. Some also described their ability to adapt to change, willingness to learn from experiences and determination to overcome obstacles. Belief in God or a higher spiritual being helps many of the women to maintain health physical and mental wellbeing and as an effective treatment modality when in distress (Dein, 2020; Turner, 2021).

Whilst thinking about my study, I would agree with the findings by various researchers (Antonovsky, 1998; Rutter, 2012; Walsh, 2016) that a combination of individual attributes such as temperament and high intelligence, as well as a sense of coherence and learned optimism in resilience may have contributed to the profile of the individuals that agreed to take part in the study.

All the mothers who participated in the study described various adversities both before and after relocating to the UK. Their daughters also described some adversities both within familial, their community and the outside world that they had ably navigated or overcome. However, they were also keen to emphasise that they had been able to overcome many of the challenges and to beat many odds. I am not suggesting that those who declined to take part were necessarily less resilient, but I am simply observing that the participants in this study demonstrated this attribute. Many of the participants reported good attachment histories with their daughters whilst utilising their ability to mentalise and to place their challenges within the respective contextual and relational spaces, as

well as building relationships (Holmes & Slade, 2018). In that regard, the people who took part in *this study* talked about how they use their resilience to build on strengths and develop new coping skills to maintain healthy mental and emotional wellbeing.

6.6.4*:* Emotional health or distress

Awareness of various mental and emotional wellbeing issues.

Mental health issues are often stigmatised and overlooked both in the West and in developing nations. This is the case for many East African communities living in UK (Henry, 2010; Linton & Walcott, 2018). Within many African communities, mental or emotional issues are often dismissed as a personal / familial weakness or spiritual problem, which can prevent individuals from seeking help. Serious stigma attached to mental illness may prevent people from speaking out (Read, Duko & De-Graft Aikins, 2015). It is particularly true for communities from East Africa living in UK, where cultural and language barriers can make it difficult for individuals to access mental health support (Ochieng, 2010). Raising awareness of mental health and destigmatising mental health challenges are some of the ways in which the challenges and barriers can be addressed. It can also help towards eradicating both social and self- stigma.

Tackling both social and self-stigma by raising awareness through community engagement and education, including mental health workshops and support groups, is key to achieving this. Crucially, this would involve providing accessible mental health services that are culturally sensitive and linguistically appropriate. This can mean providing interpreters, bilingual counsellors, and mental health services that are tailored to the specific needs of the East African community. Some research has indicated that for many BAME communities, involving community leaders and organisations, in the promotion of mental health awareness and support, would be helpful (Weich et al., 2014; Singh et al., 2013). Interestingly, the participants who took part in my study, expressed sceptism and reservation regarding this view. Some of the younger participants expressed views such as the contention that most community leaders, just like many other elders in their communities, lacked mental health literacy. Others also argued that some community leaders played some role in perpetuating some social and self-stigma through practices that tend to marginalise women.

Although in this study I was interested in the general awareness of mental and emotional health issues, I was particularly curious about the participants' self-awareness of their emotional needs and wellbeing. Systemic theory and thinking emphasise the interconnectedness of individuals

and their environment. From a systemic perspective, emotions are not solely internal to an individual, but are also influenced by the social systems in which they exist. "Any system, in our opinion, is an emotional system. Or, better, any system can be regarded *also* as an emotional system" (Bertrando & Arcelloni, 2009:79). Self-awareness of emotional wellbeing requires recognition and understanding one's emotions, and how they are influenced by one's relationships and social context. This includes being aware of how emotions are expressed and managed in different contexts, and how they impact relationships with others. Ability to effectively communicate one's emotions to others and to feedback in relationships in a constructive way is essential. Systemic frameworks also recognise the importance of the larger social systems in which individuals exist, and how these systems can impact emotional wellbeing. Self-awareness of emotional wellbeing requires acknowledging the effect of larger social systems on one's emotions, and being able to navigate these systems in a way that supports emotional wellbeing (Bertrando & Arcelloni, 2009; Bertrando, 2015). There was evidence of self-awareness in all the participants though it seemed that the two cohorts of mothers and their daughters expressed their awareness differently. Some daughters questioned why their older relatives would weep openly, after losing a loved one and, as one of the daughters put it, '*even if the dead person was really old'.* Such difference in self-awareness may help to illuminate on reasons why the mothers and their daughters, who took part in this study, seemed to disagree on how to seek help for emotional or mental distress.

Help seeking for emotional / mental wellbeing.

Systemic thinking conceptualises help seeking as a collaborative and interactive process that occurs within a social system. Help seeking is seen as a part of a larger network of relationships and interactions, and is influenced by multiple factors including cultural norms, family dynamics, and the individual's beliefs and values. Systemic thinking, a perspective that is mainly rooted in social constructivism, views emotions as co-constructed through discourse (Pocock, 2009). We learn to express our emotions, by being involved in our cultures, and these possess their specific local emotional grammars (Friedman (2004).

Weisner, Bradley & Kilbride (1997) wrote about the crises that faced the African family, suggesting that intense economic, demographic, political and social pressures were impacting heavily on the traditional African family. Intimacy, affection, and kin solidarity have traditionally been the bedrock of the African family (Geest et al., 2019). However, others fear that the extended family

system which was (is) synonymous with many African family structures and relations will eventually erode or become extinct, giving way to other forms not very familiar in African society, due to globalisation (Atta-Asiedu, 2020; Nyame & Read, 2019; Coe, 2014). Recognition that caring for members who need care, especially the sick and the vulnerable has always been the preserve of the family (Geest et al, 2019), and that the multiple roles performed by African women, are progressively experiencing structural changes (Adepoju, 2005), contribute to these fears. Nonetheless, the family is not a "mere hapless victim of global change but a proactive, resilient agent and creator of change" (Weisner et al., 1997:60).

The women in this study also talked about some barriers to help seeking that extended to community and organisational systems. These included the fear of being misunderstood both by their respective communities as well as the healthcare providers. Social stigma in the community which extends to families back in the home countries, where 'admission' to being emotionally or mentally unwell could have adverse impact on their respective families of origin was described as a concerning barrier. Both mothers and their daughters talked of their belief that institutional racism in UK, whether perceived or real, seriously impacted on how they make decisions to seek help from professionals.

For the mothers in this study, negotiating the emotional local grammar (Friedman, 2014) whilst recognising *their* interconnectedness with social systems that stretch to their home countries, seemed to inform not only how they experience and communicate emotional distress but also how they seek help. For some mothers in this study, the changing multiple roles they perform when compared to their counterparts back in their home countries, were both a source of conflict and relief. Conflict due to feeling that they were slowly losing their cherished African traditions and values, but also relieved that they did not feel compelled to conform to tradition. This conflict and relief also seem to emanate from these mothers' experiences of values held in Western cultures of independence, self-sufficiency, and some avoidance of overt displays of emotionality. It is interesting to note that though Dallos & Draper, 2005:141 regarded these values largely "as male characteristics and valued in patriarchal societies", this view has been challenged by many contemporary theorists, researchers and commentators including these same authors. It is now being recognised that human emotional systems are complex, not gender specific or obvious (Dallos & Draper, 2015; Bertrando, 2015; Pocock, 2009). Many of the daughters, on the other hand, perhaps because they possess a grasp of the local emotional grammar and are not as attached to the home countries, seemed to be

less conflicted. Nevertheless, daughters seemed to agree with their mothers on how they would go about seeking help, revealing a complex and multifaceted process in help seeking.

6.6.5: Help seeking behaviours.

Treatment modalities for emotional or mental health issues.

(i) Prayers / Religious beliefs

One of the aims of this study was to seek to understand how the women and their daughters, and by extension, people of East African descent living in UK, express emotional distress and seek help for their distress. Nearly all the participants in the study identified prayer as their most preferred treatment modality. Their views are not so different from those of many other humans. Walsh (2009:3) argued that across cultures and over the millennia, "people have lit candles, prayed together, meditated, and quietly turned to faith for solace, strength, and connectedness in their lives". The notion that spiritual beliefs foster ways of dealing with adversity, the experience of suffering, and provide meaning to symptoms, is therefore not unheard of (Walsh, 2009; Read, 2012b; Okello & Seggane Musisi, 2015; Atta-Asiedu, 2020).

Thinking about spiritual beliefs, Walsh offers that:

> "They also influence how people communicate about their problems and pain; their beliefs about the causes and future course; their attitudes towards professional helpers - in pastoral care, mental health, health care, and human services - as well as faith healers; the treatment they seek; and their preferred pathways in problem solving or recovery" (Walsh, 2009:4).

Some of the participants expressed that praying, when experiencing emotional distress or mental pain, was free and therefore easily accessible. In one of the focus groups, Wambui mentioned, "*To be honest? …I would pray first…I am a Christian you know…so I would pray*". Through prayers, many felt that they were able to connect with a God or supernatural higher power. Some participants in the study also expressed that they felt able to keep their distress or pain unknown to others around them, whilst simultaneously seeking guidance, through prayer, from a supernatural higher power. Both mothers and their daughters identified their spirituality as a fundamental factor to their resilience. Most of the older participants talked about belonging to various prayer groups. The prayer groups could be seen as spaces where some of the participants expressed and shared their distress. Prayer groups can also serve as spaces where mental health awareness is disseminated in a non-threatening / non-invasive way and indeed, many faith communities in UK and Africa are

now utilising this space for the purpose of disseminating information on health and other issues (Linton & Watson, 2018; Atta-Asiedu, 2020; Lloyd, Mengistu & Reid, 2022).

Prayer as a key feature of religions, particularly in Western monotheisms (Ladd & McIntosh,2008), is an intricate and diverse phenomenon. Prayer can function as a basis for coping, purpose and meaning in an individual's life and may facilitate social bonding (Koenig et al., 1997). Just like many participants in my study, some researchers have asserted that many aspects of prayer can enhance mental well-being (Dein, 2020; Ochieng, 2010). The participants in my study tended to refer to prayer using Western monotheisms (of Christianity in its variations) or Middle Eastern monotheism (of Islam). Many writers explain this supposed belief in monotheist religions as a function of colonial and neo-colonial legacies (Fannon, 2005; Turner, 2017; Atta-Asiedu, 2020). There was also a sense that the participants were responding to this study from a Western perspective where they made assumptions of what was required by a researcher that is based in the West (UK), regardless of this researcher possessing common ancestry with them. By this, I mean that, even when some participants were asked directly about their knowledge or views on other forms of spirituality and / or help seeking approaches, responses were either negative or derogatory. Mental / emotional distress within the global north is generally understood through natural interpretations that include medical and / or psychological discourses (Losif, 2011). According to Losif (2011), these medical and psychological discourses have largely continued to be hostile to religious systems, which have tended to draw attention to the role of spiritual aetiologies in mental / emotional health. Nevertheless, some contemporary discourses, such as some in systemic thinking, acknowledge the role that diverse spiritual aetiologies play in mental and emotional wellbeing (Walsh, 2009; Walsh, 2016; Dein, 2020).

Both mothers and their daughters in my study seemed to agree on the role of prayers and spirituality, in their personal and collective lives, even when they disagreed on how to practice or exercise their spirituality. Spirituality, including prayers, as well as belonging to a religious group, are some of the ways through which multigenerational family communication of stories and traditions are delivered. They can help to sustain continuity and stability during rapid global changes (Walsh, 2016; Burrell, 2021). For immigrant families, where it can be quite easy to lose one's sense of pride, identity, and community, due to pressures to assimilate to the predominant culture, preserving those generational traditions and rituals can be very vital when facing times of adversity. Falicov (2013) argued that most transnational families live "between two worlds" and often feel that they belong to

neither. Transnational families are encouraged to "live with two hearts" instead of a broken heart (Walsh, 2016).

Using data from the Baylor (2010) Religion Survey, Ellison et al. (2014) built on Attachment Theory and Evolutionary Threat Assessment Systems Theory (ETAS Theory by Flannelly,2017). Ellison et al. (2014) concentrated on two attributes of prayer: the connections linking prayer frequency and symptoms of anxiety and, the role of attachment to God in reconciling this relationship. They found no significant associations between prayer frequency and anxiety-related symptoms. Prayer and other religious practices are not always beneficial for some individuals suffering a mental disorder (Loewenthal, 2006; Pargament & Raiya, 2007). There seems to be an unclear or complex connection between spiritual beliefs and such mental health matters as anxiety, sexual disorders, psychosis, prejudice, and self-esteem (Dein, 2020; Ochieng & Meetoo, 2015). Similarly, Lloyd and Waller (2020) observed that some religious practices promote guilt feelings in religious believers because of their inability to follow the stringent rules of compliance, which can escalate levels of both anxiety and depression. Turner (2017), using the transpersonal perspective, observes that spiritual othering possesses both internal and external elements. The internal elements of spiritual othering maybe unconscious and involve self-annihilation in the course of being othered. Turner (2017:9) suggests that "it is the rigid nature of the judgements and opinions of the absolute which create this spiritual othering, judgements based upon fear of the infinite nature of otherness". Overall, religion and spirituality seem to be positively linked with good mental health, reduced use of drugs and alcohol, low depression, and criminal rates among the youth in the community, and positive wellbeing (Ochieng & Meetoo, 2015). It was interesting to note that spiritual beliefs in general and prayer in particular would still be preferred by the participants in my study, even when the individuals did not trust their religious and / or community leaders.

(ii) Traditional healing vs witchcraft

In many systems of African traditional medicine mental illness is known to be a consequence of discontented ancestors or through witchcraft. Traditional healers are thought by many in African communities to be experts in helping those experiencing mental / emotional issues (Okello & Seggane Musisi, 2015; Akol et al, 2018; Atta-Asiedu, 2020). Within African settings witchcraft and traditional healing are clearly distinguished. There is also a clear distinction between African tradition healing and African traditional religion (ATR) as will be explored here.

Witchcraft has been a prominent feature of the East African region for centuries. It is deeply embedded in the traditional African culture and beliefs, and many people in the region still believe in its power and use it to explain various phenomena in their lives. Witchcraft in East Africa is often associated with magic, sorcery, and supernatural powers that are used for both good and evil purposes. In East Africa, witchcraft and those who offer the services of witchcraft (witchdoctors) can be often erroneously associated with traditional healing practices. Witchdoctors employ witchcraft to diagnose and treat various ailments, including physical and mental illnesses through use of herbs, animal parts, and other natural materials to create portions and charms that are believed to have healing properties. Witchcraft is also used for divination, protection, and to gain power and influence in society (Dein, 2020; Atta-Asiedu, 2020; Read, 2012b). In many East African regions, witchcraft is largely associated with negative rituals such as sorcery, black magic, and bewitching. In many cases, people use witchcraft to harm others, and it is blamed for various misfortunes such as disease, death, and poverty. Witchcraft accusations are common in the region, and many people have been suspected and even killed for practicing witchcraft. In some cases, witchcraft accusations are used as a form of social control. People who are accused of witchcraft are often banished from their communities, and their families may be forced to pay fines or perform rituals to appease the community. Witchcraft accusations are also used as a means of settling personal disagreements or gaining power and influence over others (Abbo, 2003; Okello & Neema, 2007).

Witchcraft continues to play a significant role in East African culture and beliefs and its effect on society can be profound. While some people in the region still believe in the power of witchcraft, it is significant to note that accusations of witchcraft can be harmful and even fatal (Abbo, 2003). This may explain why many participants in my study were reluctant to discuss witchcraft. Although some of the younger participants- the daughters- expressed their curiosity by asking questions about witchcraft and traditional healing, many of the mothers seemed to be unwilling or reluctant to engage in this conversation. When they engaged, they seemed to express negative views on witchcraft. In one of the focus groups, a participant observed that the topic of witchcraft and witchdoctors was being avoided. Others observed that witchcraft, just like mental illness, was a taboo subject in East African communities. Some participants felt that the issue of witchcraft is not only misunderstood but also misrepresented whilst at the same time used to exploit those that are most vulnerable in the community such as those who are mentally or emotionally unwell. Some participants offered that some of the misunderstanding may arise from identifying some traditional rituals as a form of spirit possession, being under a curse, bewitched by others and / or demonic. This view is supported by

some research findings from studies by Dein, (2020) and Abbo, (2011) for instance, which observed that some people from the East African communities considered seeking help from witchdoctors as counterproductive and not good practice. For some of the participants in this study, the 'bad press' that witchdoctors and witchcraft generated were mainly due to Western propaganda. Many of the participants seemed to be aware of the existence of traditional healers who may not necessarily be witchdoctors. Interestingly, some knew of both witchdoctors and traditional healers of African origin that are based here in UK.

Traditional healers, on the other hand, are identified by the World Health Organisation (WHO) and defined as someone who is recognised by his or her community and other communities as skilled to deliver health services using plant, animal, and mineral substances as well as other approaches grounded in his or her social, cultural, and religious background (WHO, 1978; Abbo, 2011; Abbo, 2003). According to Okello & Ssegane Musisi (2015:250), 'traditional healing is a well-guarded family possession, with its knowledge and skills handed down through the generations. Diviners often look for "signs" in their children to distinguish to whom they might eventually pass on the traditional healing art'. Ndulo, Faxelid and Krantz, (2001) asserted that traditional healers are spread extensively and well placed to offer primary health care in the African health care system. Traditional practitioners maintain beliefs in the supernatural aetiology of mental disorders (Dein, 2020). During a study in Southwest Uganda, van Duijl, Kleijn, and de Jong (2014) observed how spirit possession was prevalent following traumatic experiences. They noted that spirit possession was a common idiom of distress at these times. Those suffering with spirit possession in Southwest Uganda generally described partial or complete recovery after consulting traditional healers. However, unlike their Western-oriented colleagues, they possess no formal training in dispersing medical procedures or medicines.

Traditional healers are not registered to practice in UK. However, this researcher has seen various leaflets and 'billboards' advertising traditional healer services in many inner-city boroughs in London, Manchester and in Scotland. Participants in my study did not talk of personal experiences of having consulted with traditional healers but some talked of being aware of their existence in UK. For some, traditional healers were the same as witchdoctors or the 'dodgy' pastors and Imams who were extortionist and sold empty promises of healing or obtaining good fortune such as getting their immigration status in UK approved by the Home Office. It is tempting to argue that attempts to assimilate within mainstream culture that is largely Western-oriented as well as the concealing nature in many African families; '*eby'omunju tebitotolwa'* – literally translated from the Luganda language as

'do not talk about what is in the house (family) to strangers' – may have contributed to how participants chose to talk about traditional healers and witchdoctors during this study. This is not only a cultural taboo in the East African region but also found in other BAME cultures such as Afghanistan (Berdondini, Kaveh & Grieve, 2021). This is a phenomenon that many family and other systemic therapists, as well as other clinicians who work with BAME communities may be very familiar with and which needs very careful navigation (Lago & Charura, 2021; Dein & Littlewood, 2020; Walsh, 2016). However, others have advanced factors like neo-colonialism, neo-Pentecostalism and the rise in black churches / increase in Islamic teachings in UK as contributing to the low profile for traditional healers both in East Africa and UK (Akol et al. 2018; Atta-Asiedu, 2020; Lloyd & Hutchinson, 2022). Some ardent proponents of the African traditional religion (ATR) argue for redressing this seeming imbalance.

(iii) African Traditional Religion (ATR)

The term African Traditional Religion (ATR) is used in most academic discourse on the subject but generally, ATR is a form of traditional healing. ATR refers mainly to the 'branch' of traditional healing that concentrates mainly on traditional spiritual beliefs, diviners, and worshipping of deceased ancestors (Mbiti, 1990; Okello & Seggane Musisi (2015); Atta-Asiedu, 2020). ATR does not include 'consultations' with witchdoctors and that is the only exclusion, but all the other forms of traditional healing are variations of ATR. According to Lloyd (2023), individuals who practice within Evangelical / Pentecostal sects of Christianity may be quick to accept spiritual aetiologies (the belief that mental illness is caused by demons, sin, diminished faith, or other spiritual causes). Ultimately, some of these individuals tend to "pray away" mental illness or suffering. This may lead to the neglect of relational, social, and wider systemic causes of mental illness which would be a very adverse outcome (Scrutton, 2020b). Many Africans including many that took part in my study have contributed to the significant rise in the 'Black church' in UK (Rogers, 2017). Whilst this rise has been applauded as a positive outcome and a mitigator of positive social and mental wellbeing (Lloyd et al., 2022; Ochieng & Meetoo, 2015), others have argued for the seeming conflict for Africans who may struggle to maintain their cultural identities as African people living in the UK / diaspora (Dien, 2020; Atta-Asiedu, 2020). Hence, some have looked to Prof John Mbiti's (1969) exposition of the African traditional religion and how this addresses the said conflict in the cultural, social, and religious identity of Africans.

ATR is an amalgamation of various religious beliefs and practices that have been observed by African tribes and communities for centuries. According to Prof. Mbiti, ATR is a holistic and unified way of life that covers all aspects of African culture, including social, economic, political, and spiritual (Mbiti,

1990). Mbiti offers that ATR encompasses a belief in a supreme being or creator, who is responsible for the formation of the universe and all living things. One of the most important features of ATR is ancestor veneration, which involves worshiping and communication with deceased ancestors who are believed to have the power to guide the lives of their living descendants (Magesa, 2014). Various rituals and ceremonies, such as offering food and drink to the ancestors or seeking their guidance through divination are some of the ways that ATR is practiced. ATR also places a strong emphasis on community and communal values, with many religious practices and ceremonies being performed by the entire community rather than individual practitioners. This sense of community and shared values is seen as essential to maintaining the balance and harmony of the natural world and the spirit realm (Magesa, 2014; Atta-Asiedu, 2020). Mbiti argues that ATR is a rich and complex system that reflects the diversity and depth of African culture and spirituality although this seems to be eroded by Western culture, post colonialism, and globalisation (Mbiti, 1990; Mbaya & Cezula, 2019; Chitando et al.,2020).

Nieder- Heitmann (1981) agreed with Mbiti's view of ATR and asserted that:

> "A great deal of African literature is mushrooming on the relationship between the Christian Faith and African religious heritage. Both theologians, pastors and ordinary Christians are showing great interest in this topic. A wide range of views are expressed … Some regard African Religion as demonic and try to keep it out of the church and Christian life. Some wish to revive and retain African Religion as the only authentic religion for Africans. For most people it is a practical matter which has to be dealt with daily, because they have to live with realties of both religions."
>
> (cited by Mbaya & Cezula, 2019:427)

Whilst expounding on ATR, Smith (1950) cited by Atta-Asiedu (2020) observed that it was unique to diverse African societies prior to the establishment of Islam and Christianity on the African continent.

Magesa (2014) makes an interesting comparison between Islam, Christian, and African spirituality, by arguing that they share many underlying associations. The importance on the union with God through prayer and works of charity are some of the most prominent links. All three belief systems underscore the importance of leading an ethical life in this world. "For African spirituality, for example, to respond to the voice of tradition is to enter into a relationship with God, the ancestors,

and the universe at large. This relationship enables and brings about the attainment of the good life: happiness and peace in the world and contentment as an ancestor as a continuation of life in the world" (Magesa, 2014:135). However, some health care professionals and scholars have discounted African Traditional Religions as animism, fetishism, magic, polytheism, idolatry, superstition (Okello & Ssegane Musisi, 2015; Akol et al., 2018). But some have pushed back, arguing that this was a consequence of colonialism, modernism, and globalisation (Chitando et al, 2020; Atta-Asiedu, 2020).

Overall, Mbiti demonstrated that indeed Africans had not only possessed a structured religion but also had a belief in the Supreme Being. This God is contacted through not only ancestral interventions but also directly through prayers. And according to Awolalu (1976:275), ATR is "a religion that has no written literature, yet it is "written" everywhere for those who care to see and read. It is largely written in the people's myths and folktales, in their proverbs and pithy sayings. It is a religion whose historical founder is neither known nor worshipped; it is a religion that has no zeal for membership drive, yet it offers persistent fascination for Africans, young or old. It is unique". Nevertheless, Chitando et al. (2020) has observed that whilst attempts to spread ATR to other parts of the world continue to be obscure, various religions have overrun many African societies and spread very fast. Chinua Achebe immortalised this observation in his 1958 book 'Things Fall Apart' when he wrote about the 'total anarchy' that the White missionaries' invasion brought to his fictional 'Umuofia' (Africa). He argued that the stigma against traditional faith and traditional worship increased exponentially (Chinua Achebe, 1958).

This study sought to explore how the participants expressed emotional / mental distress and their help seeking behaviours. Therefore, ATR was not discussed in specific terms by this researcher. This was intended to allow participants to deflect from their personal experiences of both emotional / mental ill-health as well as their knowledge and possible involvement in witchcraft or ATR (Lloyd, 2023). But as suggested elsewhere in this thesis, many people of African descent, traditional healers and 'patients' alike, are not antagonistic towards combining African traditional healing with biomedical health services for help. The simultaneous use of spiritual and biomedical healing also suggests a need on the part of many Africans to tackle the perceived spiritual and physical properties of mental / emotional illness (Read, 2012b; Okello & Ssegane Musisi, 2015; Akol et al., 2018; Atta-Asiedu, 2020). Nonetheless, this may suggest that for healthcare professionals with Western orientation, it would be helpful to understand these nuances to engage with African religious and cultural issues more meaningfully.

(iv) General Practitioners (GPs), Therapists and the Emergency Departments (EDs)

GPs, therapists, and hospitals (Emergency departments) in UK were also identified as spaces where participants can go to seek help for emotional/mental distress. There was overwhelming agreement among both young and older participants that it takes too long to access these spaces and some cost too much. Some who had experience of seeking help from their GPs expressed that use of medications was more common. Some also expressed that GPs rarely offered counselling or therapy even when they would have preferred this treatment modality. Matope described her experience; thus, "*I went to see the GP…I said I am having trouble sleeping…without even asking me any other questions…he gave me sleeping tablets…".* Matope also described another encounter where she was seen by an African GP who was younger than her. She mentioned that ordinarily she would not have dropped her guard but found herself being honest with this GP and left the surgery with a feeling that she had been helped. Another participant, Kiprotich also talked about her experience with seeking help from a GP; thus, "*Oh dear…that happened to me too…Every time I went to the GP…I came back with different tablets…I stopped going…".* Many people from BAME communities reside in high population density areas in UK. For many in these communities, the UK healthcare system (primary, secondary, and tertiary) is different from the one that they were previously exposed to prior to relocating to the UK (Sotubo, 2021).

Healthcare in all the East African countries is not 'free' at source which means that consulting GPs or other physicians can be challenging for those without means (Akyeampong, 2015). Some participants in the study talked of the additional stressor of having to send remittances back to their home countries to take care of their relatives' healthcare and other needs. For some, seeking help that is deemed to be free at source, for emotional / mental ill-health needs, may induce some guilt if they are unable to provide financially for their relatives back home. Conversely, GPs who serve in the same high population density areas are faced with a plethora of issues. These may include having to work through interpreters, complex health issues, high numbers of patient presentations, long waiting lists and low staffing levels among many other challenges (Szezepura, 2005; Smith, Kelly and Nazroo, 2009; CQC, 2022). This may partly explain why for many people from BAME communities, including those of East African descent, who may already have reservations about going to visit their GPs, presentation

to Accident and Emergency departments is significantly higher than in their counterparts in the Caucasian communities.

Several studies have explored explanatory factors that may lead to people from BAME communities presenting mainly when in crisis or to be detained for purposes of mental state assessments before presenting to health care services. Factors include fear *of the "feds"* (Police) for instance, as articulated by one of the participants in this study, stigma, racism, lack of awareness of service provision and many others (Rains, Weich, Maddock et al., 2020; Singh, Islam, Brown et al., 2013; Bhui et al., 2003). Although many daughters in my study felt that they would be able to seek help for their emotional / mental health needs, it was not clear whether they would also, like some of their mothers, only seek help when it was necessary. One of the participants, Nakku, talks about her experience thus: "*Huh, mental illness is super scary, I swear down. Imagine being sectioned for no reason… The Feds picked him up from some party…yeah…then, the next thing yeah…He is sectioned…mad…The feds are so racist I swear down…".* Similarly, trust or the lack of it was key to the whether the participants in this study like many other people either in BAME communities in UK or East Africa, would seek help for their emotional / mental health needs from healthcare service providers. Many of the participants seemed to mistrust professionals and felt that therapists were mainly motivated by monetary gains, would not understand their problems and were quite judgemental towards people from their communities. Many researchers and clinicians alike, undoubtedly hold the notion that trust is a prerequisite for successful collaboration between health care service providers, traditional practitioners, and patients (Schomerus et al.,2019; Akol et al., 2018).

Whilst some of the participants believed talking to others about their pain would place an unneeded strain on other people, talking was of benefit. Matope, a participant in one of the focus groups, when talking about going to friends or family to tell them about her emotional issues, observed that *"…may be …the person you are asking to help you has more problems than yours…"*. Nevertheless, there was some recognition that finding someone to talk to was beneficial. Talking to others was one of the more common sentiments expressed by those who participated. Many identified their own family and circle of friends. Individuals who were younger in age felt that it would be easier to talk to their '*bedrens'* - slang for friends although this may be a slight alteration from *brethren or kin*. Participants who were older in age said they were more likely to talk to their '*sisters'* – who were kin but not necessarily blood relatives. It seems that how these women view themselves in the context of their families and communities has a role in the decision of whether to discuss feelings of distress. For

instance, Uhuru stated that "*It is difficult you know…even having that conversation with a trained person is not easy… I find it easier to speak to my pastor*."

In conclusion, most of the participants felt that they can combine prayers with other treatment modalities. Although prayer was the most preferred modality, talking to family, friends, or community leaders could be augmented with herbal remedies, witchcraft, or visiting their GPs. Conversations around witchdoctors and herbalists were interesting in the sense that no one owned up to having actively participated. Systemically, this helped me to think about how the participants told their attachment stories and other systemic narratives.

6.6.6: *Systemic thinking and attachment stories*

John Bowlby is credited with being the founding father of the attachment theory. He identified how vital the nuances of the emotional tone in the home were for children's well-being (Bowlby, 1944). Ainsworth's work in Uganda, one of the East African countries, during the mid-50's and early 60's was of particular interest to this researcher. This theory essentially posits that emotional wellbeing is largely determined by the quality of attachment relationships between individuals. Secure attachment relationships promote emotional wellbeing, while insecure attachment relationships can lead to emotional distress. Bowlby introduced the notion of a secure base and internal working models (IWMs) of attachment while Ainsworth laid the foundations of attachment classifications. Both Bowlby and Ainsworth fundamentally agreed that IWMs formed an individual's emotional life through self- in – relation- to – other representations. Although *this* study was not aiming at looking at the broad theory of attachment, I was quite interested in how the mother-daughter dyads in the study would communicate their attachment histories or part of their stories. Relocating from one country to another, even when unforced, can generate numerous stressors, language (or even accents) – a vital tool for verbal communication - being one of them. Allen (2012b) observed that stress can be a nemesis of mentalisation by suggesting that the mentalising brain can go 'off-line' and move into a 'survival mode' when individuals experience high levels of anxiety.

Many mothers in this study talked about their experiences of excessive stress and anxiety and sometimes being unable not only to provide a psychological *secure base* but also a visible physical one on relocating to UK. Some talked of living for a long time with the fear of not knowing whether they would be safe in UK or whether their relatives were safe elsewhere. We see for instance, Malembe with her mother tentatively pondering on the black children's emotional wellbeing thus: "*I know mum*

will not agree…but I believe all black kids should go to therapy at a young age…" And on one of the few occasions that I ask follow- up questions during all the interviews, I said: "*that is interesting. Why?" Malembe* replies: "*Aunt…I am not playing…you know…black children are traumatised…by so many things…I can think of a few…dealing with the transferred anger from parents…"* And her mum, Matope, perhaps demonstrating her reflective functioning abilities seems to partly agree with her daughter by saying; "*No. I actually agree with you…I don't know about sending all black children to therapy…"*.

During the mothers focus group, Matope told of how she had been stranded in Russia where she had been sent by her government to study. She described going through a very stressful period, after moving to UK, on her husband's advice. When she recounts this period during the interview with me, her daughter seems to reassure and soothe her by mentioning that the children had been safe during the same time in *Usiago* – Swahili slang for village or more fittingly, 'with family / relatives'.

One of the fundamental issues for every family is how to preserve some form of identity and composition while simultaneously requiring to continually evolve, adjust, transform, and react to external stimuli (Dallos & Draper, 2005). It can be argued that preservation of the family identity as Africans or migrants in UK can pose many challenges. Malembe pointed to some of the challenges; thus, "*…our parents feel marginalised outside the family home…so they get home…how can I put it?... …erm…and transfer all their frustrations…on to their children…I mean…there are threats…both from outside…and at home…"*. The statements above not only point to the notion that was proposed by Bowlby with regards to the subtleties of emotional tones in a home. Malembe also seems to echo how co-constructed histories can impact families generationally.

Similarly, Pearce & Cronen (1980) observed that co-constructed histories have a potential to provide the framework within which current events are understood. Relationships between individuals together with the wider social and cultural systems in which people live are not only shaped by their histories but also individual experiences as well as their broader cultural and societal systems they traverse (Pocock, 2009; Holmes & Slade, 2018). The experiences of many East African mothers and their daughters in UK are shaped by a variety of factors including discrimination, social isolation, and economic challenges. These experiences may impact the transmission of cultural values and beliefs across generations, as mothers and their daughters adapt to their new environment and negotiate their identities (Atta-Asiedu, 2020; Dein, 2020; Ochieng & Meetoo, 2015). As Dallos & Draper, (2005:78) put it, "People in relationships are seen as creating meanings with one eye on the meanings, definitions, expectations of relations prevalent in their local and wider societal context".

For those people who have grown up in UK and may have different attitudes this can cause conflict and tension between generations. The older generations may view the younger generations behaviour as disrespectful and inappropriate. On the other hand, many mothers of East African descent may have experienced trauma related to migration, discrimination, or other challenges. This trauma may be passed down intergenerationally and can affect mental / emotional wellbeing and relationships. By identifying the patterns that are being passed down from one generation to the next, individuals and families can work to break negative patterns and build healthier, more positive family systems (Walsh, 2009; Flaskas, 2009; Walsh, 2016). Possessing mentalising and reflective functioning capacities within family systems are some of the ways that healthier, positive patterns can reinforced (Pocock, 2009; Holmes & Slade, 2018).

Building on the work by Bion (1970) and Winnicott (1971) many systemic theorists have acknowledged the importance of unconscious emotional processes regarding intergenerational transmissions as a more collaborative and mutually constructed process (Pocock, 2009; Walsh, 2016). Attachment histories essentially adopt a socio-personal method and must be seen systemically as a self-corrective process between infant and carer (Bowlby, 1973). It can be argued that with self corrective abilities, families can possess the capacity to regulate their own behaviours and adapt to changing situations. Some have argued that with self-corrective processes, younger generations are capable of a much more complex range of affective reactions and can operate within a wider interpersonal domain of parents, siblings, and peers (Crittenden, 2000; Walsh, 2016).

Crittenden (2000) seems to suggest that the affective span in one person may be understood as explicit adjustments within an emotional ecosystem of significant relationships. The emotional ecosystem can both be self and interactive regulated. The most favourable systems possess a balance of self and interactive regulation whereas sub-optimal systems depend mainly on extreme use of self-regulation to manage emotional arousal (Beebe & Lachmann, 2002). The work of Fonagy, Gergely, Jurist & Target (2004) which also builds on Bion (1962) ideas of self-containment seem to augment and expand Beebe and Lachmann's notions of self and interactive regulations when attempting to understand how homeostatic balance of security and arousal in intergenerational familial relationships can be achieved (Dallos & Draper, 2005; Pocock,2009). Fonagy, Gergely, Jurist & Target (2004) refer variously to the notion that children can possess the capacity to know their own emotional states of

mind besides the states of mind of another, as the capability for reflective functioning, or a capacity to develop a theory of mind, or to mentalize. Fonagy et al.'s ideas are employed by Krause (2002; 2009) when proposing that the affective repertoire of significant others is highly influenced by culture, which in turn shapes the development of self. Findings from my study would agree with Krause (2002) assertion in the way that mothers and their daughters seemed to converge or disagree on some cultural issues such as funeral rituals or how religious beliefs are exercised.

Another form of attachment, that is, the idea of attachment to God or a supernatural being, or the ancestors can look at ways in which cultural, historical, and societal factors can influence beliefs and practices. In many East African cultures, spirituality is deeply intertwined with everyday life. Religion and belief in the supernatural can provide a sense of comfort, guidance, and community. For many migrants to UK and elsewhere in the diaspora, maintaining connections to cultural and spiritual heritage can play an important role in maintaining, a sense of identity, belonging, and a balance in individual, familial and societal homeostasis (Walsh, 2016; Dallos & Draper, 2005).

Moreover, the experience of immigration and acculturation can impact these attachments. Navigating new cultural norms can generate a sense of displacement and loss. This may lead to a heightened emphasis on maintaining traditional beliefs and practices, including attachment to a higher power or ancestors which may offer a sense of safety and connection to something greater than oneself. For some, the attachment to God, a supernatural being or ancestors may be used as another form of intergenerational transmission of cultural values and rituals. Although for some daughters their experiences with spirituality and religion may be influenced by Western cultural values and may feel disconnected from their cultural and spiritual roots (Falicov, 2009; Mbaya & Cezula, 2019). This may cause tensions and conflict between generations. I sensed for instance that this may have been what Kabila (mother) and Ngala (her daughter) were experiencing during the mother – daughter interview as elaborated by some of their exchanges.

Nevertheless, there seems to be some degree of earned security, a concept that was first coined by Main and Goldwyn (1989), by both mothers and the daughters who took part in this study. Security for individuals who may have experienced adversity – whether earned or learned – through positive relationships can enhance emotional and mental wellbeing and foster good intergenerational relationships (Holmes and Slade, 2018). Traumatic and stressful events are some of the adversities that can be positively impacted through earned security and / or secure attachments.

Trauma is the Latin name for *wound* and can be experienced by individuals, families and communities with varying impact and recollection. Families and their communities are intertwined in complex ways (Betancourt and Kahn, 2007). Although some individuals are more susceptible to stress, no one is protected from suffering in adverse situations (Walsh, 2016). The effects of trauma and the potential for recovery depend greatly on whether those wounded can seek comfort, safety, and reassurance with others. "Strong connections, with trust that others will be there when needed, counteract feelings of insecurity, helplessness, or meaninglessness" (Walsh, 2016:235). That is to say that, even with those who may have undergone past traumatic experiences, including those that took part in *this study*, obtaining learned / earned security through strong positive connections can contribute to secure adult attachment stories as well as individual, familial and community resilience. Multisystemic models where professionals take a consultative role, encouraging natural leaders and change agents within the community can be promoted. Family and community members with diverse competences, abilities and ages can impact in different ways to the resilience of a community. The elders can bring memories and lessons of coping with previous adversity, while the young repair their capacity for play and resourcefulness for long term sustainability and hope for the future (Dallos and Draper, 2005; Flaskas, 2009; Walsh, 2016; Holmes and Slade, 2018).

The themes and sub themes that helped to organise and make sense of the data were by no means the only ones that I could have utilised. I was interested in instance in how younger participants referred to me as 'aunt' and older participants as 'sister' from time to time. Culturally, I understood what they meant but as a researcher, I felt slightly unsure about how to respond. Kraemer (2009:39) cites James Framo (1965) who suggested that "it is almost impossible not to get caught up in the drama of family interaction". Kraemer continues by warning that it is possible to be vulnerable to the risk of exposing the personal and private that analysts have about their patients and by extension, researchers with their study participants. I was similarly curious about how language and non-verbal cues were being used to convey storylines and narratives. Some of these issues richly informed my study but were nevertheless challenging in terms of coding and interpreting thematically.

6.6.7: Limitations and implications for further studies

"Look in the mirror…and just below the surface".

Valerie Watson (2021)

It is acknowledged that this research is limited in many ways due to concerns such as self-selection. The pandemic and eventual lockdown notwithstanding, this study had a specific timeline which had informed the nature of ethical approval that was required. This meant that I was unable to recruit known patients from within the NHS as this would have required additional ethical approval from the NHS.

The sample size was small from a novice researcher's perspective (and enthusiasm) but well within recommended group sizes for focus groups. A sample size of between 5-10 participants is recommended for most focus groups (Smithson, 2000; Krueger & Casey, 2015). 7 participants took part in each of the focus groups in this study and on reflection, this was an ample size given the fact that I was conducting the study single handedly. Future studies with larger samples may consider having more than one moderator.

The participants were limited to two UK geographical areas of London and Essex. Future research of these issues and communities may look at undertaking UK wide studies which may generate varied experiences, for instance, for people from BAME communities who live in rural areas where they are more likely to be much more isolated due to lack of ethnic density.

As discussed elsewhere in this paper, using mixed methods has its advantages and drawbacks. One of the advantages was that mixed methods can enable a researcher to generate in-depth data. However, the drawbacks including time and financial demands can be limitations to a study. As a doctoral student who also works full time, using this methodology was a challenge.

Further research needs to be carried out with other cohorts of mothers and daughters, particularly those from different cultural backgrounds, those who do not have such ready access to parenting support, and more fathers. Further studies involving people who have had experience of accessing Mental health services including families in the East African community who have had lived

experiences of accessing CAMHS or other Health Services may be of benefit to understanding emotional distress as well as other aspects of help seeking behaviours for BAME communities.

Considering the diverse East African community in the UK population, the participants in this study (majority were university educated and have lived in UK for more than 15 years on average) represented a subsection of this population; therefore, they may not represent the perceptions of all strata of the East African population in UK. Recent migrants to UK and possibly with much young children could be explored with a view to compare outcomes with my study perhaps. There could also be a comparative study between Black, White, and Asian mothers and daughters of East African origin currently living in UK with a view to understand how the different systems navigate emotional and mental wellbeing. This may enhance our understanding of the coping strategies and resilience factors for all people of East African origin now living in UK and other parts of the diaspora.

Chapter Seven: Recommendations

7.0: Summary of the recommendations

These suggested recommendations were derived from the findings in this study. They cover some wider implications that can be generalized to many BAME communities in the UK. These recommendations do not by all means address all the implications from the findings of the study but can enhance the health and wellbeing for the women that took part in this study as well as wider BAME communities in UK. These are: clinical and health policy implications, training of professionals, recognisable pathways to mental health services, improving access to psychological therapies, access, and use of services and, cultural matching.

7.1: Clinical and public health policy implications

The perspectives of people from BAME communities who make use of mental health services on the barriers that prevent them from doing so have the potential to be translated into a concrete direction and framework for the future equitable delivery of services and the professional practice of those who work in healthcare. In addition to addressing the obstacles that are present on personal and environmental levels, it is essential to place primary emphasis on reducing barriers that are experienced at the interface between service user and healthcare practitioner. These may include expanding and enhancing the role of BAME staff within the NHS, developing cultural awareness and sensitivity, raising awareness of services and access pathways, and reducing stigma.

BAME service users and their carers have a greater need for improved access to information to become equipped and empowered to participate in their own health and wellbeing. People may be better able to see the signs of mental illness and the stigma that relates to this if more people are aware of mental health issues and their symptoms. It is possible that individuals and communities alike will be encouraged to seek help at an earlier stage in the course of the illness. There is some evidence to suggest that anti-stigma programmes, such as the national Time to Change campaign, may significantly reduce prejudice and significantly increase awareness. The findings of this study agree with the above assertion.

Local health campaigns that raise awareness and empower communities can help to educate and improve access to local services. Commissioners of mental health services, local authorities,

healthcare services, and community organisations need to play a part in collating and the dissemination of such information.

7.2: *Training of Professionals*

Continuous professional development (CPD) for those working in healthcare is not only essential but also necessary. Targeted training offers better understanding of the challenges and inequities that are associated with other cultures, as well as the complex and diverse needs of the patients.

- Some participants in the study expressed a desire to have a healthcare professional that came from the same background of BAME as themselves although others felt that working with someone from the same background was at times a barrier.

Research on ethnic concordance between patients and clinicians has found that people with a BAME background who have experienced racial discrimination in healthcare prefer ethnic similarity in their healthcare providers. Furthermore, ethnic and language matching promote clinical judgments of more severe psychopathology. Delivery of interactions and services that are more culturally sensitive may be helped by employing methods that attempt to broaden and increase the engagement of BAME communities within mental health care.

7.3: *Pathways to mental health services*

Prejudice is one of the challenges people from minority ethnic groups face when attempting to gain access to primary health care. Other challenges include language barriers, a shortage of interpreters, and a lack of knowledge and information. These challenges have received a lot of attention in published work. Hurdles to broader health services in UK given issues concerning underfunding of the over-stretched NHS, make it more difficult for some minority groups to obtain assistance for issues relating to their mental health.

- Many participants in this study suggested that approaches might include employing patients and public engagement groups that address BAME needs assessments to identify gaps in service provision and suggest possible innovative and culturally relevant treatments. Some suggested the involving patient advocacy groups such as Patient Advocacy Liaison Services (PALS) which are available in all NHS Trusts in UK.

7.4: *Improving Access to Psychological Therapies (IAPT) services*

Even though there is evidence to suggest that individuals who utilise IAPT programmes are seeing a continually increasing rate of recovery, there is still significant variation in recovery rates. These groups include persons who are homeless, elderly people, children, and young people, and those who suffer from serious mental illness. IAPT services are committed to enhancing the mental health of individuals and advocate for expanding people's general understanding of psychological therapies on a widespread scale, particularly via the networks of communities. To have successful interactions with the local BAME populations, it is necessary to commission additional services that are culturally appropriate.

- Some participants in the study brought up many examples of counsellors who put their offices inside religious / community organisations to make themselves more acceptable and accessible. It is also worth noting that there were participants who did not perceive their difficulties as necessarily mental health issues. The informal use of local organisations including religious groups would help to address their struggles without labelling.
- Introducing contemporary traditional healing practices into IAPT and other training courses may improve the therapists' cultural competence which may further enhance their abilities to cultivate trusting relationships with their patients.
- IAPT and other mental health services can invite community / traditional healers to training courses or open days to begin to work collaboratively to address issues relating to the health and wellbeing of local communities (many NHS Trusts in London are already doing this). This would help to reduce the ethnic disparities that exist in the provision of mental health care.

7.5: *Access and use of services: ethnicity*

A variety of factors, including a lack of expertise, long wait times for treatment, and insufficient help for people with language barriers have a detrimental influence on the interaction that takes place between the patient and the healthcare practitioner. Practitioners can mitigate this by being open and honest with their patients (e.g., by exploring with their patients about their understanding of the presenting issues, constraints with waiting times and any other alternative solutions to the presenting issues). It was also believed that many practitioners were reluctant to discuss racism and its effect on an individual's mental health or even participate in a conversation about the subject. Some believed

that a degree of cultural awareness would be beneficial to both their engagement in the treatment process and their treatment plans.

- Participants in this study suggested that healthcare practitioners need to be provided with formal training to increase their understanding of cultural issues and be encouraged to be sensitive to the diverse needs of their patients.

* They also suggested using a reverse commissioning process to enable patients from BAME communities to identify gaps in service provision; empowering users to engage better with their own mental health and healthcare practitioners; increasing awareness and working to reduce stigma within these communities.

7.6: *Cultural matching with health practitioner*

Although cultural matching is highly touted by researchers and policymakers (Shepherd et al., 2018), my personal experience as a clinician and anecdotal comments by some women who took part in this study, does not seem to corroborate this argument. Indeed, some of my experience has been that many patients from BAME communities that I have encountered would prefer to be seen by my Caucasian colleagues. Some think that you may tell other people in the community or that you may not be able to solve their problem.

- However, some participants in the study reported a high preference for healthcare practitioners who hailed from their own cultural backgrounds.

Goodwin, Sauni and Were (2015) looked at the factors that affected the degree to which patients acknowledged depression symptoms during consultations. These factors included patient ethnic concordance and communication styles that put the patient's needs first. In contrast to the predictions, the hypothesis that ethnic concordance may have a positive impact on disclosure during the contact between a patient and a clinician was not supported by the findings of this study.

Chapter Eight: Conclusion

The horizon leans forward offering you space to place new steps of change.

Maya Angelou, "On the pulse of the morning" (1993).

This study was borne out of my curiosity about emotional expression and help seeking particularly for people with less access to healthcare services. At the time, conversations, some quite concerning in the mainstream media, about access and crisis presentation to "very stretched" NHS emergency departments by people from BAME communities were common. I was particularly curious about the emotional expression for women given that the media usually reported about young black men, violent crime, and detentions under the Mental health Act. Through use of focus groups, mother-daughter dyad interviews, and a survey that has been previously utilised on other communities in UK, I have been able to explore how some mothers and their daughters of East African descent understand and navigate various notions of emotional and mental distress. The use of thematic narrative analysis revealed the resilience of these families and the importance of community networks through intergenerational transmissions. The mother – daughter relationship is seen to be crucial in shaping the daughters' experiences of wellbeing and distress.

The findings in this study emphasise the importance of access to health and social care services that are inclusive and culturally sensitive. Healthcare providers who mainly rely on research that is generated from W.I.E.R.D (Western, Industrialised, Educated, Rich, and Democratic nations although democratic is debatable – my take) backgrounds need to take into consideration the possible limited generalisability to people from other cultural backgrounds in a bid to steer away from cultural biases. Some understanding of the social and familial ecosystems such as faith in God, one's ancestors or a higher power may augment clinical formulations and subsequent interventions for people from other cultures. The study also highlights the ability for these women to navigate complex systems in a new country. It further underscores the importance of systemic thinking and theory in addressing the unique challenges faced by immigrant families.

Emphasis should be placed on the need for policy and practice to be informed by the voices and experiences of immigrants, particularly those who are most marginalised. This can be done by ensuring that health and social services are responsive to the individual, family as well as community needs and experiences for all their service users.

Whilst my research was instigated by my curiosity about others, but in a roundabout way, I began to see and place myself in some of the stories that were being told by the participants. I am a descendant of East African *ancestors* – both living and transitioned. I am a mother. I subscribe to the *Judeo-Christianity* faith that was taken to Africa by colonisers. I am both a provider of healthcare services as a clinician and a consumer of healthcare services when I need support for myself and my family. All these identities can get submerged. My study has undoubtedly helped me to be more conscious of the many issues and not just to explore how some mothers and their daughters of East African descent express their mental / emotional distress and seek help from others. It would be interesting for me to work collaboratively with the witch doctors and traditional healers that are UK based but NHS policy does not currently permit this as these practitioners are not registered and, in most cases, work under the radar for some of the reasons that have been enumerated in this thesis. I believe my study will help clinicians and policy makers alike to broaden their understanding of the systemic ideas that influence good clinical outcomes for many individuals and families of East African descent living in UK.

Chapter Nine: Postscript

Thinking about expression of emotional distress during and after the Covid-19 pandemic.

This study was conducted and completed between 2018 and 2019 before the Covid-19 pandemic that culminated into the global lockdown. As an essential, frontline keyworker in the NHS, whose role involved attending three (3) Accident and Emergency departments that cover two NHS Trusts in London, I came into regular contact with patients, some carers, and colleagues. I was aware of the disproportionately large numbers of not only the patients but also colleagues who are from minority ethnic groups in the three hospitals that we covered during the pandemic. The media (both mainstream and social media) was also replete with news about disproportionately large numbers of BAME patients and keyworkers who were succumbing to Covid-19. Indeed, for London and the Southeast of England at least, the role of people from BAME communities was acknowledged although what seemed not to be highlighted is the resilience that manifested during this challenging pandemic.

As the world seemed to stand still, BAME communities that thrive on collective rather than individual systems were undergoing unimaginable strain that was brought about by even further isolation and loneliness (Bhatia, 2020). Whilst many from the BAME community were dying or hospitalised, those from the African communities faced an extra layer of complexity to the grieving process as families were unable to gather or travel to communal burials and funeral rites. As funeral wakes, burials and some hospital visits turned to virtual meetings, many people in the African communities could only wonder about what 'our ancestors were thinking'.

Conversations, from time to time, returned to the possible factors that were contributing or explaining the disparities in covid-19 mortality rates. Many explanations examined overcrowding, low incomes, diets and even racism as some of the socio-cultural factors that were contributory to the high numbers of people from BAME communities succumbing to Covid-19. Of course, age, pre-existing health conditions and lack of vital clinical equipment such as oxygen masks and personal protective equipment (PPEs) for staff were also contributing factors (Otu, Ahinkorah, Ameyaw et al., 2020; Smith, Bhui, and Cipriani, 2020). But there were some of us who felt that endemic institutional racism in industrialised nations may have had an ugly hand to play.

My thoughts, from time to time, returned to my research study and the participants that I had interviewed. I wondered how they were coping with the lockdown and pandemic. I was personally feeling very impacted by being unable to travel to see my family in Africa if I needed to. I worried about

my elderly parents and was resigned to the fact that were they to succumb to Covid-19 or any other illness, I would not be able to attend their funerals. For many people in the East African communities in UK, regular death announcements and go fund me pages became a regular occurrence. I at times recalled some of the conversations that I had held with some of the participants after the interviews and wondered whether the pandemic and eventual lockdown had changed some of their views.

My personal vulnerability to Covid-19, having succumbed twice, challenged some of my previously held ideas about my subjective emotional wellbeing. Fear for my health and wellbeing, although at the time mostly unconscious although now and then experienced consciously, undoubtedly impacted on the progress of my research study. There is no doubt in my mind that this study has been possible due to my experiences within the various social systems that I occupy and of course I feel that I have attained a deeper understanding of my own emotional needs and how to express these needs.

Naomba uwe na afya njema, uhai, watoto wazuri na maisha marefu! (Swahili saying) - literary translated: I pray that you have good health, vitality, good children, and long life!

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