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Mental Health Conceptualisations and Perspectives on Mental Health Services of
Black Sub-Saharan African Migrants and Refugees in Aotearoa New Zealand.

A doctoral thesis submitted in partial fulfilment of the requirements for the degree of

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Abstract

The number of African migrants and refugees is increasing in Aotearoa-New Zealand (A-NZ). However, there is still limited understanding regarding the mental health experiences of Black Sub-Saharan Africans. Without adequate knowledge of the experiences of this population, it is difficult for mental health professionals to provide culturally appropriate services. As such, it is prudent to develop an understanding of the way this population conceptualises, experiences, and manages mental health and mental distress.

This study explores how Black Sub-Saharan Africans in A-NZ conceptualise and manage mental health and their perspectives on mental health services in A-NZ. A qualitative approach was employed, with data collected through nine semi-structured individual interviews and two focus groups (each with four Black Sub-Saharan African women). Individual interview data were analysed using Interpretative Phenomenological Analysis, highlighting the role of identity in mental health conceptualisation and the intergenerational and gender differences that exist. Focus group data were analysed through Reflexive Thematic Analysis and key themes identified included barriers to accessing services and participants' preferences regarding mental health services.

Overall, this study found that culture and identity play a critical role in how Black Sub-Saharan Africans perceive mental health. These factors also influence people's experiences with mental health services. Understanding the cultural nuances of Black Sub-Saharans in A-NZ can help mental health clinicians develop an ethos of engagement that promotes better quality of care.

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In honour of my late father, Ishmael Musakwa.

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Philippians 1:6 “Being confident of this, that He who began a good work in you will carry it on to completion until the day of Christ Jesus”

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1. Introduction

Mental health cannot be understood by one universal definition as different cultures have distinct ways of making sense of their mental health experiences (Bhugra et al., 2021). Even the term “mental health” is associated with historical and cultural connotations that impact how people relate to the terms (Bertolote, 2008). In particular, the term finds its roots in Western ideologies, which promoted a scientific and reductionist understanding of health (Bertolote, 2008; Sartorius, 2006). Kleinman’s Explanatory Model of Health and Illness (1980) asserts that illness is shaped by cultural experiences that influence its perception, explanation, and experience. As such, culture influences how people understand mental distress. Furthermore, Black Sub-Saharan African migrants and refugees possess a unique worldview shaped by their migration experiences, differing from both members of their home and host countries. Their perspective reflects an interplay between navigating cultural contexts and personal lived experiences (Berry, 1997). Therefore, when attempting to conceptualise mental health, it is beneficial to consider the factors influencing their worldview, such as culture, migration, and personal experiences. As it stands, there is a scarcity of literature that specifically focuses on the mental health experiences of Black Sub-Saharan Africans in Aotearoa-New Zealand (A-NZ). With minimal understanding in this specific area, mental health professionals are often left with limited cultural competency when working with these clients. This thesis aims to address this issue.

A further gap in the literature pertains to the perspectives Black Sub-Saharan African migrants and refugees have regarding mental health services in A-NZ. This is significant as perspectives on mental health services influence treatment engagement and outcomes. As highlighted by Corrigan (2004), a client’s disbelief in the therapeutic process can hinder the treatment outcomes. While individual differences exist among Black Sub-Saharan Africans' perspectives, understanding common cultural perspectives can enhance awareness of potential barriers to

accessing care. This knowledge is beneficial for developing cultural sensitivity and improving the quality of care, which facilitates better health outcomes (Ayonrinde, 2003).

1.1 Research Question and Aim

The primary question for this study is “What are the mental health experiences for Black Sub-Saharan African migrants and refugees in A-NZ?”.

To address this question, the study aims to explore how Black Sub-Saharan African migrants and refugees in A-NZ conceptualise and manage mental health, and how they perceive mental health services.

1.2 Research Objectives

This study focuses on three key objectives:

- To explore how Black Sub-Saharan African migrants and refugees conceptualise mental health.
- To examine how they manage their mental health.
- To explore their perspectives on mental health service providers in A-NZ.

1.2.1 Conceptualisation of Mental Health

As indicated above, this study, in part, aims to explore how Black Sub-Saharan African migrants and refugees conceptualise mental health. The way individuals understand mental health forms the foundation for their management of related behaviours and actions (Kleinman, 1980). Different cultural groups interpret phenomena through distinct lenses shaped by their unique experiences and values (Corrigan, 2004; Kleinman, 1980). For migrants and refugees, multiple cultural influences – such as living in A-NZ, identifying as African, and being an immigrant – contribute to their understanding of mental health. This study seeks to identify recurring themes that arise when Black Sub-Saharan Africans discuss mental health and mental

distress. By examining these areas, this research aims to contextualise Black Sub-Saharan African migrants and refugees' perspectives and experiences, with the aim of fostering more culturally sensitive approaches to care.

1.2.2 Managing Mental Health

The second objective is to explore how Black Sub-Saharan Africans in A-NZ manage their mental health. This exploration aims to highlight some of the strategies they employ and identify what they find helpful and important for their well-being. Additionally, understanding these strategies will elucidate the subjective factors that influence mental health experiences, which provides valuable insights into the interplay between personal agency, cultural context, and mental well-being.

1.2.3 Perspectives on Mental Health Services

As such, it is important to understand people's experiences and perspectives on such services. Whether a form of intervention is viewed favourably or negatively will influence whether and how a person engages with it. These perspectives impact therapeutic engagement and can either facilitate or hinder positive therapeutic outcomes (Corrigan, 2004). Furthermore, perspectives highlight any underlying barriers that might influence whether people engage with mental health services (Botchway-Commey et al., 2024; Byrow et al., 2020). Lastly, the viewpoints of Black Sub-Saharan Africans can allow clinicians to understand what may be culturally important for these clients, thus aiding in the development of interventions that resonate with this population thus fostering greater trust and engagement (Botchway-Commey et al., 2024).

1.3 Significance of Study

1.3.1 Gap in Literature

Currently, there is limited knowledge regarding the mental health experiences of Black Sub-Saharan Africans in A-NZ, indicating this as an area to which the current research can

contribute. While many studies have explored the acculturative experiences of migrants and refugees (e.g., Adelowo et al., 2016; Kale et al., 2019; Udahemuka & Pernice, 2010), few have focused specifically on the mental health of Black Sub-Saharan Africans. While acculturation is a relevant and important factor, it does not fully capture the mental health experiences of Black Sub-Saharan Africans. As previously stated, this population is shaped by diverse cultural contexts that influence their perspectives. By addressing this gap, this research not only enriches the understanding of Black Sub-Saharan Africans' mental health but also provides insights for service providers in refining an ethics of engagement.

1.3.2 Relevant Stakeholders

This study aims to provide practical guidance for mental health service providers. A clinician's rapport with a client is influenced by their understanding of the client's cultural experiences (Asnaani & Hofmann, 2012). The better a clinician understands their client, the better they can respond to their needs (Kleinman, 1980; Kodjo, 2009). While general cultural knowledge cannot replace understanding the individual nuances of a client's background, it promotes cultural sensitivity, which helps clinicians engage more effectively with members of diverse cultural groups (Kodjo, 2009). Although this study acknowledges that individual differences exist, it also recognises the value of exploring common perspectives within minority populations, which can broaden a clinician's frame of reference and enhance their awareness of relevant cultural factors (Asnaani & Hofmann, 2012; Kodjo, 2009). As such, this study aims to provide mental health service providers with insights into the mental health perspectives of Black Sub-Saharan Africans.

Beyond benefiting mental health service providers, this study will also be valuable to other Black Sub-Saharan African migrants and refugees. Mental health stigma is prevalent among this population (Pederson, Tsai, et al., 2023). Therefore, by sharing narratives from this community, the study can help normalise mental health experiences among Black Sub-Saharan

Africans. Openly addressing this topic can help reduce stigma and promote greater sensitivity toward mental distress within the Black African community (Shahwan et al., 2022).

1.4 Position of the Researcher

I am a Black Sub-Saharan African migrant originally from Kwekwe, Zimbabwe. When I was eight, my family relocated to A-NZ because they desired better educational and employment opportunities. Growing up in A-NZ, I experienced a unique balance between maintaining my Zimbabwean cultural heritage and integrating into Kiwi society. This dual cultural context has shaped how I perceive the world, including my understanding of mental health.

As I navigated life in A-NZ, I observed shifts in my family's and my own beliefs. Initially, we viewed mental health primarily from a spiritual perspective, but over time, we began to integrate both spiritual and biological frameworks. I attributed these changes to acculturation, which was highlighted by the hybrid of two worlds—a blend of the African and Kiwi cultural perspectives. My individual experiences, African roots, life in A-NZ, and my Christian faith have all continuously shaped my evolving conceptualisation of mental health.

My interest in the interplay of mental health and culture began during my Honours research, where I studied the acculturative experiences of Africans in A-NZ. One prominent theme that emerged from this research was the mental distress participants experienced due to the challenges of acculturation. This inspired me to further explore the topic of mental health among Black Africans. Furthermore, my personal experiences working as a receptionist at a psychology clinic also fuelled my curiosity. Despite being in a position where I observed all clients entering the clinic, I never encountered a Black African client. Moreover, many of my Black African friends expressed a desire to seek help but did not make efforts to engage with mental health services. This raised critical questions: Why were Black Africans not seeking mental health support? And, what barriers were preventing them from accessing care? I began

to suspect that differences in how Black Africans understand mental health may be a key factor in the lack of engagement. This initial curiosity became the foundation of my research, which sought to understand how Black Africans conceptualise mental health and the strategies they employ while also exploring the barriers to accessing mental health services.

As a Black African, this study is personally significant, as it allows me to explore the experiences of individuals who share similar cultural and geographical backgrounds. However, I am also aware of the risk of biases, such as assuming that participants will hold the same views or experiences that I do. I recognise the importance of addressing these biases in my research methodology to ensure that a diverse range of perspectives are accurately represented.

1.5 Structure of Dissertation

The following section will briefly summarise the content of subsequent chapters of this dissertation.

Chapter two provides background information related to the research aims. This includes contextual information on the target population and a brief history of mental health in Africa.

Chapter three reviews the relevant literature. Given the importance of culture in understanding health definitions, it begins by reviewing how culture is defined. Following this is a review of health and mental health definitions. This chapter also explores theories related to mental health and migration and Black Africans' experiences with mental health and mental health strategies.

Chapter four discusses the methodology employed in this study, including a summary of the recruitment stage, data collection process (i.e., individual interviews and focus groups), and data analysis. This chapter details the Interpretative Phenomenological Analysis (IPA) framework adopted in this study. It also discusses the data analysis process, using IPA for the individual interviews and Reflexive Thematic Analysis for the focus groups.

Chapter five describes the themes that emerged from the individual interviews, while chapter six discusses the key findings found in chapter five. Chapter seven details the findings from the focus groups, and chapter eight discusses the key themes from the focus groups, including exploring how these relate to existing literature.

Lastly, chapter nine concludes with a summary of the research study. It will also discuss the limitations and recommendations for future research related to this study.

2. Research Topic Background

Chapter two provides the reader with relevant contextual information regarding the target population. The first section introduces Sub-Saharan Africa and provides geographical information, including relevant statistics. The second section defines key terms, including *Black Africans*, *migration*, *migrants*, and *refugees*. Given that “culture” is a key concept underpinning this study, the last section will review the definition of culture in relation to this study.

2.1 Background of Target Population

The target population for this study is Black Sub-Saharan African migrants and refugees in Aotearoa-New Zealand (A-NZ). Sub-Saharan Africa (SSA), as the name indicates, is located south of the Saharan desert. It includes 42 mainland countries and six (some argue seven) island nations with an estimated population of 1.2 billion in 2022 (Rector, 2023; World Bank, 2022). It is considered culturally distinct from its counterpart, North Africa, which also includes the Middle East (Middleton, 2024). Figure 1. shows the geographical location of SSA. Diversity characterises SSA in domains such as religion, history, and languages (Collins & Burns, 2013). Most people in SSA identify as Christian or Muslim, with the majority being Christian (Rector, 2023). Collins and Burns (2013) estimated that there are more than 2000 separate languages in SSA. Greenberg (1970) states that these can be grouped into four linguistic families: Niger-Congo, Afro-Asiatic, Nilo-Saharan, and Khoisan. Each group has its own major and sub-branches, creating the variety of languages seen today (Collins & Burns, 2013).

Figure 1.

Map of Sub-Saharan Africa



Note: Adapted from Sub-Saharan Africa [image], by M. Britton, (1993), Wikimedia Commons.

2.2 Defining Black African

For readability, this dissertation will use the term “Black Africans” to refer to Black Sub-Saharan African migrants and refugees. When the discussion specifically refers to migrants, refugees, or Black Africans from outside the Sub-Saharan region, a distinction will be made. I decided to use the term “Black Africans” after careful consideration. This term was deemed most appropriate for a few reasons. Firstly, “*Black Africans*” avoids any ambiguity in identifying who the target population is. “*Black Africans*” is used to identify Africans of African descent as opposed to Africans of other ancestral roots, such as European or Indian (Kalunta-Crumpton, 2020). Another option was the term “*Africans of colour*”. However, it was decided that this term may be confusing, as other groups often refer to themselves as Africans of colour regardless of their ancestral roots. As highlighted by Kalunta-Crumpton (2020), the term

“People of Colour” has been used to identify people who are visibly not of European descent. For example, Africans with Indian ancestry may identify as Africans of colour. Therefore, there were concerns that this terminology might recruit people who are not from the target population.

Another reason for using the term *“Black Africans”* is to provide an opportunity to explore both ethnic and racial experiences that might play a role in mental health conceptualisations. According to the APA Dictionary of Psychology (n.d.), “race refers to the social construction and categorisation of people based on perceived shared physical traits that result in the maintenance of a sociopolitical hierarchy”. In contrast, they define ethnicity as “a characterisation of people based on having shared culture (e.g., language, food, music, dress, values, and beliefs) related to common ancestry and shared history” (American Psychological Association, n.d.). The term Black African captures both ethnicity (African) and race (Black). These concepts are relevant to the lived experiences of the target population as they can have an impact in the psychological and interpersonal domains (Suyemoto et al., 2020).

The term “Black Africans” has been subjected to criticism, with arguments highlighting that race is a socially constructed concept without a biological basis, and therefore, its use should be reconsidered (Duello et al., 2021). Historically, race was perceived as a biological classification that manifested in the observable physical traits of a person (e.g., skin colour) (Webber et al., 2013). This perspective had profound consequences that resulted in the oppression and marginalisation of some social groups (Suyemoto et al., 2020). Given that the biological concept of race has since been discredited, there has been a growing call for researchers to avoid its use in academic literature (Suyemoto et al., 2020). However, the historical and social implications of race remain deeply ingrained, as evidenced by persistent health disparities across racial groups, which impact people’s lived experiences, perspectives, and attitudes (Suyemoto et al., 2020; Webber et al., 2013). While the use of race may be

inappropriate in the context of biological research, it retains value in exploring how particular groups conceptualise phenomena. This study seeks to explore how mental health is perceived and managed, omitting race risks ignoring the socio-political forces that contribute to the nuanced experiences of Black African migrants and refugees. Therefore, including race in this context ensures a more accurate and equitable understanding of the target population.

2.3 Defining Migration Terms

2.3.1 Migrant

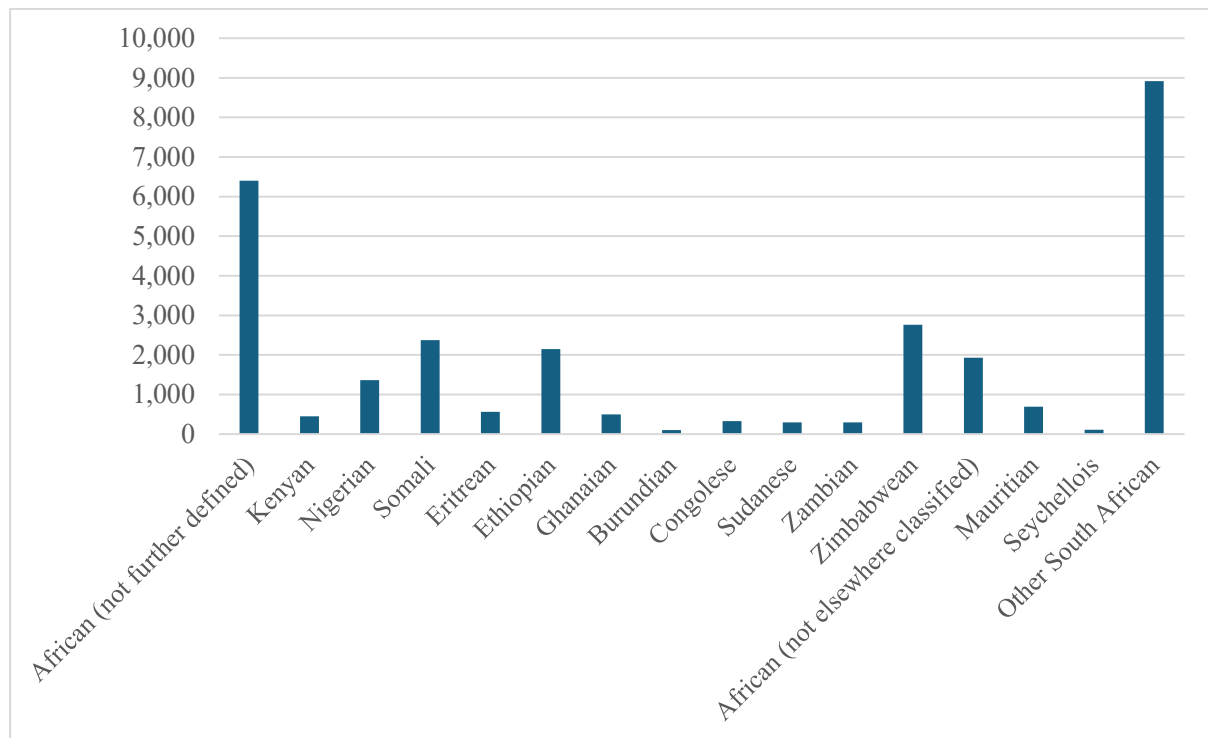
According to the World Migration Report (International Organization for Migration, 2024), there are approximately 281 million international migrants, which is predicted to continue increasing. There are various reasons for voluntary migration. Push factors are reasons that drive a person away from their country. For example, political instability or limited access to resources (Urbański, 2022). In contrast, pull factors attract a person to the new country or location. For example, vocational opportunities, better education, or reuniting with family (Urbański, 2022). Typically, a variation of push-pull drivers at both individual and societal levels influence people's migration decisions (Van Hear et al., 2018).

Statistics NZ (2023) states that the number of migrants who arrived in A-NZ in 2023 was approximately 195,000, an increase of 212% from the previous year. While it is most likely that this difference was due to COVID-19 restrictions in the previous year (Stats NZ, 2023), it is noted that there is still an increase from the long-term average of migrant arrivals in A-NZ with an approximate average of 120,000 migrants in the years preceding COVID-19 (Stats NZ, 2023). The 2023 A-NZ census showed that the population of Africans in the country was approximately 22,000, which is a significant increase from the previous 2018 census, that showed a population of just under 17,000 (Stats NZ, 2018, 2024). However, these statistics do not distinguish which proportion identifies as Black Sub-Saharan African. They also do not include South African Europeans who represent the largest proportions of Africans in A-NZ

and the fifth largest source of immigrants in the country (Stats NZ, 2024). Figure 2. highlights the population of Africans by ethnicity (Stats NZ, 2024). Ethnicities not commonly identifying as Black Africans were omitted (i.e., Afrikaner and Zimbabwean European).

Figure 2.

Africans in A-NZ. Derived from Stats NZ (2024).



2.3.2 Refugees

The United Nations High Commissioner for Refugees (2016) defines refugee as someone who flees from conflict or persecution, where remaining in their country can have life-threatening consequences. These individuals usually cannot return to their original country due to safety concerns (UNHCR, 2016). Since World War II, A-NZ has resettled more than 35,000 refugees (New Zealand Immigration, n.d). While up-to-date statistics on the total number of refugees currently residing in A-NZ are not readily available, New Zealand Immigration provides information on refugee quotas. Currently A-NZ’s annual refugee quota is set at 1,500, with most arrivals coming from Northern Africa (Immigration New Zealand, 2024). No published

statistics specific to Black Sub-Saharan refugees were identified through the databases and sources reviewed for this study.

2.4 Defining culture

It is important to consider culture when attempting to explore how Black Africans understand mental health, as culture influences how people understand the world. The term ‘culture’ has accrued various definitions over the years due to a lack of consensus regarding which definition best encapsulates all its elements (Huang et al., 2006). Attempts have been made to concisely define culture while simultaneously attempting to extrapolate its facets. However, no single definition has fully captured the meaning of culture, and, as such, each view tends to focus on a different dimension (Huang et al., 2006).

In some cases, the term culture is used to refer to matters of aesthetics, where it describes artistic expressions (Eagleton, 2016). It distinguishes artefacts and creations considered to be of high calibre, such as music, media, or literature (Baldwin et al., 2006). This definition of culture focuses on the physical products of human creation in contrast to the human experience that other definitions centre on. Other definitions also focus on products; however, they emphasise the underlying human processes involved in the context of culture. For example, Betancourt and Lopez (1993) define culture as the shared norms, behaviours, beliefs, and traditions a particular social group adheres to. From this perspective, culture is still defined by its products, but there is an understanding that these products are representative of the totality of, and motivation for, social interactions within a social group (Eagleton, 2016). Congruent with this perspective, another definition of culture states that it is a society’s way of life based on those shared elements (Baldwin et al., 2006).

Another view of culture is that it is a process defined by how humans create and attach meaning to the world based on the lessons passed down from generation to generation (Allan, 1998).

This perspective assumes that how humans interact with the world will affect how they view what is normative within their society (Allan, 1998). Their ethos is, therefore, formed by these generational lessons and present experiences. In this way, culture can be considered a dynamic and multifaceted process. Kim and Matsumoto (2001) define these cultural processes as where people adapt human and natural resources to live within the context of their environments. As such, based on their experiences, they use resources such as, but not limited to, shared traditions, religion, and normative behaviours to adapt to the social and natural environment they exist in (Betancourt & López, 1993; Kim & Matsumoto, 2001). Furthermore, as individuals progress through life, they become members of different social groups with unique cultures (Crisp & Hewstone, 2007). As such, these different memberships and experiences shape and influence how they understand the world, adding to the complexity of fully understanding the process of culture (Crisp & Hewstone, 2007).

For this study, culture is defined as the process through which people make sense of the world around them. It is their way of life that is constantly evolving (Eagleton, 2016; Kim & Matsumoto, 2001). It is a dynamic process that is influenced by a variety of factors, such as generational lessons, personal experience, and the environmental context a person lives in (Allan, 1998; Kim & Matsumoto, 2001). The culture a person identifies with affects how they conceptualise the world. In some cases, this process is unconscious and unbeknownst to the person regarding what situational factors have influenced their current behaviour (Baldwin et al., 2006). Some of the products that emerge through cultural processes include the behaviours, beliefs, values, shared artefacts, and traditions held by a group or individual (Baldwin et al., 2006). As such, it is important to consider cultural processes when attempting to understand how a phenomenon is conceptualised.

Mio et al. (2012) state that culture affects how individuals conceptualise their environment and context. From a mental health perspective, culturally associated mental health beliefs may

provide insight into how Black Africans conceptualise their mental distress (Abdullah & Brown, 2011; Choudhry et al., 2016; Kirmayer et al., 2011). This is particularly important as it frames how clients may report their symptoms, describe major events, or respond to treatment interventions (Abdullah & Brown, 2011; Kleinman et al., 1978). Black Africans have a unique cultural history that is embedded with complexities. The African history of colonisation and the journey of migration shapes the way that individuals belonging to this group view the world (Jackson, 1999). As Jackson (1999, p. 38) asserts, mental health in Africa is “interwoven with histories of struggle”. It is important to acknowledge this history as it shapes African migrants and refugees’ cultural processes, which in turn influences how they experience mental health (Abdullah & Brown, 2011). Building an understanding of the historical context of mental health in Africa can help establish a foundation for understanding some of the preconceived notions, biases, and normative behaviours and beliefs that Black African migrants and refugees may hold regarding mental distress. The relationship between mental health and the history of Africa will be discussed further in chapter three.

It is important to note that although groups such as Black Africans can have a similar culture, intra-group differences also exist among people. A cultural process is not bound to the one social group that a person is affiliated to. Personal experiences and opinions can have an impact (Bond, 2002). This means that there will always be difficulty in fully understanding all the elements of a person’s culture. As Lowell (1915) highlights:

There is nothing more elusive [than culture]. One cannot analyse it, for its components are infinite. One cannot describe it for it is a Protean shape. An attempt to encompass its meaning in words is like trying to seize the air in the hand, when one finds that it is everywhere except within one’s own grasp. (p. 113)

As such, this section only intends to highlight the depth of culture through historical experiences and how this affects how Black African migrants and refugees may have a different way of forming an understanding of mental health.

2.5 Conclusion

The purpose of this chapter was to orient the reader to the target population and relevant terminology. A brief background to Sub-Saharan Africa was provided. This was followed by contextual information related to Black African migrants and refugees. This included defining migration, migrants, and refugees and providing the rationale for the use of the term “Black African”. As culture is a key concept in this study, the chapter concluded with reviewing the nuances associated with defining culture and concluding with how culture will be defined in this study.

3. Scoping Literature Review

Black African Mental Health: Definitions, Histories, and Experiences

This chapter reviews the literature relevant to the present study, exploring how Black Africans construct meaning around mental health. To establish a foundation, the chapter begins with a brief review of definitions of health, emphasising the variations and evolving perspectives currently existing in the literature. After establishing a broad understanding of how health is defined, this chapter will focus on the history of mental health in Africa. Societal histories shape contemporary viewpoints for Black Africans, which makes it essential to consider the influences of traditional African beliefs, religious perspectives, and the impact of colonisation on mental health in African contexts. Since this study is interested in migrants and refugees, the chapter will also review migration and mental health theories. Lastly, literature related to the mental health experiences of Black Africans will be reviewed to ascertain common themes in studies conducted in other predominantly Western countries.

For this study, “Western countries” refer to nations in Europe, North America, and Australasia. While not identical, these countries share a historical, cultural, and political heritage rooted in Western Europe (Stearns, 2008). These nations are characterised by “individualism, analytical thinking, and systems-oriented culture” (Widiastuti et al., 2023, p. 3). They yield influences such as Greek rationalism and Judeo-Christianity (Stearns, 2008). From an academic perspective Western philosophies historically hold a positivist approach whereby the assertion of the existence of a single truth and identifiable reality (Humphrey & Bliuc, 2021; Park et al., 2020). It is important to note that in this study, “Western countries” does not encompass Indigenous communities living within these nations (e.g., Aboriginal people in Australia, Māori people in A-NZ, or Native Americans in North America).

3.1 Health Definitions

Health definitions influence how health is conceptualised, approached, and promoted (McCartney et al., 2019). Over time, numerous definitions have emerged, and each reflects varying perspectives, contexts, and priorities (Oleribe et al., 2018). These definitions often highlight tensions, such as the balance between biomedical and holistic approaches. This section explores the diversity of health definitions and examines their implications.

3.1.1 World Health Organisation Definitions of Health

The World Health Organisation (2020) defines health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" (p. 1). This definition was introduced in 1948 and countered the previous reductionist perspectives emphasised in Eurocentric definitions (Leonardi, 2018). The WHO's definition was considered revolutionary at the time and was applauded for its attempt to go beyond the "negative" unidimensional definitions of health to one that was considered multifaceted (Huber et al., 2011). However, in more recent times, this definition has been heavily criticised and considered outdated (Huber et al., 2011; Leonardi, 2018; Svalastog et al., 2017).

Huber et al. (2011) identified three key limitations in the WHO definition of health. First, the definition assumes health requires a state of complete wellbeing across all domains, which is a standard criticised as unrealistic and unattainable (Huber et al., 2011; Leonardi, 2018; Oleribe et al., 2018). Second, it fails to account for changes in population demographics and the evolving nature of diseases, such as the increasing prevalence of chronic illnesses (Huber et al., 2011). For instance, the advancement of medical knowledge and interventions has made it increasingly common for people to age while managing chronic conditions (Huber et al., 2011; Leonardi, 2018). As such, one argument questions whether the WHO's definition neglects individuals who can live a long and fulfilling life while having a disability or chronic illness (Huber et al., 2011; Leonardi, 2018; Witt et al., 2017). Lastly, the third limitation questions the

possibility of operationalising the definition due to the difficulty of ascertaining what constitutes "complete" health (Huber et al., 2011). Therefore, it is considered difficult to measure, which some argue means concrete and useful health standards cannot be determined (Leonardi, 2018).

While no new official definition has been adopted, the WHO has developed various renditions of health definitions to capture different domains (McCartney et al., 2019). For example, in 1986, on a sponsored work in the Ottawa Charter, the WHO defined health as the ability to identify and actualise aspirations in life and satisfy needs. This definition framed health as a positive resource for addressing social, personal, and physical demands (McCartney et al., 2019). However, it was criticised for being absolutist and conflating health with happiness (McCartney et al., 2019). Subsequent definitions attempted to address these critiques by introducing phrases such as "health is *the extent to which* an individual or group is able..." (as cited in (McCartney et al., 2019)). This approach aimed to conceptualise health along a continuum, addressing concerns about absolutism.

3.1.2 Categories of Health Definitions

Sartorius (2006) argued that health definitions can be considered in three categories within Western literature (all of which can be noted in the WHO definition debates discussed in the previous section):

1. Health is defined as the absence of disease or injury.
2. Health is a state that allows a person to cope with life's demands (which requires the absence of disease and impairment).
3. Health is a state of equilibrium between a person, their internal processes, and the social and physical environment.

The first category defines health as the absence of disease and injury (Sartorius, 2006). This draws on biomedical theories and health perspectives and aligns with original Western definitions of health (Boorse, 1977; Huber et al., 2011). However, this framework has been criticised for neglecting other domains of well-being (Huber et al., 2011). The second category expands the concept of health beyond the absence of illness to include a person's ability to cope with daily life (Sartorius, 2006). These definitions have been criticised for not acknowledging other health domains (e.g., spirituality) and the subjective experiences of an individual (Sartorius, 2006). For instance, they do not account for people living with a disease but still functioning well (Leonardi, 2018; Sartorius, 2006).

In contrast, the third category considers health as the connection between a person and their environment (Sartorius, 2006). In this perspective, health is no longer bound by the presence of a disease but rather by a person's ability to *feel* in harmony with their body and their environment (Sartorius, 2006). While this definition is useful in considering the subjective experience of health, it leaves the question of whether a person is healthy if they have a disease but are content within their body and can live a fulfilling life (Sartorius, 2006). Criticisms from definitions that stray from the biomedical perspective often stem from difficulty assessing domains such as spirituality through a rigorous scientific method (Boorse, 1977). Consequently, some argue that concepts lacking objective measurability are difficult to validate and generalise to the population (Boorse, 1977).

Modern definitions of health tend to align with the third category (Svalastog et al., 2017; Witt et al., 2017). Svalastog et al. (2017, p. 432) offered a summary that captures the general view of how health is currently defined.

The holistic concept of health is contained in the expression of wholeness. Health is a relative state in which one is able to function well physically, mentally, socially, and

spiritually to express the full range of one's unique potentialities within the environment in which one lives. Both health and illness are dynamic processes, and each person is located on a graduated scale or continuous spectrum ranging from wellness and optimal functioning in every aspect of one's life at one end to illness culminating in death at the other.

Svalastog et al. (2017) discuss the importance of self-realisation and self-fulfilment in relation to a person's environment as a key feature in defining health. Furthermore, this perspective does not see health as dichotomous but considers it as a spectrum, acknowledging the gradients people can experience regarding their health.

3.1.3 Indigenous Definitions of Health

Compared to historic Western views of health, modern definitions share more commonalities with Indigenous perspectives, which adopt a holistic view of health (Glover et al., 2008; Omonzejele, 2008). In contrast to the individualistic approach of the biomedical model, Indigenous perspectives are collectivist (Glover et al., 2008). Health is viewed holistically, involving the entire community's well-being and influenced by cultural, environmental, and spiritual factors (Glover et al., 2008; Omonzejele, 2008). Historically, across societies such as Ancient Greece, Indian, and Chinese communities, health has always been considered as an equilibrium between a person and their environment, a harmonious union between the soul, the body, and nature (Svalastog et al., 2017).

This is the same for Indigenous African beliefs around health. Health extends beyond one's physical functioning or the absence of disease and includes spiritual and environmental components (Omonzejele, 2008). Health is considered a collectivistic process, meaning that a person's functioning is understood within the context of their community (Ajima & Ubana, 2018).

3.1.3.1 Māori Definitions of Health

In addition to potential influences from Western definitions of health, Black Africans in A-NZ may also draw insights from Māori perspectives, given the cultural interplay within A-NZ society. Māori health perspectives emphasise the significance of holistic factors, including whānau and nature. While whānau is often translated as “family”, its meaning is far more complex. As described in *Te Ara, the Encyclopedia of New Zealand* (2011), whānau includes extended family and the broader community, as well as physical, emotional, and spiritual dimensions rooted in whakapapa (ancestral genealogy). Health, therefore, extends beyond the individual to the community and other interconnected dimensions (Walker, 2011).

One prominent model that reflects this holistic perspective is *Te Whare Tapa Whā*, which was developed by Sir Mason Durie (1985). This model conceptualises health as being supported by four pillars: *taha tinana* (physical), *taha hinengaro* (emotional), *taha wairua* (spiritual), *taha whānau* (family and community). Underpinning these pillars is the *whenua*, which represents a person’s physical and spiritual connection to the land and nature. These pillars are interdependent as each affects a person’s overall wellbeing (Durie, 1985). This model is often used by health professionals in A-NZ to conceptualise health through a holistic lens (Rochford, 2004).

Expanding from *Te Whare Tapa Whā*, the *Meihana* model further broadens health understandings by including additional factors, such as *iwi katoa* (wider societal factors) and *taiao* (environmental factors) (Pitama et al., 2017). Furthermore, it also explicitly acknowledges the impact of external factors such as marginalisation, colonisation, racism, and migration. These models emphasise the holistic nature of Māori health, which more closely aligns with African health perspectives. Māori and African health conceptualisations both emphasise the interconnectedness of an individual, community, and environment. They recognise health as a balance between physical and spiritual dimensions.

3.1.4 Importance of Health Definitions

It is important to note that the purpose of this section is to highlight that health has been defined in various ways. This is reflected by the contention in the literature regarding which definition is most appropriate (Svalastog et al., 2017). Depending on the paradigm or viewpoint, it can influence how people respond and manage their health. Those who hold a largely biomedical definition of health will approach their well-being in a similar manner. This can be seen by how when the dominating definition was the absence of disease, medicine and biological treatments were the focus for health professionals (Eberst, 1984). In contrast, those who hold health definitions consistent with Indigenous or holistic perspectives might adopt understandings and behaviours that extend beyond a person's physical well-being, such as spiritual rituals (Omonzejele, 2008).

3.2 Kleinman's Explanatory Model of Health and Illness

Kleinman's Explanatory Model of Health and Illness is a seminal model in which he argued for the acknowledgement of alternative health frameworks to the biomedical perspective (Kleinman, 1986). The purpose of this model was to understand how culture shapes health. According to Kleinman (1978), he defined healthcare systems as health, illness, and other health-related aspects. He considered these healthcare systems as similar to other cultural systems (e.g., religion, kinship, and other symbolic systems) in that they emerge from society's meanings, values, and norms. For him, healthcare systems carry cultural idioms that determine an individual's beliefs about an illness and health. These include elements such as, but are not limited to, beliefs about the cause, course, and treatment of sickness (Kleinman, 1978).

Kleinman's (1978) considered healthcare systems as comprised of three main structures. These represent the different contexts that influence a person's healthcare system. Kleinman highlighted that, similar to other cultural systems, each domain contains beliefs and expectations. This included the *Popular* factor, which included aspects such as family, social,

and community systems that influence beliefs about health. *Professional*, which drew from scientific communities and related to Western medicine and professionalised Indigenous healing to understand health. Whilst *Folk* referred to non-professional healers. Kleinman stated that the general public's meaning-making of health and illness typically occurs in the *Popular* domain through the influences of family and the society that they live in, while health professionals tend to draw from the *Professional* domain (Kleinman, 1978).

Kleinman (1978) highlighted how professionals and patients typically hold different perspectives on health and sickness. He asserted that professionals mainly focus on the disease aspect of health while the public focuses on illness. Illness and disease were differentiated, with disease representing a person's biological and psychological malfunction, while illness refers to the experience of the disease (Kleinman, 1978). Kleinman argued that these different clinical realities between the general public and professionals can result in mismatched expectations and miscommunications, ultimately negatively impacting a person's health outcome (Kleinman, 1978).

Elaborating on this notion of illness, Kleinman's model offers the concept of Explanatory Models (EMs). He asserts that people utilise EMs, and in so doing, these govern the way they perceive an illness. These are derived from the social and cultural context and a person's prior experiences and knowledge. Kleinman believed that problems can arise when there are institutional conflicts between a patient and a practitioner based on their different Explanatory Models. EMs may be understood as "the cultural construction of illness as a psychosocial experience", which "entails complex psycho and socio-somatic processes that feedback to affect disease and play a role in the process of healing disease and illness" (Kleinman, 1978, p. 90). It is important to understand how people experience their illness or disease to understand their healing process.

Given the increased emphasis in the literature on developing an understanding of mental health that extends beyond the biomedical framework, there is, therefore, the need to explore mental health views within a person's historical and cultural context (Svalastog et al., 2017). For Black Africans, their world ethos is influenced by the complex history that is comprised of interwoven strands that include ancestral traditions, colonisation, racism, and the migration process, thus creating a unique outlook of the world (Ocheni & Nwankwo, 2012). Therefore, imposing pre-existing explanatory models on this population risks neglecting the nuances that shape their understanding and the underlying factors that impact whether they seek treatment or not. As such, Kleinman's framework creates a foundation to acknowledge this complex cultural process and its implications on the experience of mental health.

3.3 History of Mental Health in Africa

History and culture are intertwined. History tells of the experiences and knowledge of ancestors passed down from generation to generation to impact today's culture (Nunn, 2012). African history sheds light on some of the previous experiences that have shaped the culture of Black Africans. This becomes a useful tool in understanding the factors that may have shaped their conceptualisation of mental health. This review will briefly consider the history before and after colonisation regarding mental health.

3.3.1 African Views of Mental Health

Indigenous African worldviews are characterised by their holistic nature. It is understood that the universe is interconnected, and no one entity acts separately (Johnson, 1994). According to this view, the world comprises both a physical and spiritual realm where each realm influences the other, emphasizing interconnectedness and indivisibility (Asante & Mazama, 2005; Johnson, 1994). Illness may arise from disharmony in any dimension, with its effects often impacting other areas (Johnson, 1994). As such, fully understanding a person involves considering what is seen and unseen, such as spirituality.

In the same way, mental health is viewed from a holistic perspective. Most Indigenous African beliefs acknowledge that mental health extends beyond the mind and body (Choudhry et al., 2016; Johnson, 1994; Sorsdahl et al., 2009). According to Omonzejele (2008), ill health is believed to occur when a person is susceptible to interpreting reality in unusual ways (Omonzejele, 2008). Theories related to aetiologies of mental distress align with African cosmological beliefs that link the physical to the spiritual realm. One belief asserts that mental distress is the manifestation of punishment for one's severe sins brought forth by ancestral spirits (Choudhry et al., 2016; Okello & Musisi, 2015; Sorsdahl et al., 2009). Another belief attributes mental distress to bewitchment. It is claimed that a person may be cursed, which results in the symptoms they experience (Akyeampong, 2015). Based on these aetiological assumptions, the treatment of mental health tends to focus on the spirituality of a person.

According to Jackson (1999), historically, in Sub-Saharan Africa (SSA), the dominant treatment for mental health issues was seeking assistance from traditional healers. The World Health Organisation (2019) defines traditional healers as individuals who utilize practices based on a community's beliefs and Indigenous theories. The primary healers in most SSA countries include herbalists and witch doctors (Okello & Musisi, 2015). Engaging with traditional healers typically commences with paying the required price to the traditional healer (Freeman & Motsei, 1992; Patel, 2011). Depending on the healer, they will use various practices to help the individual. Herbalists will utilise natural herbs, while witchdoctors use rituals to contact ancestral spirits (Freeman & Motsei, 1992; Okello & Musisi, 2015). As per African beliefs regarding holistic health, traditional healers may include all areas of an individual when assisting them. For example, the healer may suggest interventions related to spirituality, physical health, or the wider community (Freeman & Motsei, 1992).

It is important to note that in Indigenous African perspectives, behaviour that is deviant from the norm is not always viewed as an indication of pathology. Okello and Musisi (2015)

describe that traditional healers are chosen through traditional diviners who will look for signs among people in the community that distinguish them as those selected by ancestral spirits to carry the art of healing. These signs may include nonconformist behaviours or hallucinations (Okello & Musisi, 2015). Instead of interpreting these behaviours as mental distress, diviners may see it as a sign that an individual has been selected to be trained as a traditional healer (Okello & Musisi, 2015).

3.3.2 African Perspectives vs Western Perspectives

These African perspectives can be contradictory to the Western worldview of mental health. The Western mental health perspective emphasises Cartesian dualism, which views the mind and body as separate entities that influence one another (Kovach, 2017). As such, aetiological theories and treatment plans for mental health usually draw on the mind and body being separate (Kovach, 2018). In contrast, Indigenous African perspectives assert that these areas are intertwined and indivisible (Johnson, 1994). The different beliefs impact how mental health is understood and approached among the two communities. From a Western perspective, one might see a doctor or a psychologist to assist with the body or mind (Johnson, 1994). Meanwhile, Africans may seek the assistance of a traditional healer who considers other domains, such as spirituality (Johnson, 1994; Ozekhome, 1990). In addition, rather than health being a personal issue, as seen in Western communities, from an African perspective, it can involve the community a person belongs to (Johnson, 1994).

As such, when Africans were introduced to Western approaches to mental health, it had a substantial effect on the way mental health was approached in Africa. Africans had to navigate between two conflicting modes of thought, which changed not only the way mental health distress was understood but also how it was approached (Keller, 2001).

3.3.3 Implications of Colonisation

As highlighted by Asante and Mazama (2005), the current African epistemology is not only based on Indigenous beliefs, but it is entrenched in the history of African colonialism, neo-colonialism and racism experienced by Africans. Therefore, it is important to review the impact of colonial actions on the culture of Africans and how this relates to mental health. Colonisation is a process where a group exerts control over another group to establish dominancy and claim authority (Jackson, 1999). In the nineteenth century, Sub-Saharan African countries were colonised by European countries such as Britain, France, Portugal, and Germany (Maddox, 2018). This had profound implications for the structure and functioning of these countries.

The effects of colonisation can be considered at a macro, meso, and micro level. At a macro level, African countries' political and economic systems were significantly changed. According to Ocheni and Nwanko (2012), one of the primary goals of colonisation was to establish African countries as the primary international epicentre for industrial manufacturing. This led to the exploitation of natural resources and African people (Maddox, 2018; Ocheni & Nwankwo, 2012; Viriri & Mungwini, 2010). Maddox (2018) notes that the colonisation of a country was often established through diplomatic pressure and military interventions. The conquest by Western political powers resulted in the introduction of legislation that had significant socio-economic implications for Africans. For example, laws were introduced that brought systematic normalisation of issues such as forced labour, monetisation, and taxation on African communities (Ocheni & Nwankwo, 2012). Segregation was another system introduced by colonisation that separated European communities from African communities (Jackson, 1999). This system prioritised the well-being of European groups by providing better educational, occupational, and political opportunities to people of European descent. Consequently, Africans were left in severely disadvantaged positions (Viriri & Mungwini, 2010).

The macro implications of colonisations filtered down to affect meso- and micro-systems. The slave-based economy established during this time promoted prejudice against Black Africans (Ocheni & Nwankwo, 2012). Black Africans were denied access to certain resources such as quality education, medical care, and occupations (Jackson, 1999). Inadequate resources resulted in difficulties, such as Black Africans inhabiting areas with less fertile land, poor hygienic conditions, and low socio-economic status (Ocheni & Nwankwo, 2012). Consequently, this had a profound impact on Black Africans at a micro-level. Due to the dominating presence and promotion of Western culture, the Indigenous African culture was comparatively treated as a primitive and an unacceptable way of life (Arowolo, 2010; Jackson, 1999). According to Arowolo (2010), the Western culture was endorsed as the modern approach and the way one should conduct oneself. These ideas encouraged the dismissal of African cultural heritage among families through negating and diminishing African perspectives (Jackson, 1999). Arowolo (2010) further adds to this by highlighting colonisation's impact on African civilisation. He defines civilisation as "a totality of people's history, way of life, their expectations, their frustrations, their desire, and their aspirations" (p. 5). The introduction of colonisation affected all these aspects of African civilisation. It created a new environment where Black Africans were forced to amalgamate a cultural identity with elements of Western culture and elements of African culture while processing the complex history of the trauma of colonisation. It is experiences such as these that impact how a person conceptualises the world around them.

Regarding mental health, the colonial era saw the development of mental health services such as psychiatric or psychological clinics (Cooper & Nicholas, 2012; Richards et al., 2012). Political systems continued to prioritise Western perspectives, and this, too, was evident in the mental health field. Psychology was originally only practised by Western clinicians who utilised Western conceptualisations of mental health. In some countries, non-European

clinicians were prohibited from practising and, in some cases, non-Europeans were prohibited from training to become clinicians (Cooper & Nicholas, 2012; Richards et al., 2012). This had a significant impact on the way psychological clinics treated Black Africans as the systematically entrenched prejudice expressed itself in the mental health sector (Swartz, 1995). Black Africans were assessed for mental health distress via Western criteria (Keller, 2001). The holistic nature previously found in traditional approaches was forgone for a more bio-medical approach to mental health (Keller, 2001).

In addition, racial discrimination affected the quality of treatment accessible to Africans (Keller, 2001). The literature describes discrepancies between in-patient treatment for Europeans and Black Africans in mental health institutions. For example, Jackson (1999) and Keller (2001) described Africans in Zimbabwe being placed in prison-like facilities while Europeans were provided with comparatively more habitable facilities. According to Jackson, one of the reasons that the first asylum was built in Zimbabwe was due to overcrowding resulting from the placement of Africans with mental distress in prisons. As such, in-patient Africans had prison-like treatment (Jackson, 1999). The accumulation of exposure to issues such as an absence of African clinicians, inappropriate assessment, and inadequate mental health facilities was likely to have a significant influence on Africans' perspectives of mental health (Akyeampong, 2015; Cooper & Nicholas, 2012; Jackson, 1999).

Another critical historical change that colonisation brought about was the introduction of new religions. This is significant as adopting a new religion can influence the cosmological beliefs held by an individual (Berry, 1996). Religions typically offer beliefs on how the universe operates and how individuals should conduct their lives (Berry, 1996; Hordern, 2016). Among the countries that colonised Sub-Saharan Africa (SSA), Christianity was the dominant religion (Adogame, 2007). Many missionaries introduced the religion to Africans, who later adopted it (Adogame, 2007). Even after colonisation, most Southern Africans identify themselves as

religious, with Christianity being the dominant religion (Mayeya et al., 2004). This impacted how mental illness was understood and approached among Africans. Religion offered an alternative theological explanation. It was commonly believed that mental illness was because of the punishment from God for sins committed (Koenig, 2009; Mayeya et al., 2004). Another belief asserted that mental illness was the outward manifestation of demonic possession (Koenig, 2009). Religious beliefs about mental health influenced how people responded to related distress. Instead of traditional healers, religious leaders, such as pastors and prophets, increasingly became the main source for seeking treatment for mental illnesses (Adogame, 2007; Burns & Tomita, 2015). Religious leaders would engage in practices such as prayer and exorcism to eradicate the problematic symptoms (Koenig, 2009; Mayeya et al., 2004).

For some Black Africans, these experiences have led to negative stigma regarding mental distress (Egbe et al., 2014). Aetiological beliefs such as demon possession play a large role in maintaining these negative assumptions (Egbe et al., 2014). As such, people with mental distress were often ostracised and neglected within the community. Both external stigma from the community and internal stigma experienced by the person with the distress can be a barrier for Black Africans seeking treatment for mental distress (Egbe et al., 2014).

In addition, colonial implications are still prevalent as many SSA countries continue to struggle with issues such as poverty, malnutrition, lack of adequate healthcare, and poor education (Ocheni & Nwankwo, 2012). This impacts mental health in Africa as these concerns often take precedence over mental health issues (Desjarlais, 1995). As such, there are limited resources and attention dedicated to mental health distress in SSA countries (Desjarlais, 1995; Okello & Musisi, 2015). This has led to some communities where mental health is seldom addressed unless an individual is in an acute condition (Okasha, 2002). Negative stigmas surrounding mental health and lack of resources are often the result of the historic experiences that have framed the mental health of Black Africans in a negative light, particularly during the colonial

era (Alemu et al., 2023). Viriri and Mungwini (2010) argue that the colonial implications have affected contemporary Africa metaphysically and epistemologically, thus, inherently influencing how some Africans understand and approach matters such as mental distress. Although more Africans consider mental health clinics to be a potential aid, the lack of resources makes it difficult for them to receive support (Sankoh et al., 2018). Before delving into the experiences of African migrants, it is important to acknowledge these historical experiences as African migrants carry this generational history, which consequently affects their personal cosmological, ontological, and epistemological views of how mental health operates.

3.4 Migration and Mental Health

Migrating to a new country is a complex process that can predispose individuals to develop psychological distress. Berry's (1997) Acculturation Theory provides broad insight into how migration can impact individuals' mental health. According to this theory, people who migrate undergo a process of acculturation, whereby individuals from different cultures come into continuous contact, leading to changes in their original culture. This also includes psychological acculturation, where people adopt new behaviours to allow for adequate adaptation to the new cultural context (Berry, 1997). Part of this involves negotiating which behaviours are maintained and which must be unlearned in a process termed 'cultural shedding'. Berry (1997) argued that an inability to achieve psychological adaptation can lead to cultural conflict, leading to the development of acculturative stress. Acculturative stress is a decline in a person's psychological, social, or physical health due to adapting to a new culture (Berry, 1997, 2003). Berry (2003) theorised that if acculturative stress is not managed and becomes pervasive and life-long, it predisposes individuals to develop mental disorders and psychological distress.

It is important to note that Berry's acculturation theory has been criticised for being unidimensional. This is due to the theory primarily attributing the mental health of migrants to post-migration factors (Idemudia & Boehnke, 2020). It neglects other nuanced factors that are not directly related to the acculturation process. Idemudia and Boehnke (2020) argued that migrants and refugees experience significant stressors that affect their well-being before they migrate. As such, though this theory provides useful insight, it does not acknowledge other important factors that may contribute to the mental well-being of migrants and refugees.

Lazarus and Folkman (1984) offer a more comprehensive theory that can help explain the vulnerability to mental distress among migrants and refugees. Lazarus and Folkman's (1984) Transactional Model of Stress and Coping states that when people face a stressor, they respond through primary and secondary cognitive appraisals. Primary appraisals involve the evaluation of the stressor and ascribing meaning to it as benign-positive, irrelevant, or stressful. If an event is perceived as stressful, it can be evaluated as threatening, challenging, or harmful. This initiates the secondary appraisals, which are a person's coping responses to the event. This can include strategies such as social support, confrontation, or avoidance. It is through the use of coping strategies that migrants and refugees mitigate acculturative stress. As highlighted by Idemudia and Boehnke (2020), this model offers an understanding of how people understand their stressors during the pre-, mid-, and post-migration stages, which has implications for their mental health. It is a framework that acknowledges that mental distress is influenced by how a person understands their situation and approaches it. For migrants and refugees, this is not limited to their post-migration experiences but to every aspect of their lives.

Another seminal article by Bhugra (2004) examines the relationship between migration and mental health. Bhugra differentiates the stages of migration as they relate to psychopathology. In his article, the stages of migration include the premigration, migration, and post-migration. Depending on the situational factors related to the migration process, a person can become

more susceptible to experiencing distress. Figure 3. showcases some of the likely psychopathological phenomena Bhugra hypothesised occur during the different stages of migration. According to Bhugra, factors such as push-pull influences, whether a person's migration is forced or voluntary, and the geographical distance traversed in the migration process will play a role in the genesis of acculturative stress. As seen in Figure 4., Bhugra extended this idea by creating a hypothetical model that considers how complex experiences may impact the development of mental disorders. For example, his theory highlighted how experiences such as the stress of adapting to a new environment, cultural dislocation, and racism can increase someone's vulnerability to mental health conditions such as post-traumatic stress disorder or even schizophrenia. Bhugra's model is useful in considering the implications of migration on mental health. It allows for a broader overview and the acknowledgement of the influence of nuanced experiences on psychopathology. However, to develop an understanding of mental health, it is also important to consider how people interpret these experiences.

Figure 3

Stages of migration and psychopathology. Retrieved from Bhugra (2004)

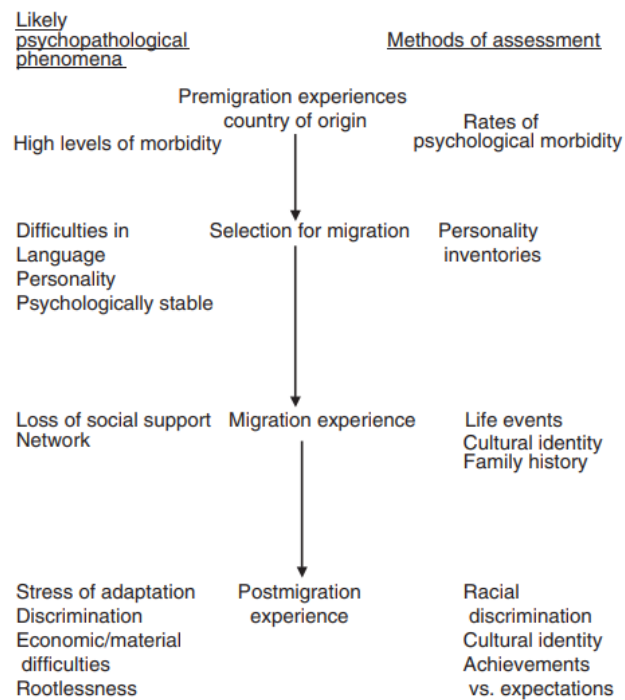
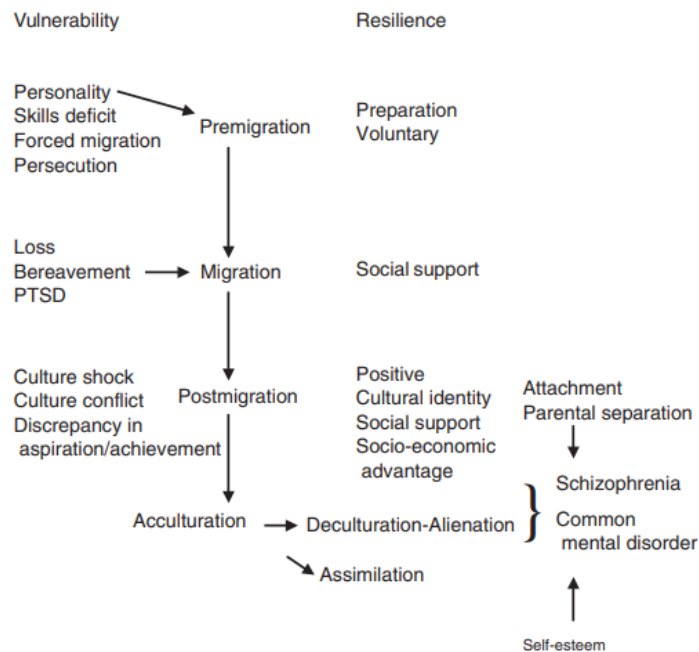


Figure 4

Migration and psychiatric disorders a hypothetical model. Retrieved from Bhugra (2004)



3.5 Mental Health Experiences of Black Africans

The number of Black African refugees and migrants around the world is increasing (Stats NZ, 2024). As such, while research may be scarce within an A-NZ context, studies from other Western societies can provide valuable insight into understanding the mental health experiences of Black Africans. The following section will provide a scoping review of the literature on Black Africans' mental health conceptualisations, experiences, and help-seeking barriers and protective factors. This is based on literature from other Western countries such as Australia, Canada, the United Kingdom (UK), and the United States (US).

3.5.1 Mental Health Conceptualisations

Studies conducted in Western countries indicate that Black Africans' understanding of mental health is shaped by various factors, including African worldviews, spirituality, and religious beliefs (Nganga, 2022; Pederson et al., 2023; Tuffour, 2023). For example, some individuals attribute mental distress to spiritual reasons, such as demon possession or the will of God (Nganga, 2022). Similar findings have been reported in other studies conducted in countries such as America, UK, and Canada, which suggest the persistence of spiritual and religious frameworks in interpreting mental health across various contexts (Nganga, 2022; Omenka et al., 2020; Pederson et al., 2023; Tuffour, 2023). Such observations align with the beliefs prevalent among some African communities, where mental distress is often interpreted through spiritual or religious lenses (Koenig, 2009), this suggesting that for some Black Africans, their conceptualisation of mental health remained the same as those seen in some African communities.

A recent study by Tuffour (2023) reviewed the explanatory models of mental health among Black Africans in England. Results found that participants often attributed their mental distress to African worldviews. In addition, the study highlighted the complexities of migration and negative life experiences as other factors involved in Black Africans' explanatory models.

Tuffour (2023) linked these findings to Bhugra and Jones' (2010) stages of migration: pre-migration, migration, and post-migration. In doing so, Tuffour illustrated how factors such as traumatic events in home countries, exposure to discrimination in host countries, and stigmatising beliefs about mental health (e.g., witchcraft) influenced participants' understanding of mental distress. These evolving perspectives throughout the migration process suggest that, for some Black Africans, migration evokes new variables that influence their conceptualisation of mental health, while others maintain beliefs consistent with those held in African communities. This aligns with findings from other Western-based studies, which highlight the shared themes in how Black Africans associate mental distress with cultural, spiritual and contextual factors globally (Omenka et al., 2020; Pederson et al., 2022; Tuffour, 2023). It is also important to highlight that while religious and spiritual beliefs were prevalent, other Black Africans attributed mental distress to factors such as general life stress (Este et al., 2017).

As highlighted in Okeke-Ihejirika et al.'s (2020) scoping review on Black Africans in Canada, many studies have documented that mental health is often associated with a negative stigma due to factors such as the threat of social ostracisation and negative word associations such as "crazy" (Este et al., 2017; Okeke-Ihejirika et al., 2020; Pederson, et al., 2023; Tuffour, 2023). This stigma was consistently reported across studies from various Western countries and extended to different ages, genders, and various life circumstances (e.g., pregnant women) (Allam & Binnie, 2024; Baiden & Evans, 2021; Este et al., 2017; Fauk et al., 2021; Pederson, Earnshaw, et al., 2023). Such findings suggest that stigma may be a component of how some Black Africans make meaning of their mental health experiences.

3.5.2 Mental Health Experiences of Black Migrants

The literature has documented some of the common forms of mental distress experienced by Black Africans. One of the main contributors to mental distress among Black Africans is pre-

migration stressors. For example, exposure to war-torn countries, family loss, harsh living conditions, and other traumatic events can make people more vulnerable to developing mental distress (Idemudia & Boehnke, 2020; Murphy et al., 2021). Idemudia and Boehnke (2020) conducted a systematic review examining Black Caribbean migrants in England. They examined the impact of pre- and post-migration stressors on mental health and post-traumatic stress disorder (PTSD). Results showed that the stressors experienced during the pre-migration stage were predictive of PTSD. However, variability across different host countries was noted, with some countries indicating higher prevalence rates of PTSD than others; while this could be due to multiple factors, it may suggest that the quality of the post-migration environment can impact mental health.

Another study found that among Black African refugees in Ireland, experiences such as shame and self-loathing, anger and mistrust, and rumination were common everyday mental health experiences for asylum seekers (Murphy et al., 2021). While these experiences were associated with pre-migration stressors, they were also linked to post-migration stressors such as awaiting visas or asylum. Similarly, in a recent Australia-based study, Black Africans seeking to resettle in Australia faced similar mental distress challenges, such as underlying feelings of guilt and depression. Consistent with other studies around the world, factors such as homesickness, cultural conflicts, and employment difficulties resulted in mental health challenges for Black Africans in Australia (Ikafa et al., 2024).

Some gender differences were noted in the literature. A Paris-based study by Pannetier et al. (2017) found that amongst Sub-Saharan Black African women, depressive and anxiety symptoms were strongly associated with pre-migration factors such as threat to life and leaving their home country. In contrast, for men, the same symptoms were associated with factors threatening their migration experience, such as visa difficulties. Furthermore, in Olawo's (2019) study, gender-based stereotypes impacted the mental health experiences of Black

Africans. In particular, beliefs related to masculinity resulted in African men viewing mental distress as a form of weakness. This led to the minimisation of symptoms and avoidance of addressing mental distress. Therefore, this suggests that common stereotypes and societal norms influence people's understanding and experience of mental health.

In addition to the aforementioned experiences, Black Africans are also more vulnerable to severe mental distress, such as psychosis and schizophrenia. This was evidenced in Torteilli et al.'s (2015) UK study which asserted that Black Africans and Caribbean migrants were almost five times more likely to experience a psychotic disorder than non-migrants. A seminal review article by Wilson (2001) also noted that Black women in Britain were more likely to be diagnosed with schizophrenia. This was consistent with findings from Sutherland's (2006) study, which documented similar sentiments regarding Black men and women in the UK. The disproportionate findings brought into focus the racial disadvantages experienced by Black people in Western countries. With little understanding of Black mental health experiences, it becomes difficult to ascertain whether the resources used to assess migrants are culturally appropriate and acknowledge the cultural nuances of the individuals. Given that the A-NZ healthcare system also predominantly draws from Western modes of health, understanding these challenges can be relevant to people in A-NZ.

3.5.3 Racial Experiences

Numerous studies have associated mental distress experiences with Black Africans' experiences with both external and internalised racism (Ikafa et al., 2024). Universally, racism-based experiences among Black Africans in Western countries are significantly associated with increased depression and anxiety (Astell-Burt et al., 2012; Motley et al., 2024; Salami et al., 2021). For example, a recent Australian-based study by Ikafa et al., (2024) found that racial and external discriminatory experiences were a risk factor for post-migration stress and psychological distress for Black Africans. This was consistent with other Australian studies that

described similar findings (Ferdinand et al., 2015; Ikafa et al., 2022). This suggests that racial experiences can lead to negative mental health consequences for Black African migrants and refugees.

3.5.4 A-NZ Black Africans Mental Health Experiences

A few studies have examined the mental health of Africans in A-NZ. However, most literature does not focus specifically on Black Sub-Saharan Africans. Most studies consider Africans' acculturation experiences and focus on how people adjust to life in A-NZ (Bennett et al., 1997; Philipp & Ho, 2010; Udahemuka & Pernice, 2010; Winbush & Selby, 2015). Although this provides useful information, it does not consider the nuanced cultural factors that influence experiences of mental health. As highlighted by Kanengoni et al. (2020), there is a dearth of literature regarding the health of Black Africans in A-NZ more so with mental health literature. This population is often neglected in the literature or clustered with other cultural groups. This makes it difficult to extrapolate information from their experiences.

An earlier study by Guerin et al. (2004) explored Somali migrants in A-NZ's conceptions and expectations regarding mental health. Although Somalis are not Southern African, their experience in an A-NZ context offers relevant insights. The author found that many participants associated mental illness with severe cases only. Treatment for both physical and mental health often involved religious practices such as reading the Koran. However, in situations where mental health issues were somatic, the authors noted a strong reliance on general practitioners for support.

While studies such as Guerin et al.'s (2004) are scarce, the acculturative studies do provide insights into stressors that can impact the mental health of Black Africans. For example, the study by Winbush et al. (2015) found that culture shock often results in high anxiety among migrants and refugees due to cultural disorientation and identity vulnerability. Culture shock

refers to the confusion a person experiences when they are transplanted from their original cultural context to a new one. This can lead to grief and a sense of loss due to the change in environment (Winbush & Selby, 2015). While participants in this study were African, they were described as having Afrikaans ancestry, meaning they were not Black Africans. These findings are consistent with those noted in my Honours thesis that reviewed the acculturative experiences of African women in A-NZ (Musakwa, 2018). Participants in this study included both Black and non-Black African women. The results from this work showed that culture shock was associated with depressive and anxious symptoms.

3.5.5 Implications of Te Tiriti o Waitangi

The history of Aotearoa New Zealand is marked by the colonisation of Māori and the silencing of Indigenous voices (Moewaka Barnes & McCreanor, 2019). Although efforts have been made to address the negative impacts of colonisation, its effects are still visible today through health disparities faced by Māori (Sheridan et al., 2024). The shared colonial history between Africa and A-NZ means that there are some similarities regarding the experiences of Black Africans and Māori. In response to this, it is important to acknowledge the significance of Te Tiriti o Waitangi when considering healthcare in A-NZ. Te Tiriti emphasises the equity, partnership, and the safeguarding of Māori wellbeing (Came et al., 2021). The three core principles relevant to healthcare are partnership, participation, and protection, which guide how services are designed and delivered. Partnership means collaborating with Māori at all levels, from governance to service delivery, including involving Indigenous peoples in decision-making. Participation refers to supporting Māori to fully engage with healthcare services by removing access barriers and promoting Māori leadership. Protection requires safeguarding Māori health and wellbeing by ensuring equitable access to services, addressing health disparities, and embedding Indigenous perspectives within healthcare systems (Came et al., 2021).

Although Te Tiriti specifically upholds Māori rights as tangata whenua, its principles have wider implications for providing equitable healthcare to other minority groups, including Black Africans in A-NZ. Te Tiriti informs a multicultural approach that values diversity and promotes inclusive, culturally safe care (DeSouza, 2006). While it does not directly reference the healthcare needs of immigrants, its influence on health policy and service delivery helps address systemic barriers faced by Black Africans. Since Black African communities uphold beliefs and traditions that differ from the dominant biomedical model of mental health, Te Tiriti's framework encourages clinicians to incorporate diverse worldviews (DeSouza, 2006). In this way, practitioners can utilise the principles of Te Tiriti to reduce health inequities, recognise cultural differences, and create safe therapeutic environments.

3.6 Barriers to Accessing Mental Health Services

As highlighted throughout this literature review, the way Black Africans conceptualise mental health will impact how they engage with mental health services, including complete avoidance of such services (Mays et al., 2017). As such, this section will examine some of the mental health protective factors and help-seeking barriers to Black Africans' access to mental health services. Both protective factors and help-seeking barriers impact whether people engage with mental health services. Therefore, these matters are important to review as they provide insight into mental health service engagement factors.

3.6.1 Protective Factors

In this section, protective factors refer to the strategies that Black Africans in Africa use to manage their mental health. The main strategies indicated in the literature include consulting traditional and faith healers. Historically, the use of traditional healers was common in Africa and has continued to be used in Sub-Saharan Africa (Burns & Tomita, 2015). Another protective factor is the use of faith healers. A faith healer is a religious leader who provides advice, prayer, or exorcisms to support individuals with illnesses (Koenig, 2009). Koenig

(2009) and Mayeya et al. (2004) claim that Africans prefer to seek the support of faith healers rather than mental health services. This highlights how people's underlying beliefs about the aetiology of mental health influence behaviours to manage mental health. The use of faith and traditional healers speaks to the beliefs surrounding the role of spiritual entities in mental health. This decreases the likelihood for members of this community to engage with Eurocentric mental health services that derive from different aetiological assumptions about mental health (Tuffour, 2023).

For Black African migrants and refugees, compared to traditional healers, religious practices were the dominant protective factor (Pannetier et al., 2017). Pannetier et al. (2017) found that religiosity for Black Africans was associated with decreased reports of mental distress and managing mental health. Factors such as prayer, meditation, and having purpose in faith were associated with lower levels of mental distress (Ekwonye et al., 2021; Pederson et al., 2023). In addition, the literature has also shown that the social interactions people obtain from religiosity are a strong protective factor for mental distress (Ekwonye et al., 2021). This provides individuals with emotional support, a sense of belonging, and practical assistance, all of which can help individuals manage mental health without professional services (Ekwonye et al., 2021; Nguyen, 2020).

Even outside of a religious context, social connection is a protective factor and is central to African culture (Na et al., 2019). For most Africans, extended family and the community are usually the first line of support for people experiencing mental distress (Altweck et al., 2015). For instance, a key phrase in some Sub-Saharan African countries is “ubuntu”, which translates to *I am because we are*, symbolising an individual's strong connection with the collective (Lutz, 2009). Through facilitating social connectedness, individuals experience benefits such as emotional support, a sense of belonging, and encouragement, which leads to outcomes such as reduced symptoms of mental distress, for instance, loneliness, anxiety, or depression

(Bjørlykhaug et al., 2022; Gottlieb & Bergen, 2010). Social support is also helpful in developing a sense of resilience to help cope with future stressors (Machisa et al., 2018). However, Amuyunzi-Nyamongo (2013) acknowledges that with increased urbanisation in Africa and Western countries, there is the risk that this strong social connection may diminish in favour of individualistic approaches.

3.6.2 Help-Seeking Barriers.

In addition to protective factors, many barriers may discourage seeking help. Some noted in the literature include stigma, lack of mental health literacy, absence of culturally competent resources, and such services being a financial burden (McCann et al., 2016). For some Black Africans, stigma can be associated with beliefs of the origin of mental distress, such as demon possession and ancestral curses. This can create negative associations with mental health, resulting in avoidance of addressing underlying distress (Adewuya & Makanjuola, 2008; Makanjuola et al., 2016). Moreover, stigma is a societal issue, and the fear of being discovered by others, especially by members of one's community, can serve as a barrier to seeking support for mental distress (Arday, 2021; Whittaker et al., 2005). This comes from a fear of negative social judgement and being ostracised for experiencing mental distress (Arday, 2021). In Whittaker et al.'s (2005) UK-based study, Somali refugees expressed a desire to seek support but refrained due to a fear of judgment. This tension highlights how such fears can hinder individuals from engaging with available services.

Other barriers to accessing care include limited knowledge and discrimination. A study by Arday (2018) explored the relationship between mental health knowledge and the use of mental health services. Findings indicated that for Black Africans in England, limited knowledge of mental health disorders reduced the likelihood of seeking and engaging with these services. Conversely, individuals who were aware of severe disorders were more likely to access mental health support. In another UK-based study by Arday (2021), experiences of overt

discrimination and a lack of culturally appropriate services were barriers to Black Africans accessing mental health support. Similar findings were noted in Mays et al.'s (2017) American study, where perceived discrimination in healthcare services was associated with early treatment termination. However, it is noted that the sample used for the study did not differentiate between Black African Americans and Black Africans. Compared to protective factors that provide an alternative way to managing mental health, these barriers do not offer an alternative means of managing well-being and can result in negative mental health experiences. There remains limited understanding regarding the engagement of mental health services and Black Africans in A-NZ. As such, this study aims to explore whether protective factors or help-seeking barriers deter Black Africans from engaging in formal mental health services.

3.6.3 Mental Health Services for Immigrants in A-NZ

With the growing population of migrants and refugees in A-NZ, policies and strategies have been developed to support settlement and adaptation to life in A-NZ. Historically, policies have transitioned from monoculturalism to the acknowledgement of diversity and multiculturalism (DeSouza, 2006). Particular to refugees, the New Zealand Resettlement Strategy is a policy for the resettlement in A-NZ (Immigration New Zealand, n.d.). It outlines the government's commitment to integrate refugees into A-NZ society. It focuses on these main areas: inclusion and participation, health and wellbeing, housing, education and English language training, and employment and self-sufficiency (Vanderpyl et al., 2025).

With regard to mental health, some efforts have been made to comply with the NZRS initiative. At a government level, policies such as the Health and Disability Commissioner Act 1994 and the New Zealand Public Health and Disability Act 2000 aim to address the cultural needs of people in A-NZ (DeSouza, 2006). At a national and local level, specialised mental health services such as Refugees as Survivors New Zealand (RASNZ) and New Zealand Red Cross

aim to provide trauma-informed and culturally appropriate care (RASNZ, n.d.; Red Cross New Zealand, n.d.). These services aim to acknowledge the unique difficulties that are faced by immigrants such as, but not limited to, experiences of war, displacement, and trauma (DeSouza, 2006).

Despite these initiatives, barriers persist. In Ho's (2004) seminal article, they highlight how cultural differences in mental health assessment and treatment, limited English proficiency, and lack of awareness about available services hinder immigrants' access to mental health support. Furthermore, mental health services in A-NZ are primarily delivered by statutory agencies and non-government organisations (DeSouza, 2006). However, issues such as language barriers, eligibility thresholds, limited capacity and resources, as well as restricted geographical coverage mean that many needs remain unmet (Brannelly et al., 2024). For instance, support services like the Accident Compensation Corporation that provide trauma-informed care often exclude refugees and migrants due to trauma experiences occurring outside A-NZ (Brannelly et al., 2024).

A significant issue is accessibility, which plays a key role in the ability of individuals in A-NZ to engage with mental health services. This includes costs, lengthy wait times, limited clinician availability, and insufficient service locations (He Ara Oranga, 2018; Kulshrestha & Shahid, 2022). The Government Inquiry into Mental Health and Addictions report highlighted that many people in A-NZ have experienced long delays and overburdened staff within the current health system, leading to clients not receiving adequate care (He Ara Oranga, 2018). A key phrase from this report indicates that individuals often feel they must "fight for access". In other words, many felt they had to prove they were unwell enough to qualify for support. While accessibility challenges affect all ethnic groups, they are particularly pronounced among minority populations (He Ara Oranga, 2018). These further highlights systemic barriers that prevent migrants and refugees from accessing care.

Additionally, as noted in Vanderpyl et al.'s (2025) article, the current outcome measures used to assess the effectiveness of mental health services for refugees are inadequate, providing limited information about what specific changes could better support refugees and migrants. They recommend re-evaluating these measures to better reflect the needs of refugees in A-NZ and thus improve service delivery. This issue is also evidenced by the scarcity of literature addressing the mental health needs and experiences of Black Africans in A-NZ, highlighting the invisibility of some groups within existing research and policy.

3.7 Conclusion

This chapter reviewed the existing literature on mental health among Black Africans. It discussed various definitions of mental health and the significance of understanding how individuals conceptualise this phenomenon. A central message from the literature review is that people's perspectives on mental health profoundly influence their management of it and their interactions with formal mental health services. Kleinman's Explanatory Model of Health and Illness emphasises that culture plays a crucial role in shaping individuals' conceptualisation of health. As a result, these conceptualisations impact how people perceive and respond to mental health issues. The cultural context of Black Africans in A-NZ is unique. It is influenced by A-NZ culture, African customs, colonial history, and migration experiences. This study seeks to examine the experiences of this population to deepen our understanding of their mental health challenges. Furthermore, existing literature suggests that there may be barriers preventing Black Africans from accessing formal mental health support. Investigating these issues within the context of A-NZ-based Black Africans can provide valuable insights for mental health service providers, aiding them in understanding the cultural frameworks that guide their practices. This scoping literature review provides context and background to the following analysis which explores how Black Africans in A-NZ understand and manage mental health, and their perspectives toward mental health services.

4. Methodology

This chapter details this study's research design and methodology. First, I outline the research question and the theoretical framework used. The second section describes the research design, including participants, recruitment process, data collection methods, and ethical considerations. The third part discusses the type of analysis used (i.e., Interpretative Phenomenological Analysis and Reflexive Thematic Analysis). Finally, the chapter concludes with considerations of the quality of the study.

4.1 Ontology and Epistemology

Ontology refers to the nature of being. It considers assumptions about reality (Gray, 2021). Given that the present study utilised an Interpretative Phenomenological Analysis (IPA) approach, the philosophical assumptions underpinning this study were congruent with IPA. According to Eatough and Smith (2017), IPA aligns with an “expressivist ontology”. This position argues that the nature of the world is revealed to us through our everyday, practical, and invested engagements with it. While the world imposes limitations on our actions and sense making through ‘material and biological conditions and social, cultural, historical linguistic processes’ (p. 22), varying interpretations are possible within those constraints. It is through these various interpretations that social realities are created (Eatough & Smith, 2017).

While ontology addresses ‘what is’, epistemology is concerned with ‘what it is to know’ (Gray, 2021; Moon & Blackman, 2014). It examines the nature of knowledge and how it is acquired. Given the aforementioned ontological position, knowledge emerges through interaction with the world. However, knowledge is always a matter of situated interpretation where there are no ‘pure facts’ (Caputo, 2018). However, Caputo (2018) cautions that while knowledge is always situated in interpretation and that there are no absolute truths, not all interpretations are equal.

Some can be considered better than others due to our ability to provide good reasons for something being the case and by them being well-tested.

Adopting these ontological and epistemological foundations aligned with this study's aim to explore how Black Africans conceptualise mental health. In contrast, other perspectives, such as positivism, can be helpful, but they adopt a stance that assumes knowledge exists in the void of any consciousness (Gray, 2021). While this might be valuable, it might overlook the nuanced experiences of Black Africans and how these might shape understanding of mental health. Therefore, this study adopted an 'expressivist' position that recognises the uniqueness of participants' perspectives, shaped by their interactions with the world.

4.2 Methodology

A research design provides the data collection and analysis framework, which ensures alignment with a study's philosophical foundations (Gray, 2021). Given this research's abovementioned philosophical foundations, a qualitative methodology was deemed most appropriate. A qualitative approach is suited to studies that strive to provide a nuanced understanding of people's experiences, contexts, and behaviours (Gray, 2021). It is recommended for studies exploring, understanding, or describing a particular topic. Unlike quantitative methods, which rely on statistical analysis, qualitative approaches assume multiple interpretations of reality, which allows for a deeper exploration of individual perspectives (Cleland, 2017). This made qualitative methods, specifically IPA and RTA, ideal for exploring Black Africans' lived experiences and perspectives, which offer depth and understanding that quantitative cannot provide.

This study had two distinct components. The first part examined how Black Africans conceptualised mental health, using semi-structured individual interviews and IPA. The second part explored their perspectives on mental health services in A-NZ through focus groups and

Reflexive Thematic Analysis (RTA). IPA works within defined philosophical assumptions, including phenomenology, hermeneutics, and idiography (see 4.2.1 Interpretative Phenomenological Analysis (IPA) below). Its focus on individual lived experience complemented the study's aim to understand the personal meanings participants ascribed to mental health. As discussed later in this chapter (i.e., 4.7 Data Analysis), there is limited evidence of the effectiveness of using IPA with focus group data; as such, an alternative analysis was adopted (Love et al., 2020). RTA was chosen for its flexibility, as it is not bound to a specific theoretical framework. The focus groups were still concerned with the lived experience of group participants with mental health services in A-NZ. As such, the theoretical foundations of IPA also grounded the focus groups and RTA.

4.2.1 Interpretative Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis approach (IPA) was developed by Jonathan Smith as a research methodology that focuses on examining how a person makes sense of a phenomenon (Pietkiewicz & Smith, 2014). Consistent with the foundations of this study, IPA is a qualitative approach positioned within a constructivist paradigm (Gray, 2021). IPA is grounded on three fundamental theoretical underpinnings: phenomenology, hermeneutics, and idiography. All three are considered different forms of interpretivism, theorising that reality interpretations are derived from culture and historical context (Gray, 2021; Moon & Blackman, 2014).

4.2.1.1 Phenomenology

The first theoretical orientation of IPA is phenomenology. It concerns the study of experience (Larkin et al., 2021). It was developed by Edmund Husserl and emphasises examining phenomena as they occur, free from pre-existing assumptions (Gray, 2021; Larkin et al., 2021). It employs eidetic reduction to reveal the fundamental components of an experience and what

makes it unique (Pietkiewicz & Smith, 2014). Eidetic reduction identifies a mental object's essential parts. Utilising this orientation requires researchers to forgo their previous understanding of the experience they are examining (Pietkiewicz & Smith, 2014). Accordingly, IPA explores how participants make sense of their experiences (Smith & Osborn, 2015). The issue of bracketing refers to a practise where IPA researchers intentionally set aside their personal beliefs, to understand and accurately interpret the lived experience of participants (Chan et al., 2015). In Husserl's description of phenomenological research, this was a key component of achieving objectivity in data collection and interpretation (Lavery, 2003). However, this notion has since been contested due to difficulty in completely suspending one's preconceived notions and biases (Chan et al., 2015). As such, it is argued that it sets an unrealistic expectation of complete neutrality (Tuffour, 2017). In contrast, Heidegger, argued that an individual cannot be separated from their experiences. The pre-understandings and historicity of a person cannot be removed (Lavery, 2003).

4.2.1.2 Hermeneutics

IPA draws its roots from hermeneutics, which is concerned with interpretation (Pietkiewicz & Smith, 2014). Hermeneutics stresses the importance of interpretation to develop a more profound understanding of social reality (Gray, 2021). In IPA, the hermeneutic foundations mean that researchers attempt to interpret the participants' experiences. The IPA process is sometimes known as 'double hermeneutics' (Pietkiewicz & Smith, 2014), as there is a two-step interpretation process. First, participants interpret the world around them, and second, the researcher interprets the participants' interpretations.

4.2.1.3 Idiography

The last theoretical orientation that IPA draws from is idiography. As Larkin et al. (2021) highlight, idiography is concerned with the particular. It involves an in-depth analysis of each individual case. Idiography focuses on making specific statements about the participants of a study (Pietkiewicz & Smith, 2014). In this regard, IPA focuses on each case before making more general statements (Larkin et al., 2021). IPA, therefore, emphasises the use of small sample sizes to achieve richness in data.

4.2.1.4 Criticisms of IPA

It is essential to acknowledge some criticisms of the IPA approach. Criticisms argue that IPA may not be an authentic form of phenomenology (Van Manen, 2017). Critics assert that phenomenology may not be appropriate as it assumes that subjects create meaning about a phenomenon, but the fundamental idea of phenomenology is that meaning already exists without interpretation (Marion, 2020; Van Manen, 2017). They argue that Husserl's original intention for phenomenology was to understand experience free from interpretation and phenomena in their essential components (Van Manen, 2017). Van Manen (2017) claims that true phenomenology does not study how individuals make sense of their own experiences. He argues that IPA does not aim to understand the phenomenon itself but the interpretation of the phenomenon. Therefore, it should be appropriately termed *Interpretative Psychological Analysis* instead of *Interpretative Phenomenological Analysis* (Van Manen, 2017).

Although there are ongoing criticisms regarding the semantics of IPA (i.e., phenomenological vs psychological), this methodology remains the most appropriate for this study. This is because the overall goal of IPA is to understand how individuals make sense of phenomena, which is consistent with this study's aims (Larkin et al., 2021). As such, utilising IPA allowed

for an in-depth account of the experiences of Black Africans and recognition of any individual differences that arise within the study (Larkin et al., 2021).

4.4 Participants

4.4.1 Inclusion and Exclusion Criteria

Participants were required to be Black Sub-Saharan African migrants or refugees residing in Aotearoa-New Zealand (A-NZ). They had to be over 18 years old and to have lived in A-NZ for at least one year. This was to allow for some adjustment period for individuals who had recently moved to the country. All participants had to be able to speak and understand English to minimise the risk of misinterpretation and miscommunication between participants and the researcher. Research can become severely compromised if the researcher draws incorrect conclusions due to language barriers (Temple & Young, 2004). It is important to acknowledge a limitation regarding possible semantic misunderstandings, as participants may have had difficulty expressing certain concepts in English (Kaushanskaya, 2023). As such, sensitivity was applied for participants who used non-English terms to capture meaning or used gestures to communicate beyond language. Attempts were also made to capture these in the interview transcriptions.

Furthermore, given the linguistic diversity of Africa, with over 2000 languages spoken, and the relatively small population of Black Africans in A-NZ, it would not be feasible to provide interpreters for all potential languages (Harvard University, n.d.). In addition, the availability of interpreters for African languages is generally limited. For example, following a search on the New Zealand Society of Translators and Interpreters database, no accredited interpreters were listed for most African languages (New Zealand Society of Translators & Interpreters, n.d.). Consequently, requiring participants to be fluent in English was considered the most practical and realistic approach, as it also reduced the likelihood of misinterpretation.

4.4.2 Information Power

Information power refers to the idea that the number of participants required for a study depends on the data's quality, relevance, and richness (Malterud et al., 2016). In other words, rather than focusing on predetermining the sample size alone, the focus becomes a dynamic consideration of several factors and how these contribute to the study aims. Malterud et al. (2016) propose that the primary considerations pertaining to information power should include the study aim, participant specificity, established theory use, and dialogue quality. The following section will discuss this study's number of participants in relation to information power.

4.4.2.1 Research Aim

For information power, a broader aim generally requires a higher number of participants because capturing various perspectives and experiences related to a broad topic requires more data (Malterud et al., 2016). The present study aims to explore how Black Africans in A-NZ conceptualise mental health and their perspectives on mental health services. Mental health encompasses various dimensions and experiences. These experiences can vary significantly, and how people attribute meaning to their experiences can also differ. Based on this factor, a larger number of participants would be beneficial.

4.4.2.2 Participants Specificity

While the study aims were broad, the chosen participants were relatively specific. According to Malterud et al. (2016), the more homogenous the group of interest is, the fewer participants are required. This is due to the likelihood that homogenous individuals will produce similar information; therefore, less data is required. A key component of IPA research is to ensure the sample is homogenous due to its fundamental aim of acquiring an in-depth understanding of

how individuals make sense of a particular phenomenon. This study recruited adult Black Sub-Saharan African migrants and refugees living in A-NZ for at least one year. This was considered a specific and homogenous group of interest; therefore, a small number of participants would suffice in achieving information power.

4.4.2.3 Established Theory

Studies grounded in established theories require fewer participants (Malterud et al., 2016). This is because analysis can build on pre-existing theories. The study topic has limited research on Black Africans in A-NZ. However, as shown in the literature review, there is a multitude of literature in other parts of the world that explores the mental health experiences of Black African migrants and refugees. Furthermore, seminal theories such as Kleinman's Explanatory Model of Health and Illness highlight how culture influences people's perspectives on mental health (Kleinman, 1986). The literature review also references other migration-related theories, such as Bhugra's Stages of Migration and Psychopathology (Bhugra, 2004). As such, while literature based in A-NZ is limited, there are other robust literature and theories on which this study is grounded, which means information power can be effectively addressed through engaging with a small group of participants.

4.4.2.4 Quality of Dialogues

Lastly, and most importantly, information power depends on the quality of interview dialogues, with higher-quality dialogues reducing the need to continue recruiting more participants. As a clinical psychology student, I received training in interviewing skills, which enhanced the data collection process. My Honours research, which involved individual interviews with African migrants, further developed my experience in this area.

To ensure high-quality dialogue, I conducted several pilot interviews before data collection to build my confidence as a researcher. One of these interviews was reviewed by my supervisory team, who were experienced in qualitative research and interviewing skills and provided constructive feedback (e.g., encouraging a more detailed exploration of key themes raised by participants). This feedback improved my interviewing approach.

Additionally, my background as a Black African migrant facilitated me connecting with participants on a cultural level, which helped me understand the nuances of their experiences. This cultural familiarity enhanced the quality and richness of the data collected.

According to Malterud et al. (2016), a smaller group of participants is sufficient when the quality of the dialogue is high. Based on my training, prior experience, guidance from the supervisory team, and insights from my pilot interviews, I concluded that fewer participants were needed to achieve information power in this study. Following data collection, it was considered that information power was achieved. Rapport with participants was built during interviews and participants provided detailed accounts that generated rich and nuanced transcripts.

4.4.2.5 Number of Participants

The aforementioned factors provided more rationale for recruiting a small group of participants to achieve information power despite the broad research aim. As such, I initially aimed to recruit 8-10 participants for the individual interviews and the same number for the focus groups. This also coincided with the literature recommending a small IPA research sample (Smith & Osborn, 2015). The literature also recommended small groups for focus groups due to the ease of communication in smaller groups (Gray, 2021).

4.4.3 Recruitment Process

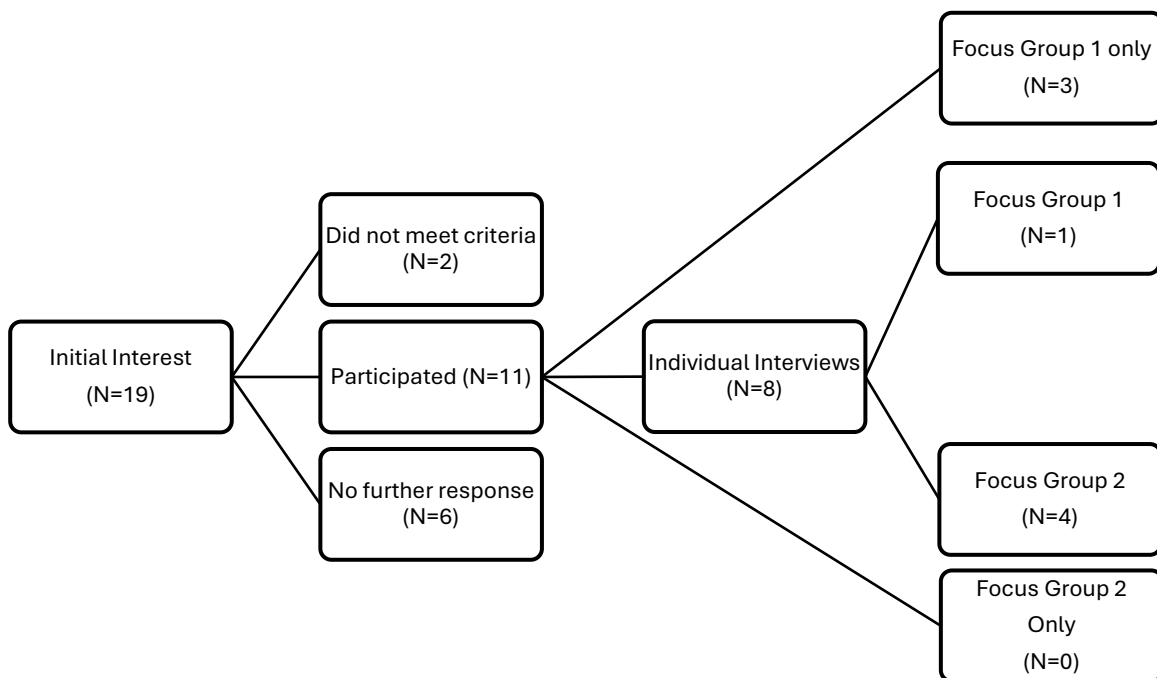
Convenience sampling was adopted for this study. This approach is appropriate when the target population is relatively small, with possible recruitment difficulties. As Naderifar et al. (2017) highlighted, this method is most helpful when research calls for a specific interest group and current participants can lead to recruiting more participants. With their consent, an advertisement poster for participants was shared among relevant organisations and social groups, including the Multicultural Centre in Palmerston North, the African Club at Massey University, and the African Girls in Aotearoa Facebook Page (Appendix A). It is noted that a snowball effect was observed as some participants reported receiving information about the study from other participants. For example, one person described sharing the advertisement poster on a men's sports group page.

All potential participants indicated initial interest using a designated email address on the advertisement poster. After the initial contact, an information sheet and consent form was sent regarding the individual interviews and focus groups (Appendix B, C, D, E). Participants were invited to participate in either one or both parts of the study. Since focus groups were conducted after the individual interviews, it was prudent to avoid compliance bias. This is where participants may have engaged in the focus groups due to perceived pressure to agree following an individual interview. As such, participants who wished to participate in both aspects had to express interest in the focus groups before the individual interview. After participants had consented, they were given various interview times from which to select. Once they chose the most suitable time, a Zoom link was sent to them for the individual interview, focus group, or both. Figure 5. provides a summary of the research participants, including people who showed initial interest and participated, those who did not show any further response after initial contact, and those who did not meet criteria due to being born in A-NZ.

Due to the small population of Black Africans, participants were given the option to take part in either one or both data collection processes to maximise recruitment opportunities. For those who participated in both, their viewpoints appeared in both sections of the study. However, this was not considered a major limitation, as the focus of the individual interviews and focus groups differed: individual interviews explored how participants understand mental health, while focus groups examined experiences with mental health services. Additionally, the individual interviews were conducted first to ensure that group dynamics did not influence participants' personal perspectives on mental health.

Figure 5

Summary of the recruitment process.



4.4.4 Demographic Information

Participants were requested to complete a demographic survey before the interviews. The information obtained was based on the information summarised in *Chapter 3. Literature Review* regarding potential influences for mental health conceptualisations such as country of origin, refugee/migrant status, employment, age, and length of stay in the new country. Table

1 details data from the individual interviews, while Table 2 summarises this data from the focus groups.

Table 1

Demographic Data from Individual Interview Participants.

Participants (Pseudonyms)	Gender	Age	Country	Status	Occupation	Years in NZ	Religion
Andrew	M	50-54	Zambia	Migrant	Healthcare	11-15	Christian
Betty	F	25-29	Zambia	Migrant	Arts	16-20	Undecided
Callie	F	20-24	Zimbabwe	Migrant	Customer Service	0-5	Agnostic
			Zambia/ South Africa				
Diane	F	20-24		Migrant	Healthcare	16-20	Christian
Ella	F	20-24	Zimbabwe	Migrant	Healthcare Student	11-15	Christian
Fiona	F	35-39	Zimbabwe	Migrant	Healthcare	6-10	Christian
Gemma	F	25-29	Tanzania	Migrant	Finance	6-10	Christian
Holly	F	30-34	Zambia	Migrant	Health care	6-10	Christian

Table 2

Demographic Data from the Women Focus Group Participants – Group One

Name (Group)	Age	Country	Status	Employment	Years in NZ	Religion
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Betty	25-29	Zambia	Migrant	Arts/Entertainment	18	Undecided
Isla	25-29	Zimbabwe	Migrant	Self-employed	18	Unstated
Jane	25-29	Rwanda	Refugee	Arts/Entertainment	23	Unstated
Kelly	25-29	Zimbabwe	Migrant	Arts/Entertainment	17	Christian

Table 3

Demographic Data for the Women Focus Group Participants – Group Two

Name	Age	Country	Status	Employment	Years in A-NZ	Religion
Diane	20-24	Zambia/ South Africa	Migrant	Healthcare	18	Christian
Ella	20-24	Zimbabwe	Migrant	Student (Healthcare)	14	Christian
Gemma	25-29	Tanzania	Migrant	Finance	8	Christian
Holly	30-34	Zambia	Migrant	Healthcare	7	Christian

4.5 Data Collection

4.5.1 Semi-Structured Interviews

Semi-structured interviews refers to a non-standardised data collection method involving developing an interview schedule to guide the interview. While the schedule provides a guide, questions may divert from the plan depending on the interview's direction, enabling researchers to explore important unanticipated themes (DeJonckheere & Vaughn, 2019). Gray (2021)

highlighted that this becomes critical for research adopting a phenomenological approach where the primary goal is to ascertain how a participant experiences or understands a phenomenon. The present study adopted both semi-structured individual interviews and focus groups. One of the requirements for engaging in interviews is for the interviewer to have sufficient skills to facilitate good-quality discussions (DeJonckheere & Vaughn, 2019). This was addressed by valuing reflexivity and drawing on previous interviewing experiences. This is discussed further when the quality of the study is reviewed (i.e., 4.8 Quality of Research).

A structured interview format was considered; however, it would have been overly restrictive without much allowance for further exploration of any unpredicted topics (Mueller & Segal, 2014). Thus limiting how accurately the themes captured in the study represent how participants conceptualise mental health. In addition, while an unstructured approach would have been beneficial in exploring themes and gaining depth of understanding, the breadth of the concept of "mental health" was thought to require some guidance to ensure research questions were addressed.

4.5.2 COVID-19 Research Design Changes.

Data collection was initially planned to be conducted in person. As Dialsingh (2008) states, in-person interviews are optimal as they minimise non-response risk and are more appropriate when discussing sensitive topics such as mental distress. However, due to frequent regulation changes at a national level in response to COVID-19, it was deemed more appropriate to host interviews via Zoom. Zoom is a telecommunication platform that allows for video and audio calls to individuals or groups using internet access (Zoom Video Communications, 2023). While this method was not the first choice, it provided benefits such as accessing participants in different regions, greater flexibility for arranging interview times, and cost-effectiveness (Archibald et al., 2019; Keen et al., 2022). This study recognises the limitations of gathering data through video calls, such as unintentionally excluding people without technological

competence or resources, difficulty observing body language, and risks of participants' fatigue and home distractions (Döring et al., 2022; Keen et al., 2022). However, despite common misconceptions about the inability to develop rapport via videoconference, the literature suggests rapport is achievable, and it is possible to produce the same richness of data as face-to-face interviews (Keen et al., 2022). This was evident in the data collection, where participants provided substantial and relevant information related to the research topic.

4.5.3 Interview Schedules

The interview schedule used a funnel technique, where broad questions were initially asked before providing more specific questions (Appendix G). Participants were asked how they understood wellness in general before being asked more specifically about mental health. The second part of the interview queried how individuals manage mental health. The interview schedule was reviewed with research supervisors and piloted with three participants.

4.5.4 Pilot Interviews

Pilot interviews were conducted prior to data collection. Once an interview schedule was prepared, an in-person pilot interview with a Black Caribbean woman, using the same schedule, was carried out. This interview underscored the need for participants to have questions rephrased for better understanding. Some questions were edited and simplified for clarity; however, the overall theme remained intact. After the initial edits, the first main interview was conducted. This interview was transcribed, and research supervisors offered guidance on areas that could have benefitted from further exploration. While relevant and important data was collected, I felt it was appropriate to develop my interviewing skills further. Consequently, I conducted two additional pilot studies, one with a Black African woman and another with a non-African woman, to refine my interviewing skills. This process was beneficial in increasing my confidence and competence in using semi-structured approaches. Following this, I could

more effectively divert from the interview schedule to explore nuanced themes. The pilot interviews were not included in the analysis

4.5.5 Individual interviews

Individual interviews involve verbal exchanges to obtain information and understanding from another person (Gray, 2021). This may include exploring an individual's attitudes, beliefs, or experiences about a particular topic (Rowley, 2012). As Gray (2021) highlighted, interviews become most beneficial when the goals of a study are primarily exploratory. As such, interviews were deemed most appropriate to explore how Black Africans understand mental health. Compared to focus groups, one-on-one interviews allow for an in-depth exploration of each participant's experiences and perspectives without influence from others (Gill & Baillie, 2018). Furthermore, this style of data collection is more effective when gathering sensitive information (Guest et al., 2017). Given this study's aims, it was important that the method used for understanding mental health experiences and conceptualisations was free of social influence and evoked emotional safety for participants to potentially disclose sensitive information.

In addition, the semi-structured approach allowed for follow-up questions, which fostered a deeper exploration. Although there was an interview schedule, I attempted to remain participant-led. In contrast, the focus groups examined attitudes and perspectives on mental health services in A-NZ. However, during the individual interviews, if participants spontaneously shared their views on mental health services, they were allowed to continue without interruption.

4.5.5.1 Interview Process

At the beginning of the individual interviews, I provided an introduction detailing who I was, where I was from, and my reasons for conducting the study. Abell et al. (2006) assert how self-disclosure can help counteract the power imbalances and build rapport between participants

and a researcher. As such, my self-disclosure of my cultural background was used to build rapport and promote a sense of safety for participants to share their stories (Abell et al., 2006). Following this, a summary of the information sheet was provided. Participants were given an opportunity to ask questions before giving verbal consent and participants also provided their written consent via email. A copy of the consent forms was kept in a password-secure computer that is only accessible to myself. These will be forwarded to the primary supervisor at the end of the research study for safe-keeping until three years after the study is completed. After which, they will be destroyed. Participants were encouraged to make their space comfortable by sitting comfortably or having a glass of water or a hot beverage at hand.

Once the introductory phase was completed, the audio and video recording of the call was commenced. Video recording was beneficial as it minimised the risk of misinterpreting participants' words during transcription. By observing participants' mouth movements, greater accuracy in capturing their spoken responses was ensured. All calls were locked to prevent uninvited parties from connecting to the call. The interviews ranged between 60 to 90 minutes. There were minimal technical difficulties; however, a brief apology was offered when they did occur, and participants were asked to repeat their statements. Following every interview, I briefed with supervisors to discuss how to manage the following interview, key themes, and any risk issues that may have arisen. However, no risk concerns were ever noted in interviews. Confidentiality and security were upheld by locking the Zoom call when participants arrived. Furthermore, to access the call, participants were required to use a password which further increased security.

4.5.6 Focus Groups

Focus groups involve a moderated discussion between a small group of individuals on a predetermined topic. This method is beneficial for exploring collective perspectives, behaviours, and attitudes (Gibbs, 1997; Gray, 2021). This study utilised focus groups to discuss

attitudes toward mental health service providers. This method was chosen as it relies on group dynamics to facilitate conversations. The interactive nature allows for information to be gathered that may otherwise be missed in individual interviews. Focus groups were most appropriate as they allowed participants to draw from each other's experiences with mental health services, to agree and disagree, and to discuss new ideas separate from the interview schedule. Overall, while one limitation of this method may be the decreased depth of information, it allowed for a broader exploration of themes associated with Black Africans' experience of mental health service providers (Litoasseliti, 2003).

4.5.6.1 Interview Process

Similar to the interviews, participants contacted me via email upon initial interest in the study and were provided with an information sheet. Given that eight African women wished to participate in the focus groups, with no African men, it was decided that two women focus groups would be conducted. Attempts were made to recruit African men through contacting social groups involving African men. However, none showed interest in the focus groups and only one for the individual interviews. Participants were then offered one of two times to choose from and were subsequently sent the relevant Zoom link. The literature regarding the use of video calls for focus groups is reasonably novel. Greenspan et al.'s (2021) paper highlights some of the benefits and drawbacks of using Zoom for research purposes. Furthermore, similar to online individual interviews, other benefits include cost-effectiveness, flexibility, and recruiting from a broader pool (Greenspan et al., 2021). They note that online focus groups have the same ability to collate rich data as in-person focus groups. However, they note the importance of being mindful of different technological abilities among group members, possible technical issues (such as call drop-offs), and the increased attrition rate with this data collection modality (Greenspan et al., 2021). In this study, no participants reported

any technology issues, and they were able to use Zoom without assistance. Furthermore, participants were encouraged to use the chat function if there were any auditory issues. However, no participant utilised this function. Greenspan et al.'s (2021) paper suggested incentivising focus group participation to minimise the potential attrition rate. Participants were provided with a \$40 gift card to thank them for their time. However, careful consideration was taken when providing compensation to ensure it was not coercive. This will be discussed further in the 4.6 Ethical Considerations section of this chapter

At the commencement of each focus group, I provided a similar introduction as in the individual interviews. In addition to this, a round of introductions between participants was facilitated. The interview schedule was then used to guide the focus groups; however, participants were encouraged to introduce any new relevant points. The groups lasted 105 and 120 minutes, respectively.

4.6 Ethical Considerations

The current study was approved by the Massey University Ethics Committee (SOB 21/06). Before data collection, ethical points were considered through consultation with my research supervisors and a review of the committee guidelines. Following this, a comprehensive ethics application was completed, detailing the research process, potential ethical issues, and how those issues would be mitigated. Some ethical issues included informed consent, risk considerations, confidentiality, and storage of data.

4.6.1 Informed Consent

Informed consent is a process in which participants must fully understand what a study entails before providing consent (Massey University, 2018). As such, all participants were sent the information sheet for the individual interviews and focus groups following indicating initial interest. Participants were encouraged to read these forms and advised which part of the study

they wished to participate in (i.e., individual interviews, focus groups, or both). Once confirmed, they were emailed consent forms. During the interviews, participants were provided with a verbal description of the information sheet to account for any reading difficulties and were provided an opportunity to ask any questions. Interviews only proceeded once participants had provided consent.

4.6.2 Privacy and Confidentiality

All interviews and focus groups were held via Zoom due to the lack of feasibility of face-to-face contact during COVID-19 restrictions. To ensure participants' privacy was maintained, interviews were conducted in a private room and ensured all calls were locked to prevent uninvited attendees from entering the call. Participants were allocated a pseudonym to ensure their confidentiality. Subsequently, any distinctively identifying information in the transcripts (e.g., names of family members) was omitted and replaced with a broad descriptive word. For example, [family member]. Furthermore, all participant data was stored in a password-protected laptop that was accessible only to myself. This included all interview data and consent forms. Participants were offered to be sent a copy of the individual interview recordings and the transcripts to review. However, no participant wished to review the transcripts or the video recordings. In contrast, with focus groups all participants' data is merged, making it difficult to provide recordings and transcripts to a single person without violating the confidentiality of other members. Consequently, it was deemed most appropriate to refrain from offering participants the opportunity to review the collected data from focus groups. However, participants were informed of this before commencing the focus group interviews. All recorded data was deleted once the analysis stage was completed. Furthermore, after the study, consent forms will be forwarded to the primary research supervisor to be disposed of after three years.

4.6.3 Risk Considerations

It was acknowledged that interviews may evoke emotional distress in participants. Telling about challenging mental health experiences may be emotionally difficult for some participants, and specific safety procedures needed to be determined before commencing with the study. Firstly, participants were made aware they were allowed to skip a question, take a break, or stop the interviews at any moment. They were also informed of their right to withdraw from the study within three weeks of completing the interviews. Secondly, the participants' information sheet contained a list of resources for various support services should they require it. Lastly, a risk management flowchart was created to account for any disclosure of suicidal risk (Appendix H). No risk issues were identified during data collection.

4.6.4 Storage of Data

All research data was stored in a password-protected computer and was only accessible to me. Data was also held in a password-protected external hard drive in a locked office space, similarly only accessible to me. All recordings were deleted once interview data was transcribed and participants had reviewed the transcripts. Other research data will be destroyed after three years. All signed consent forms will be forwarded to the primary research supervisor at the end of the study.

4.6.5 Reimbursement

Qualitative research can take considerable time for participants, as the primary goal is to obtain as much richness of data as possible (Gray, 2021). Participants were required to allocate time to partake in the study, have access to a computer with internet access, and share personal accounts of their lives. As compensation, a \$40 Prezzy card was provided, which was deemed reasonable given that it was not of a magnitude that could be considered coercive. Since interviews were conducted virtually, vouchers were mailed to participants. To maintain privacy, participants' addresses were only accessed by myself.

4.6.6 Cultural Considerations

It is also important to note that many African groups hold patriarchal beliefs that may affect the interview processes. According to Sathiparsad and Dlamini (2008), gender roles in African culture are significant, with men carrying a more authoritative position than women. These roles may make it difficult for both men and women to discuss their experiences with mental health services in the same room. For example, discussing mental health is often seen as a demasculinising topic. Therefore, it may be uncomfortable for men to describe their experiences within a mixed-gender focus group (Gough & Novikova, 2020). As such, it was initially planned for two focus groups to be held: one for African men and the other for African women. However, as noted previously above, due to no responses from African men, the focus groups only consisted of African women.

4.7 Data Analysis

4.7.1 Interpretative Phenomenological Analysis

Consistent with the theoretical foundations of this study, an IPA approach was used to analyse the individual interviews. Since IPA requires that each interview be examined in-depth, the analysis stage begins as soon as the first interview is completed to ensure substantial time was spent analysing each interview (Pietkiewicz & Smith, 2014). The guide to analysis as provided by Larkin et al. (2021) was used to guide the analysis stage of the study. At the beginning of the day, during the analysis stage, the steps for engaging in IPA were reviewed to ensure the researcher was appropriately oriented to the process and purpose of this type of analysis. The steps include:

1. *Read and re-read the data* – this involved becoming thoroughly acquainted with the data. Part of this stage involved transcribing the interview data. Once transcribed, interviews were read alongside the recording to ensure accuracy

and to capture the tone of the interviews. The transcript was then re-read to ensure the content was understood.

2. *Initial noting*—This step involved making initial notes of any interesting information in the transcripts. Three initial notes were compiled: descriptive, linguistic, and conceptual comments, which were distinguished using different fonts.
3. *Developing emergent themes* – following the initial notes, this step involved interpreting the notes into themes.
4. *Searching for connections across emergent themes* - This included examining the themes and assessing which related to each other more closely. An Excel spreadsheet was used to complete this step. Smith et al. (2022) advised caution when using a computer, as researchers run the risk of emphasising earlier themes than others. To account for this, I used Excel to create a randomised list of the initial themes.
5. *Moving to the next case and repeating steps 1 – 4 for each case* – since the proposed study had more than one participant, this step reiterated the importance of engaging in each step for every case.
6. *Looking for patterns across cases* – this step involved exploring cases and noting any patterns identified between cases.

4.7.2 Reflexive Thematic Analysis

In addition to IPA, Reflexive Thematic Analysis (RTA) was used to analyse the data from the focus groups. The fundamental purpose of IPA is to highlight individual voices during the data analysis. However, this becomes difficult when analysing a focus group. As highlighted by Love et al. (2020), the complexity of using IPA for focus groups is the difficulty of extrapolating individual voices. Furthermore, although IPA has a strong theoretical foundation for one-on-

one interviews, it is not as robust with focus groups. As such, the existing literature indicates scepticism about using IPA for analysing focus groups (Eatough & Tomkins, 2010; Love et al., 2020; Smith, 2004).

RTA was initially developed by Braun and Clarke (2006) to provide a method for analysing data. It is a flexible method that can be used with a range of epistemological orientations, including constructivism (Braun & Clarke, 2006; Kiger & Varpio, 2020). Kiger and Varpio (2020) offer a guide for conducting RTA. They draw on the six steps provided in Braun and Clarke's original study. These are summarised below.

Step 1: Familiarise with the data – this step involved repeated active reading of the data. Manually transcribing the data prior to repeatedly reading the transcripts helped with this step.

Step 2: Developing initial codes – this entailed taking notes of preliminary ideas and generating codes. As Kiger and Varpio (2020) recommended, these codes had to be defined in ways that do not overlap with other codes.

Step 3: Search for underlying themes – after identifying initial codes, these were grouped into relevant broader themes. This was completed through analysing, comparing, and examining the codes.

Step 4: Review themes – this was a two-level process. The first part involved reviewing all the relevant codes and themes and assessing whether each theme had sufficient data. At this stage, themes were edited accordingly to develop the final set of themes. The second part of the process involved assessing whether the individual themes accurately represented all the data collected as a whole. This involved re-reading the transcripts and then re-examining the themes and codes to ensure all facets were aligned.

Step 5: Defining and naming the themes – this entailed defining each theme and linking it to the broader research question. This section involved selecting appropriate data extracts to use as illustrations for the themes.

Step 6: Producing the report – this step was concerned with consolidating all the findings into a coherent written form (as seen in the Findings – Focus Group chapter).

RTA was considered suitable for this study as it analysed qualitative information, allowed the study to remain consistent with theoretical foundations, and helped explore and identify prominent themes regarding the attitudes and perspectives of participants toward mental health.

4.8 Quality of Research

Traditionally, the quality of research was assessed by reviewing the study's replicability. While this concept helps evaluate quantitative studies, it does not apply to qualitative research. In contrast, qualitative researchers suggest using alternative methods to assess a qualitative study's quality. As highlighted by Yardley (2000), quantitative methods of reviewing qualitative research may be inappropriate as the aim of qualitative works is often to offer one of many possible interpretations of a particular phenomenon. The objective is typically not to make conclusive generalisations about the population but to explore a topic (Yardley, 2000). This study utilises the characteristics of good qualitative research listed in Yardley's (2000) seminal article to review the quality of the research. This includes sensitivity to context, commitment and rigour, transparency and coherence. In each of the characteristics listed by Yardley, I reflected on how my processes may have influenced the study. I also concluded this section by summarising some key reflexive processes I engaged in during this study.

4.8.1 Sensitivity to Context

Yardley (2000) asserts that sensitivity to research context is essential in ensuring research quality. This refers to immersing oneself in the relevant literature, theory, and cultural context

and considering the characteristics of the researcher in relation to the participants. Black African migrants and refugees have a complex hybrid of cultural contexts, histories, and identities. For example, being a blend of African and Kiwi, living in a Western and African society, and experiencing acculturative processes. All these experiences (and more) influence the complex context that impacts how they understand phenomena such as mental health. To be sensitive to this, I spent the initial stages of this study engaging in the literature related to the history of mental health in Africa and how colonial experiences shaped the mental health experiences of Black individuals in Africa (Akyeampong, 2015; Jackson, 1999; Tylor, 1871). I also considered how the narratives of mental health in the diaspora might influence how they understand this phenomenon. Furthermore, I reviewed the literature on migrants' and refugees' experiences of mental health to acknowledge my participants' context fully. In addition, reviewing relevant theories related to the conceptualisation of health and migration processes, in general, was another way in which efforts were made to be sensitive to the context of participants (Berry, 1997; Bhugra et al., 2021; Idemudia & Boehnke, 2020; Lazarus & Folkman, 1984).

Going into the study, I knew my role as a Black African woman would influence the interviews. Initially, my primary concern related to interviewing African men and how traditional perspectives of the roles of men and women in African communities may affect the depth of information provided. Although only one African man was recruited, it was helpful to consider how my attributes would affect the study. Similarly, my position as an African influenced the information participants provided. I reflected on the underlying assumptions that I held as an African that might prevent me from asking further questions due to potential assumed knowledge. Debriefing with research supervisors who were not Black Africans allowed for different viewpoints during the data collection stage to mitigate some of my preconceived biases.

4.8.2 Commitment and Rigour

Commitment speaks to an in-depth engagement with the topic, the researcher's competence in the methods used, and prolonged engagement with the relevant data (Yardley, 2000). Yardley (2000) defines rigour as the "resulting completeness of the data collection and analysis" (p. 221). Regarding my competence as a qualitative researcher, I had a few considerations. Firstly, my Honours thesis topic involved interviewing African women regarding their acculturative experiences. This opportunity introduced me to qualitative research with an African community. Furthermore, aspects of the Doctor of Clinical Psychology programme equipped me with basic interviewing skills such as micro-skills, rapport building, questioning strategies, and reflective communication, which enhanced my skills in engaging in semi-structured interviews regarding mental health.

Following the pilot studies, I reflected on how my anxiety as a researcher hampered my ability to appropriately deviate from the interview schedule to obtain a greater depth of information. I reviewed my pilot interviews with supervisors for advice and guidance and conducted more practice interviews to develop skills and confidence before commencing interviews. It is important to acknowledge that I am a novice at IPA research. While I have some experience with qualitative research (through my Honours project), this is my first research project utilising IPA methods and analysis. This likely influenced my research process, particularly in the way I may have conducted the interviews and analysed the data.

4.8.3 Transparency and Coherence

According to Yardley (2000), the transparency and coherence of a study refers to its clarity and cogency. In other words, it details all aspects of the research process and data excerpts. One way transparency was achieved was through respondent validation. As Koch (2006) advises, this also improves the rigour of qualitative research. This was done by allowing all participants to review the individual interviews. Due to issues pertaining to the confidentiality of other

participants, this could not be done for the focus groups. Yardley (2000) also likens transparency to being reflexive. Reflexivity is acknowledging these factors and understanding how they may influence the study. Creswell (2007) urges qualitative researchers to be aware of pre-existing assumptions and personal characteristics they bring to the research process.

I am a Black Christian African migrant who is a clinical psychology trainee. I am aware that each of these identities holds different beliefs and assumptions about how the world works. In some ways, I adopt a strong emic perspective to the research. There are benefits to this as it allows participants to feel connected to the researcher and, thus, feel safer to share deeply (van Heugten, 2004). There were elements of the participants' discussions that were familiar to me due to our shared similarities in life pathways. In addition, my lived experience as an African living in A-NZ provided the opportunity to gain an understanding of the cultural and social background that most participants came from. However, there are some limitations to this. As stated before, because I have my own preconceived biases, it becomes easier to focus on those elements that promote my viewpoint and make assumptions about participants without asking relevant questions than I may have done with an etic approach. Dwyer and Buckle (2009) also assert that adopting an insider role can lead to greater susceptibility to strong emotional reactions during the data collection stage. To address this, I kept a reflective journal throughout my research journey. This began at the conception of the study during the literature review stage. For example, reading about the colonial history of mental health in Africa provoked strong emotions I could reflect upon in my reflective journal and address in my supervision meetings (Jackson, 1999; Tylor, 1871). In being transparent about these underlying biases with my supervisory team, it allowed me to be aware of the impact of my biases at every stage of the research process.

4.8.4 Impact and Importance

As Yardley (2000) argues, one criterion against which to review the quality of research is its impact and importance. While this was mainly discussed in earlier chapters of this report, it will be briefly summarised here. Mental health continues to be a growing concern in A-NZ. With the country being a multicultural society, the voices of minority populations often become lost amongst the voices of dominant groups. Therefore, it is prudent that these voices are acknowledged in the literature as how people experience mental health is diverse, with nuanced ways of making sense of the phenomenon (Cooper, 2010). This becomes important as how individuals understand mental health and their attitudes and views toward service providers can impact their engagement with mental health services (Corrigan, 2004). As such, this study is important as it explores those factors for Black Africans in A-NZ and identifies some of the themes that might be a barrier for people accessing mental health services.

4.9 Conclusion

The purpose of this chapter was to describe the methodology adopted for this study. This research is grounded in an IPA approach and utilises the ontological and epistemological frameworks of this approach (i.e., hermeneutics, phenomenology, and idiography). This entails a qualitative methodology, and individual interviews and focus groups were adopted. This chapter summarised the recruitment process, data collection, and relevant ethical considerations. Consistent with the theoretical frameworks, the individual interviews were analysed using IPA and the focus groups using RTA. This chapter concluded with a review of the quality of the study and adopted Yardley's (2000) considerations for the quality of qualitative research.

5. Findings

Individual Interviews

This chapter discusses the findings from individual interviews that explored how Black Africans in A-NZ conceptualise mental health and their strategies for managing their mental health. All participants were identified by pseudonyms, and any potentially identifying information was omitted. Using IPA, the findings are organised into three major themes: identity and mental health, differences in mental health perspectives, and limitations of mental health services in A-NZ. Each theme is supported by quotes that illustrate their lived experiences and perspectives. Table 4. summarises the main themes and subthemes identified.

Table 4

Summary of major themes and subthemes.

Major Theme	Subtheme
Identity and Mental health	<ol style="list-style-type: none">1. Identity and mental health perspectives.2. Identity and mental health strategies.3. Fluidity of identity and mental health (perspectives and strategies)
Differences in mental health perspectives.	<ol style="list-style-type: none">1. Stigma versus Embrace.2. Intergenerational and gender differences.
Limitation of Mental Health Services in A-NZ	<ol style="list-style-type: none">1. Feeling unheard.2. Limited understanding of family dynamics.3. Limited knowledge of mental health services in A-NZ.

5.1 Theme One: Identity and Mental Health

Theme one explores the relationship between participants' identity and their mental health. Participants' identities were linked to the social groups they affiliated with, such as ethnicity, geographic location, or religious beliefs. The cultural norms present within these groups appeared to shape participants' perceptions of mental health. This theme consists of three subthemes: 1) identity and mental health perspectives, 2) identity and mental health strategies, and 3) the fluidity of identity.

5.1.1 Subtheme One: Identity and Mental Health Perspectives

It appeared that participants who spent more time in African communities generally perceived mental health as associated with the attainment of resource security, often valuing external factors over mental health issues.

For Andrew, a participant who relocated to A-NZ as an adult, his understanding of mental health was directly associated with resource security. He expressed that before coming to A-NZ, he considered the word 'stress' to be a "rich man's term," indicating that for him, it was an experience exclusive to those with financial stability. His accounts alluded to the 'stress paradox', or the idea that stress increases when external resources are abundant. He described how, while in Africa, he felt somewhat disconnected from the idea of "stress". During his time in A-NZ, he associated mental health with a sense of mental peace, which he related to attaining resource security, both physically and financially. Thus, consistent with the 'stress paradox', as his resources increased, so did his connection with the idea of 'stress'. Yet, in both of his experiences, he associated mental health with external factors such as physical health and finances as they pertained to his life. For example, when he lived in Africa, this view manifested as involuntary contentment with resources provided due to the inability to obtain more, but while living in A-NZ, this was shown through Andrew's experiencing the "luxury" of stress due to increased resources.

Andrew speaking to what mental health means to him now:

I guess mental health is the mind being at peace. Um... how can I put it? Being less stressed, okay? Again, stress is such a broad term, but not worrying about yourself, not worrying about where things are going to come from tomorrow, for example, food or if you're going to have enough money to pay for your rentals and bills and things like that. So, the mind generally being at peace. (Andrew).

Andrew contrasted the above excerpt with how he viewed mental health/stress when he lived in Africa:

Well, there are two things. One, it's almost the same, but the definition of stress is slightly different. Um, I guess stress was seen... If you would have said stress to me, I would have said that it's sort of a rich man's term for those that have money or wealth. For some of us, we are so free. Stress doesn't apply to us. [...] Then, for example, being at school, school generally was ... the resources were not that much, so you get to learn from a younger age to make do with what you have. You don't have the luxury of choosing, and you just get on with life. (Andrew).

Fiona, who moved to A-NZ as an adult, shared similar sentiments to those of Andrew. When discussing mental health, she listed other external resources as being of primary importance over mental health. Fiona attributed this to her experiences and lessons from her parents and how they shaped her. She reflected on the impact of exposure to and living in a low socio-economic community on her priorities. At the time of the interviews, Fiona's employment role was in the mental health sector. Despite this, the exposure to low socio-economic countries and lessons from her parents appeared to have a greater impact on how she viewed/prioritised mental health.

Yeah, so what's important is food, education and employment. Those are the three important things. Anything else comes later. (Fiona)

I think it was just the way I was raised by my parents. Because it wasn't important because there was five of us and one salary, my dad's salary, and it was not like we were very rich. We were raised in a poor society. So, if you are poor, honestly, mental health comes later because you want to know if you have something to eat. (Fiona)

Expanding on the significance of contextual influences, Fiona's narratives also indicated how the absence of Western mental health terminology in Africa might have shaped how mental health issues were conceptualised. For instance, she indicated that individuals who lived in Africa did not readily identify with mental health issues. This observation extended beyond her personal experience to include others, as she expressed, "*We don't have that*". Instead, aetiologies of mental health were related to external factors such as punishment for bad behaviour or witchcraft rather than the diagnostic explanations offered by Western perspectives.

But, I had never heard of depression or anxiety or suicide or borderline personality disorder. We don't have that. And, um, I think a lot of people... some people who struggle with mental health difficulties, it would be put on cultural things. What have you done bad? Have you hurt your parents? Who have you wronged that has cast a curse on you that has made you mentally unwell. And the other was like witchcraft. So, those are the two-three main causes of mental health. (Fiona)

In contrast, some participants who moved to A-NZ as children were inclined to associate mental health with internal experiences. Compared to Fiona and Andrew, who linked mental health with external factors, for Betty, mental health was associated with emotional awareness, which

spoke to internal experiences. For these participants, their primary context for meaning making was A-NZ compared to Africa.

Mental health, for me, means being aware of how I'm feeling or not feeling. (Betty)

In the same way, another participant, Ella (who moved to A-NZ as a child), associated mental health with the ability to reflect on what is going on internally: a pursuit of self-discovery.

I think for me, it's definitely... I don't know if it's because of the way I'm wired, but it's definitely about understanding what's going on in my mind, and having the tools to be able to navigate what is going on internally is what I would say mental health is. (Ella)

For Diane, who also migrated to A-NZ as a child, the link between mental health and self-awareness was pivotal in how she defined mental health. However, her viewpoint was unique in that her understanding of her inner experiences lacked the expectation of improvement in her mental health issues. While she recognized the idea of seeking help as a possibility she would contemplate, this aspect was not essential to her concept of mental health. This view stood in stark contrast to Andrew and Fiona, whose stories highlighted a focus on striving to achieve or progress toward certain goals.

I think it would be being aware of what I'm feeling and, like, why I'm feeling like that, but like, if I don't know how to make it better, that's fine, but at least being aware of like, 'Okay this is what I'm feeling. This is what I feel like I am going through', and then slowly seeing, 'okay how can I get help for this or what do I need to do to like change this'. That mindset. (Diane)

5.1.2 Subtheme Two: Identity and Mental Health Strategies

Subtheme two centres on participants' identities and the mental health strategies they adopted. These strategies seemed to be shaped by culture. However, culture was not confined to

geographical location or ethnicity; other social groups, such as religious groups, also appeared to influence the strategies adopted.

Callie described feeling connected to her home as a key strategy. Her use of the word “home” suggested a sense of belonging and primary identification with her ethnic heritage. Callie explained that she relied on practices that facilitated a deeper connection to Africa while in A-NZ. She described using music, media, and social connections to achieve that.

I feel like also maybe feeling connected to home. Um, so things like, I don't know, it might be as simple as listening to a bunch of African music or watching like watching an African movie or speaking to my friends from back home. You know, 'cause I feel like there are times where I feel really disconnected. (Callie)

In a similar pattern, Fiona, who spent most of her life in Africa, also spoke of reconnecting with her African roots to manage her mental health. Despite having lived in A-NZ, Western media did not have the same impact as African media in managing her mental health, thus indicating a stronger bond with her African identity. Furthermore, both Callie and Fiona shared the common strategy of using music to foster that connection.

I think when all those things are not going well, I turn back into my original mode, which is my Zimbabwean mode, ay. I go back and listen to the African songs and all that. That's all. I can't listen to the Western music or anything. It doesn't work. I think I have to go back to my me being me, to my roots. That's all. (Callie)

Passive approaches to managing mental health were also highlighted. Ella reported that when she was in Africa, rather than actively addressing mental distress, concerns were not overtly discussed and expected to resolve naturally over time.

I think for myself in Zimbabwe, because I was ten, I didn't really know how to deal with, um, mental health. I would just, again, just kind of sit with it and think about it and not

do anything and just hope it resolves that kind of thing. In terms of my family, from what I remember from my parents is just like you kind of hope it goes away kind of thing. You kind of wait for it to resolve itself, or you just like, yeah, leave it be. (Ella)

Although Ella initially outlined a passive approach, she also provided insights into alternative coping methods her family used during her time in Africa. While she expressed a lack of overt strategies for addressing mental health, family interventions seemed to serve as the primary means of tackling these issues. Ella seemed to distance herself from this approach, characterising it as a method others use to deal with problems rather than by herself or her family.

Um, or like issues that come up. You just kind of like don't really talk about them, or you do, but there's no like steps to go somewhere or to go to someone as such. From what I remember, it was usually like our family giving out help rather than asking for help. Uncles and aunties would come to my parents (Ella).

However, regarding approaches that resonated with Ella, she leaned toward methods that promoted self-reflection and social support. This contrasted with the family-oriented approaches she was exposed to during her upbringing, which her extended family members adopted.

I think... a couple of things like journaling is one. For example, if I get angry, I have an anchor journal. I also keep a gratitude journal. It has really changed my mental health because I tend to focus on things that are not going well, and it helps shift my perspective. Yeah, journaling. (Ella)

5.1.2.1 Religious Beliefs and Mental Health Strategies

Culturally based influences were not limited to geographical or ethnic identity but included religious beliefs. These appeared to influence the strategies of both mental health perspective participants.

For Fiona, despite strongly identifying with her African identity, her Christian identity also impacted the way she managed her mental health. Similar to how she used African music, listening to Christian music was also a strategy she used. Being a Christian appeared to influence where she went to manage her mental health. Religious practices such as reading the Bible were seen as a source of strength. Phrases such as “cornerstone” suggested that her religion was foundational to her way of living and, therefore, how she navigated her mental health.

...also, going back to Jesus, my faith, my cornerstone. Can you see why faith is important to me? Because that's where I go back and look at the Bible and get some re-strength. I get it from the Bible. (Fiona)

Another participant, Holly, also listed the use of religious practices. For Holly, her religion was something that she had the autonomy to choose and, therefore, live out. Like other participants, music, specifically Christian music, appeared to be essential in her management of mental health. The act of worship and praise was intertwined with creating a sense of inner “calmness.” For Holly, managing mental health was associated with orienting herself toward and focusing on God.

Um, my faith and my choice to live my life as a Christian and just like putting God in my lifestyle. Kind of like gives me that faith, the hope, the... the strength to carry on. Just worshipping God, and praising Him, and praying to Him does... it's both beneficial to God and to me because I find it very therapeutic. And like, if I need, like, the presence

of God, I can just go to Him anytime, anywhere. I can just play my worship music, and it's calming, and I know, like, I can just interact with Him when I need to talk to Him. That kind of thing. (Holly)

While most participants identified with Christianity, strategies were not limited to this perspective. Andrew's experiences suggested that despite identifying as a Christian, there was fluidity in the religious strategies he adopted. He detailed incorporating other approaches from Buddhism and selectively adopting beneficial strategies. Additionally, engaging in physical religious practices, such as attending church, was recognised as a valuable strategy. His narrative indicated the fluidity of identity and strategies used for managing mental health. Similarly, the physical act of religious practices, such as going to church, was considered a useful strategy.

Yeah, yeah, yeah, of course. I am a Christian, and I do go to church regularly, and that does help. My wife is a Buddhist, and every so often, I go to Buddhist sessions. I particularly find those helpful because Buddhism has the teaching on how to handle stress and the mind. I think it is more developed than that African-Christian teachings. So, I find that, yes, I do rely on those teachings when I feel stressed. They are quite helpful. (Andrew)

5.1.3 Subtheme Three: Fluidity of Identity

The third subtheme emerging from the analysis of the interviews was the fluidity of identity and, in turn, the fluidity of views on mental health perspectives and strategies. Some participants showcased how cultural belonging can be subject to change.

For Callie, throughout the interview, she detailed her experience navigating an existential crisis when she left her religion. This included a shift in the usual mental health support available to her and the process she underwent in renegotiating how to replace what was lost during her

identity shift. For instance, although she previously engaged in religious activities like attending church and socialising with fellow Christians, these practices became unavailable. Although her transformation was a personal choice, it seemed to affect her community, resulting in lost friendships and shifts in her family dynamics.

I lost quite a bit of friends because of it because they wanted to distance themselves from the idea that I was no longer a Christian. Cause, you know, certain churches have that do not associate with people who are of the world. Um, my main family, like my actual immediate family, um, my mom was pretty good, and she supported me through it, but my dad, our relationship broke because of that. It's recovering slowly, but yeah, I can still feel that if I had remained Christian, we would have had a strong relationship, but I'm not, and it's created this drift. (Callie)

Callie's narrative detailed her journey of rediscovering how to manage mental health. Initially, it appeared to be a process of avoidance strategies such as substance use and redirecting focus to something else. However, there were still attempts to utilise social support. There appeared to be a transitional period where she was trialling compensatory strategies.

Temporarily, it was alcohol. Um, so it's not a very good coping mechanism, but I did it. It helped, it helps for a short while, um, but obviously, it's not a long-term solution. Um, and then, I guess working, you know, just being hyper focused on work, doing a bunch of overtime, um, trying to go out with friends as much as possible. (Callie)

Finally, Callie reflects on how her self-discovery journey has led her to adopt a selective approach similar to Andrew's. Like him, she selected aspects from various belief systems to identify what resonated most and was most effective for her.

Yeah, from different religions or belief systems. So like, if I find something and I'm like, "Oh wow. That sounds really interesting" or "That sounds really helpful", I might

start doing it like, I don't know, seeing a psychic, going to get a reading done, um, you know, yeah. (Callie)

Another participant, Betty, detailed her identity crisis when she decided to leave her religion. In making this change, she reflected on how this changed where her identity lay and what she did to manage her mental health. Interestingly, for Betty, this catalyst event resulted in her wanting to focus more on her ethnic identity, despite having moved to A-NZ as a child. Betty's narrative suggests that while she never truly lost her African identity, the dominance of her religious identity led to her elevating religious modes of well-being over African practices.

It wasn't until I left that I thought, "Oh, I actually forgot about my culture" because the religion aspect of it was so prominent and dominant. So, once I left, I felt like I had more space to focus on "Oh, I have African friends". I don't know what I am trying to say, but it made me I guess my experience as a [particular religious denomination], it took away a lot of my time to focus on other things. So, when I left, I had more time to hang out with people and listen to African music and watch African music and stuff like that. (Betty)

While the previous excerpts indicated a change in identity, Fiona highlighted that some simultaneously co-existing identities can influence how she responded to a situation depending on the context. Fiona drew on her occupational identity for work stressors associated with using resources available and related to work.

Uh, also, I think it's mental well-being. If I'm really struggling, I'll always have to book an appointment with my clinical supervisor just to talk through things so she can guide me and give me some guidance on how to carry on, especially when you are having sleepless nights because of clients, and you're under a lot of stress. (Fiona)

However, for Fiona, this changed when she described having emotional difficulties and reported that she, instead, uses Christian modes of coping.

Yes, I love music. I love Christian music. You know, when I'm so low and down, and then I listen to music. I think music always makes me. It makes my mood go back.
(Fiona)

In summary, Theme One demonstrated how identity influences participants' perspectives on mental health and their coping strategies. Identity was linked to the social groups participants belonged to and how exposure to these groups' cultural norms and practices shaped their views on mental health. This theme also underscored the fluid nature of identity, highlighting how the understanding and management of mental health can change over time.

5.2 Theme Two: Differences in Mental Health Perspectives

The second theme from the interviews related to differences in mental health perspectives. This included two subthemes: 1) differences between Africa and A-NZ and 2) intergenerational and gender differences.

5.2.1 Subtheme One: Stigma Versus Embrace

One key theme highlighted by participants was the difference in perspectives on mental health between Africa and A-NZ. Most participants indicated the stigma surrounding mental health in Africa and noted the lack of discourse on the topic, contrasting it with the general acceptance of discussion about mental health in A-NZ.

Fiona described the differences between mental health perspectives in African communities and those in A-NZ communities. The aetiologies of mental health were largely linked to spiritual processes and were similarly addressed through spiritual approaches. However, because the aetiology was often connected to negative connotations (i.e., evil spirits), there was a stigma surrounding how Africans perceived mental health.

It was different. So, if it was witchcraft, then you are supposed to go to church or to the traditional healer. So that they can heal you from those evil spirits. So, it was all... it was like it was all caused by evil spirits. But if you had done something wrong, it was a way of going back and asking for forgiveness and reconciliation. And there was not a lot about medication, and not a lot would talk about mental health because of that stigma which surrounded it. (Fiona)

Similarly, Holly shared her observations about the stigma surrounding mental health she encountered while living in Africa.

It's our culture because whenever anyone has anything related to mental health that is not good, then you are mad like something is definitely wrong with you, you know. Even now, I could be watching Zambian TV shows, and they are trying to educate Zambians in terms of mental health and stuff, but it's still not accepted very well. Do you know what I mean? (Holly)

Another example is Gemma, who highlighted similar views in African communities. She described a distance that people in Africa create between themselves and mental health issues. According to her, these issues are perceived as affecting non-Africans rather than Africans. She also noted some generational differences, as young people may wish to acknowledge mental health but might be hindered by their parents' views that could invalidate those experiences.

They see it as a Western thing. I hope I won't sound rude, but they will see it as like it's a white people's thing and that you don't need to do that. I'm just remembering my younger friends and, you know, they go through something, and they would be like, "Ah, I cannot go and tell my parents about this because they would be like, I should just toughen up; you know. I shouldn't even go to counselling because you don't need it". They will diminish the problem even though the problem is actually big. (Gemma)

Gemma elaborated on the tendency to avoid issues related to mental health and highlighted the significance of looking well on the outside. Similar to Fiona's point regarding spirituality, Gemma also utilised religious practices (such as prayer) instead of Western methods for coping.

Back home, I did not deal with it, and I ate. I did not talk to friends about it. I think the two things that I did back home was to eat a lot, to pray, and cry it out. Yeah, cry it out. And I tried to act like I am okay a lot outside, which took a lot of strength from me. Man, how did I survive back then? (Gemma)

Diane also noted the lack of discussion about mental health among Africans. Her narrative did not imply stigma; instead, there was no clear recognition of mental health issues, including within the African community in A-NZ.

Um, I think in terms of Africans, and I guess in a little sense, some New Zealanders. Um, but especially other Africans who have moved here, pretty much have been raised here, it's not really something that we have talked about in detail. It's not really something that we have talked about, um, within our community. Like recently, yes, but we haven't really heard about it in the past. (Diane)

Likewise, Ella stated that discussions around mental health were largely absent in Africa. Nonetheless, coping strategies were often more subtle, relying on family members and the wider familial community.

Um, yeah, I think that's the biggest difference between being in A-NZ and being in Africa. It's like it's done in the family kind of thing. You go to your elders, aunties, as you probably know. (Ella)

Gemma shared her experiences with depression, explaining how her understanding of mental health in Africa influenced her self-perception during her struggles in A-NZ. Due to a lack of open dialogue about mental health within her community, she did not connect her symptoms

to mental health issues. This led to self-blame and feelings of being “lazy.” She attempted to understand her mental health through a framework that ignored mental health difficulties.

Just being in bed and not wanting to get up. Not, not really knowing what to do because, in our culture, there is no such thing as depression, there is no such thing as anxiety, and there is no such thing as stress. It is not seen as anything, and no one really talks about it. So, it happens, and you're like, "You're just being lazy. You should be getting up. Why aren't you doing anything? Why are you just..." and on top of that, you just want to push yourself and be like, "oh yeah, I'm going to work. I'm going to this, I'm going to do that" just to keep yourself busy and just to make sure you're not lazy.
(Gemma)

Most participants discussed the greater acceptance of mental health narratives in A-NZ, a phenomenon less common in Africa. Ella emphasised that, during her time in Africa, she was largely unaware of the concept of mental health until she moved to A-NZ. She addressed the complexity surrounding mental health awareness and personal experiences, noting the uncertainty of whether her current perspectives result from her exposure in A-NZ or if she would have reached similar conclusions had she remained in Zimbabwe.

Um, okay. Um, probably the fact that when I was younger or recently moved to A-NZ, there was nothing as such, at least for me, there was no concept of mental well-being. Um, or mental health and also in Zimbabwe as well. Slowly, I have come to realise that... I don't know if it would have been different if I had grown up in Zimbabwe and had gotten older there as well. Like, as in, if I had grown up there, would I have eventually found it kind of thing. Or, is it because I have moved here that it's...? I think that's the most important thing for me that it wasn't a thing, and now it's a thing. (Ella)

Diane expressed a similar idea about the transition from unawareness to awareness regarding mental health. She explained that a shift occurred while she was in A-NZ, leading her to understand what mental health meant for her. Her awareness did not stem from personal experience but from observing those around her who were struggling with mental health issues.

I think to start of... so maybe like around the end of high school-ish, I probably just viewed it, like, "Oh, okay, it's just a thing that people have. That's fine", and I just left it at that. Oh, if people said I am struggling with mental health, well, not really struggling but like, "Oh, I am wanting to work on my mental health", or something like that, I'd just be like, "Okay, that's cool. Just let me know if you need someone to like talk to". I'll just at least leave that open invitation if they needed that extra help or support. I didn't really think about it. Um, yeah. (Diane)

Ella described an event or trigger that led her to become consciously aware of mental health. While this was not an identity shift, it represented a shift in her framework to embracing mental health. For Ella, this change was precipitated by the cumulative stress of starting university and moving away from home. This significant transition heightened her awareness of the internal responses that emerged when faced with change or stress. Ultimately, this heightened awareness served as the catalyst for Ella acknowledging mental health.

In the past, I would say I probably didn't know mental health was a thing or consider it a concept or a part of well-being. Um, I more so came to it... I think to realising what it is, maybe first or second year of Uni. I went through a big transition with moving from high school and then moving out of home to go to Uni and live with other people and all these changes and having to process all of these changes and being in a new environment with different people that I relate to differently compared to my family. Whereas, like at home, I could just, I don't know, not have to explain what I'm thinking

and why. And then, moving in with new people, you kind of have to go through that more. That's when I started noticing that, hey, there is this internal world. I don't know if that makes sense. (Ella)

For Betty, her catalyst event was leaving her religion. This transition towards a greater awareness of her mental health was linked not to her African identity but to her former religious identity. Betty also expressed that awareness of mental health can be triggered by someone else bringing it to attention.

For me, it was through a friend. She was like, "You probably should talk to someone about that". For me, it was leaving being [religious group] It was a very traumatic experience for me, and my friend picked it out. (Betty)

5.2.2 Subtheme Two: Intergenerational and Gender Differences

The second subtheme pertained to experiences of gender and intergenerational differences. Some participants shared their experiences or observations regarding intergenerational differences among Black Africans in A-NZ in relation to their views on mental health. Specifically, older generations were described as avoidant when it came to discussions about mental health, while younger generations tended to be more accepting and proactive in addressing mental distress.

Gemma shared her insights on the minimisation of mental health issues that many African parents tend to exhibit. While she recognised individual differences, she believed this is a common trend among African parents based on her experience.

So, the parents will diminish the problem. I guess it depends on the parents, but I have seen a pattern where I think most African parents think the same way. (Gemma)

Similarly, Callie detailed how her parents' stigma toward mental health impacted how they viewed the way she managed her own mental health. She highlighted how the language her

parents used suggested a negative perception towards Western approaches to addressing mental health (i.e., therapy and medication). This led to her parents criticising how Callie managed her mental health.

Um, even something as simple as like just going to therapy or doing counselling, it's kind of like an "Oh, that's a white people thing", like, "You don't need that". Like, "You have work. You know, you're too busy to be sad". Or even taking medication was a big thing, "It's going to mess up your body, and it does nothing to help you. You're gonna stay on this medication for the rest of your life". You know, that wasn't really something that was supported because of, like, I guess, the stigma around acknowledging that you might have a mental health problem and you want to fix it.
(Callie)

Furthermore, Holly explained how her mother's work in the mental health sector influenced her and made her more open to discussions about mental health. Despite this, Holly stated that mental health conversations were still not common in her family.

Um, but my mum is a mental health worker, so it was easy to talk to her about it. Even though we have never really discussed mental health in our home, but I know that she is already in the industry, and I could just... she's my mum. Regardless of what it is, she will always do what is best for me when I am unable to do it. (Holly)

Ella mentioned that, compared to her parents, she and her sister were more aware of mental health. However, she also highlighted how a change in her mother's occupational identity led to a shift in her view of mental health. Similar to Holly, her description of this change did not indicate a complete shift in the family's perspective, as the other parent continued to refrain addressing mental health issues at home. Moreover, her father maintained the same beliefs.

Um, I think the biggest difference is, say, for example, me and sister grew up here, and I think we think really similarly, and we are aware that it's a thing. So, we will talk about what's going on internally and process with each other. How events have changed us, kind of things like growing up. Um, so we kind of have that understanding. Whereas if I was to compare to my parents, um, I would say my mum is more aware of it now than she used to be before because she is training to be a counsellor, so she is definitely more in touch with it. Whereas for my dad, I don't think it's a thing well, at least we don't talk about it. (Ella)

While most participants spoke from the perspective of a child reflecting on their parents, Fiona provided insights from a mother's perspective. She also compared the experiences of her two daughters, where one was portrayed as less resilient due to her emphasis on expressing emotions compared to her elder sister. Elements of her dialogue revealed a disconnect between how her youngest perceives the world and her own perspective. For Fiona, the focus seemed to be on obtaining resources and necessities, whereas her daughter was more inclined to reflect on internal processes. The child who concentrated on internal processes was viewed as lacking resilience compared to the one who focused on resource acquisition.

And, um, [second child] talks more about her emotions. Every day she comes and talks about her emotions. How she felt, if she was sad, and all that. I think it's because at school they talk about it a lot. Whereas in our school back home, you didn't talk much about emotions. There were not there in the syllabus. So, she always comes home and says, "Mum, so and so. I feel like so and so and all that". And um, I think also looking at it, um, we didn't have a lot of money back home when we moved here with [first child]. So, she appreciates food. Whereas this one doesn't appreciate it. She thinks everything should be there on the table. That's where... when I am comparing my kids, I can see that [first child] has some resilience, [second child] doesn't. And that's where

you see that when there is mental health issues, it all comes to resilience. And resilience... and mental health... it just means you need to be able to live a fulfilling life despite mental health challenges. That's where the resilience comes into play. So, um, I feel like because they have never tasted hardship, in terms of material hardship, so, that is why, to them, when anything blows, anytime the wind blows, they can't bounce back.

(Fiona)

To a lesser extent than the intergenerational differences, participants highlighted the difference in gender perceptions of mental health. Gemma stated that discussions surrounding mental health are notably absent among African men. She perceives the reluctance to address mental health as an outdated strategy in comparison to women, who are actively seeking to confront mental health issues.

Um, so I was saying that the men were behind and that they don't have a group like ours where we can post and support each other. Um, I feel like their groups are mainly for sports. I'm thinking of my brother, who they do talk to other African guys, but it's just about sports, and they don't talk about mental wellness. (Gemma)

5.3 Theme Three: Limitations to Mental Health Services in A-NZ

Theme Three deals with the experiences of mental health services in A-NZ. This theme was unique because it was derived from the unprompted accounts of their experiences and/or perspectives on mental health services in A-NZ. Theme Three outlines the experiences shared by participants regarding the limitations they faced when accessing mental health services. For some, these were personal experiences, while for others, they were relayed through the experiences of those around them. Overall, the barriers included feeling unheard by service providers, the inadequate understanding of African dynamics and nuances from service

providers, and Black Africans' limited awareness of and access to mental health services in A-NZ.

5.3.1 Subtheme One: Feeling Unheard

The first subtheme related to feeling unheard by A-NZ mental health service providers. Holly detailed her experience with her first depressive episode and the confusion she felt. She highlighted her efforts to seek medical assistance to understand what was happening to her. At the time, while she accepted the treatment plan, she reflected on feeling unheard. Her description of the experience suggested that one perspective on managing mental health was prioritised over others.

I didn't understand it myself, and I went to see my doctor, and he was like, "We will start you on, um, what do you call it, cilazapril". I think so. It's just this antidepressant that they put you on. So, um, even like speaking to my doctor about everything that I was going through, it just felt like I'm not being listened to, and they just want to put me on medication. (Holly)

While Holly's initial reason for seeking medical support from the doctors was to explain and treat the physiological experiences of depression, what she ultimately wanted was options beyond a medical understanding of well-being. Underlying Holly's narrative appeared to be a desire to target the root of her distress rather than the symptoms of her depression.

So, just decided to go and see the doctor and get some help because I was gaining weight and diabetes runs in my family, and I was like, hmm, let's not go there. (Holly)

I had felt like I wasn't really told an alternative, like how can I... like what can I do to become...to just relieve the pressures and stuff like that, like how to manage my mental health. (Holly).

Despite feeling unheard, Holly accepted the doctor's recommendations because she believed her understanding was too limited to make a different choice. Consequently, her limited knowledge of mental health seemed to be a major factor in adopting a biomedical approach to managing mental health.

It was just straight to medication, and so, for me, I didn't know anything, and I was just like, "Okay, I'll take it", but actually, that medication just made my symptoms worse.
(Holly)

Another participant, Gemma, shared her experiences accessing mental health support in A-NZ. Notably, she contrasted the differences between engaging with an A-NZ service provider and video calling a therapist in Africa. In particular, she described struggling with the focus on solution-based responses offered by the A-NZ counsellor. For her, this conveyed a feeling of being unheard. It seemed that her need to be listened to took precedence over her desire for solutions regarding her situation. The capacity of the African clinician to engage in active listening without the compulsion to respond was of greater significance to Gemma.

I feel like the A-NZ counsellors used the textbook. They didn't listen to listen. They listened to answer. They didn't listen to understand. They listened to answer. But, for the African counsellor, they listened to understand. Like, they wouldn't give me answers straight away. I did, I think, two or three sessions with them, and I remember the first session; she never told me anything. She was just listening and asking me questions and questions and questions. Do you know what I mean? But, for the Kiwi counsellor, they listened, asked questions, but then they told me their thoughts. So, yeah, those are the differences that I noticed. (Gemma)

Gemma expanded on the differences between having a therapist who came from the same background versus a different background. While the efforts to understand the African culture

of the A-NZ therapist were acknowledged, it appeared to be insufficient to the value gained from a therapist who had a pre-existing understanding of the African context, dynamics, and nuances.

Um, as I mentioned previously that I feel like Africans will understand each other, like the upbringing or the family dynamics and whatnot. So, I feel like when I talk about my experiences, let's say about my childhood or something, to a A-NZ counsellor, they wouldn't understand where I am coming from. They would try to understand it in the way that they see it or the way they know, but for an African counsellor, they know exactly what I'm talking about. Do you know what I mean? They would like... they might even end up finishing my sentence if they would, but for an A-NZ counsellor, they wouldn't understand the dynamics. The African dynamics. (Gemma)

Similarly, the excerpt below by Fiona expresses comparable sentiments regarding the desire to be heard by mental health services. Interestingly, Fiona shared her perspective as a medical practitioner working in a hospital and her belief that the services offered in A-NZ currently do not align with how Africans prefer to engage. Fiona's reflections highlight systemic issues that hinder the allocation of adequate time for individuals seeking support from mental health services. She reflected on her own practice and the limitations she faces in being fully present with someone due to the demands of her work. The excerpt below outlines an interaction Fiona had with one of her clients.

I think one of the things that is important to me is being listened to. That effective communication, you know. (Fiona)

This guy I was assessing was saying that... was hearing voices, and his voices were commanding him to kill people. So, tell me, Michelle, I'm like, "Hold on", while he is in the middle of telling me all this, and I say, "Hold on, I have to take this call". And I

get out of the office to take this call. And then I came back and say, oh... because this was another client, and then I say, "Oh, wait, and I'll call you later. I'm still in the process of assessing someone. I'll call you after this". Went back to this guy and said, "Look, I'm back. Where were we, and do you think the voices would be still there?". "There is mistrust now because I was telling you something important, but you told me to hold on. You have to answer this other phone call. It isn't sitting well with me".

(Fiona)

She also reflected on the impact this might have on a person's comfort sharing traditional conceptualisations of mental health issues from an African perspective (e.g., *kutandabotso* – a curse obtained from disrespecting your mother). Similar to Gemma, the feeling of being listened to facilitates a safe space for the person to share their mental health narrative.

And that's what I'm saying, like, as Africans, we want to be listened to. I want you to show me that you are listening. But, if you can't even have time to talk and say, "Oh, okay. I'm going to answer this other call", how are you... how am I going to tell you about all my stories and about, I think, maybe ndiri kutandabotso. And you're trying to say, "No, no, no. It's the dopamine here", and then you say, "Oh, hold on. Hold on," and you come back later. (Fiona)

5.3.2 Subtheme Two: Limited Understanding of Family Dynamics

The second subtheme relates to the limited understanding service providers have of Black African family dynamics. Diane emphasised the significance of mental health service providers grasping the various family dynamics present in a Black African household. Her explanations detailed how gender roles have influenced her experiences and how shifting the focus to one's mental health might be perceived as 'rebellion' by other family members. According to Diane,

these family dynamics and gender roles can act as barriers for Black Africans seeking mental health support.

I guess, like, family dynamics or, like, um... 'cause, like, I know the girls would always be the ones to do the cooking and the cleaning and stuff, and then the boys, they would just do whatever. Um, so maybe it might be seen as, like, ... not really a form of laziness but of like rebellion, but like, you're just choosing no, I don't want to do this anymore. Um, or if there may be specific, um, practices that the family might have, um, and you're suddenly deciding, "No, I don't want to do this because I need to work on [mental health issues]". Um, then that might be like a barrier as well. (Diane)

Gemma also acknowledged the importance for mental health service providers to understand how parent-child family dynamics can affect approaches to mental health. When asked to elaborate on potential limitations of health services, she stated that a lack of understanding of family system hierarchies can become a limitation.

Um, I don't know if I mentioned this, but the respect that we have for our parents. I guess Kiwis won't be able to understand that. (Gemma)

5.3.3 Subtheme Three: Limited Knowledge of Mental Health Services in A-NZ

Another limitation highlighted by participants was the lack of knowledge of which services are available for people. One participant, Ella, detailed her desire to engage in mental health services for self-discovery; however, despite her willingness to engage, she was unaware of services available to her.

It's always been something that I have wanted to do, but I didn't know it was available, like, for free, until I was in Uni in, like, my second year. I think it's always been something that I wanted to do because, I don't know, I like analysing myself and figuring out what's wrong kind of thing. So, yeah. (Ella)

Diane shared similar sentiments by highlighting the importance of knowing which mental health services are available. She noted reflections that were drawn from other people's experiences rather than her own. However, while she knew these services were available to her, she desired this knowledge to be accessible to others as well.

Yup, so I know that there is Helpline. Um, and I know that there is like a whole bunch of different people that I can reach out to or numbers that I can get to, um, if I like, google mental health in A-NZ. Um, and I don't know about other employers, but I know our employer they have, like, a... I forgot what it's called, but I think it's like EPP? So, whether that's like mental... you can talk to a counsellor about like anything. It doesn't just have to be work-related, and you don't have to disclose to work that you are going to see someone for this. Um, but yeah, I know some resources that I can dip into, but I don't think everyone else has that advantage. (Ella)

In contrast to Ella, who showed a strong desire to engage in mental health services, Diane exhibited some hesitancy, as indicated by her belief that mental health services are only necessary when the need for support is substantial.

Yup. It might take me a little bit of time to actually reach out to them. Um, but I know it's not... 'cause it's not something that is easy to do. Um, but then I would eventually get to that stage where I'm like, "No, actually, I need to get... like, speak to someone". (Dianne)

Overall, Theme Three highlights the experiences participants had with mental health services. Some limitations noted were feelings of being unheard. This was characterised by participants perceiving the way clinicians in A-NZ engaged with them as minimising their mental health experiences and perspectives. Secondly, they emphasised the importance of clinicians understanding the influence of family dynamics in an African household and how this can

affect a person's mental health experiences and viewpoints. Lastly, participants explained that having limited knowledge of the services available to them was another limitation.

5.4 Chapter Summary

Chapter Five outlines the findings from the individual interviews conducted through Interpretative Phenomenological Analysis. Three main themes were identified: identity and mental health, differences in mental health perspectives, and limitations of mental health services in A-NZ.

The findings indicated that identity affects how individuals comprehend and manage mental health. Cultural norms linked to their chosen social groups shape the perspectives of Black Africans. Identity encompasses not only ethnic identity but also other factors such as occupation and religion. Moreover, identity is subject to change due to life circumstances, meaning that how Black Africans conceptualise mental health is also dynamic and liable to evolve over time.

Differences in how Black Africans perceive mental health were also noted. In particular, while in Africa, the predominant discourse surrounding the topic conveyed stigma and covert coping strategies. In contrast, in A-NZ, participants noted a more open dialogue of mental health. Intergenerational and gender differences were also reported, with younger generations and women being more receptive to engaging in mental health discourse and approaching service providers.

Lastly, participants noted that the limitations of mental health services were significant to them. These limitations included feeling unheard, a lack of understanding of African family dynamics by service providers, and limited awareness of available services in A-NZ.

6. Discussion

Individual Interviews

The first section of this study employed a qualitative methodology to explore how Black Africans conceptualise and manage mental health. Data was collected through individual interviews and analysed using Interpretative Phenomenological Analysis (IPA). Findings indicated that participants' identities influenced their understanding of mental health. Three main themes were identified: identity and mental health, differing perspectives on mental health among Black Africans, and experiences with mental health services in A-NZ. Consequently, this chapter will discuss how identity shapes mental health perspectives. It will also consider how the fluidity of identity affects meaning-making and acknowledge the diversity among Black African migrants. While experiences with mental health services emerged as a theme in the individual interviews, these will be discussed in the next chapter since the theme was the focus and elaborated upon in the focus groups (i.e., 8. Discussion—Focus Group).

6.1 Identity

Identity is a complex phenomenon fundamental to the human experience (Crocetti et al., 2023). It refers to a person's sense of self (personal identity) and is intertwined with their connectedness to others (social identity) (Crocetti et al., 2023). Several prominent theories have been proposed to explain identity formation and processes. For this study, identity is understood through the narrative and social identity theories.

6.1.1 Narrative Identity Theory

Narrative Identity Theory was developed by Dan McAdams in the 1980s and posits that identity develops through the processing of life experiences into meaningful and internalised stories (McAdams, 2021). These personal narratives continuously evolve, enabling individuals to

make sense of their past and present while shaping a sense of purpose for the future. According to McAdams, individuals begin constructing their life stories in late adolescence, and this identity formation process continues throughout their lifespan. Cultural norms play a significant role in shaping these narratives. Narrative theories emphasise the dynamic, process-oriented nature of identity development and meaning-making (McAdams, 2021).

6.1.2 Social Identity Theory

A significant theory in identity literature is Social Identity Theory (SIT), introduced by Henri Tajfel and John Turner (Hammack, 2015). This theory explores how individuals form their identities based on group affiliations. According to SIT, categorising individuals into social groups facilitates the organisation of social information and the prediction of behaviours (Tajfel & Turner, 2004). Once categorised, individuals align themselves with specific groups, fostering a sense of belonging and emotional connection. A person's behaviour and social interactions are shaped by these group memberships (Tajfel & Turner, 2004).

6.1.3 Relevance of NIT and SIT

This study primarily considers identity through the lenses of narrative and social identity theories. Conscious identity formation is believed to commence during adolescence due to the development of cognitive skills necessary for this process. It is influenced by childhood events, cultural experiences, and access to opportunities (Shiner et al., 2021). NIT aligns with the findings from this study, as cultural, childhood, and situational factors shaped the narratives participants constructed regarding mental health. Furthermore, the identity fluidity indicated by participants supports the assertion of narrative theories that identity is dynamic and evolves in adulthood with new experiences. As identity matures, so do a person's self-perceptions and worldviews (Hammack, 2015; McAdams, 2021). Additionally, SIT provides insight into how group membership shapes identity, influencing beliefs, values, and behaviours based on a sense of belonging (Tajfel & Turner, 2004). Once again, the findings from this study aligned with

this theory, as participants' perspectives were strongly influenced by the norms and beliefs of their chosen group affiliation. Consequently, NIT and SIT provide a valuable framework for considering identity and its effects on conceptualising mental health.

6.2 Identity and Migration

Migration can have implications on an individual's identity. Acculturation processes prompt individuals to renegotiate their cultural values due to exposure to the host country's culture (Rabiau, 2019). This means exposure to different social expectations, values, and interaction patterns (Berry, 1997). For some, this process may lead to assimilation or the integration of new cultural perspectives, while others may retain their original cultural views (Berry, 1997). Since identity formation begins during adolescence, this process is more arduous for migrants and refugees (Hammack, 2015; Rabiau, 2019). Individuals navigate the normative developmental processes typical of adolescence and explore multiple identities shaped by their country of origin and host country (Berry, 1997; Hammack, 2015; Rabiau, 2019). The intersection of navigating identity formation during adolescence and renegotiating cultural values due to migration can influence identity formation for migrants and refugees. Increased exposure to Western cultures may lead to the adoption of new perspectives, resulting in novel ways of understanding the world, including complex phenomena like mental health (Berry, 1997; Rabiau, 2019).

Given the varied migration ages of participants in this study to A-NZ, with some arriving in childhood and others in adulthood, considering the impact of migration on identity formation can be insightful. Participants who spent their adolescent years in Africa appeared to align their views with dominant mental health perspectives in Africa (i.e., an emphasis on external factors). Conversely, those who lived in A-NZ during adolescence predominantly held views consistent with Western paradigms (i.e., an emphasis on internal factors). This contrast

underscores the pivotal role of identity formation in adolescence and the influence of migration experiences.

6.2.1 Mental Health Perspectives from Southern Africa and A-NZ.

Understanding how mental health is perceived in A-NZ and African communities provides essential context for interpreting participants' views. This section provides a concise overview of key mental health beliefs within these two cultural contexts. A clear contrast emerged in one of the subthemes, 5.2.1 Stigma versus Embrace, where participants described differences in how mental health is viewed in Africa compared to A-NZ. Specifically, they highlighted the stigma surrounding mental distress in African communities, noting that discussions about mental health are often limited or avoided. In contrast, A-NZ communities were characterised as more open to mental health discussions, with greater encouragement for seeking support and engaging in related discourse.

African perspectives on mental health have been shaped by cultural views, colonial influences, and socioeconomic factors (Njenga, 2007). Historically, many Sub-Saharan African communities attributed mental health distress to supernatural influences, such as bewitchment, curses from ancestors, or God's punishment (Egbe et al., 2014; Jackson, 1999). These explanations often carry negative connotations, which contribute to stigma and social exclusion of those experiencing mental distress (Egbe et al., 2014). Furthermore, studies have shown that media portrayals in Africa have been shown to reinforce derogatory narratives about mental illness, further perpetuating stigma (Masinga et al., 2022; Miller et al., 2020). This is consistent with reports from participants in this study where the aetiological beliefs of mental health distress resulted in stigma surrounding the very discussion of mental health topics. Despite this, recent efforts have been made to change the mental health narratives through new initiatives. For example, in Zimbabwe, there is an evidence-based initiative called the Friendship Bench, which aims to address mental health disorders such as anxiety and depression through trained

lay health workers (Chibanda et al., 2015). The success of this intervention can be seen through its use in the community, with reports noting that 30,000 people were using the service in 2017 (Centre for Global Mental Health, n.d.). However, despite such initiatives, participants in this study noted that stigmatising attitudes toward mental health remained prevalent during their time in Sub-Saharan Africa.

In contrast, mental health perspectives in A-NZ have historically been grounded in a biopsychosocial model, which emphasises diagnosis and treatment through psychological frameworks and medication (He Ara Oranga, 2018). However, there has been a shift toward reclaiming a holistic understanding of mental health, taking into account Indigenous perspectives such as Te Whare Tapa Whā, which considers domains such as whānau (family) and spirituality as key components of wellbeing (Bennett & Liu, 2018). Compared to African communities, A-NZ communities tend to engage more openly in mental health discussions. A 2024 global survey on mental health perspectives showed that people in A-NZ were more likely to think about mental health than the global average. Additionally, the survey reported that the majority of A-NZ respondents viewed mental health as the country's most significant health concern (IPSOS, 2024). Thus, it suggests a greater awareness and acceptance of mental health conversations, which is consistent with this study's findings.

According to Desjarlais (1995), countries with lower socioeconomic factors tend to prioritise issues concerning the basic needs of their citizens. As such, mental health matters are generally emphasised less (Desjarlais, 1995). The difference in prioritisation of mental health among African countries and A-NZ is evident in the distribution of government finances. According to the World Health Organisation, African governments typically invest less than 50 US cents per person on mental health. This amount falls short of the recommended \$2 per capita for low-income countries (WHO, 2022). While the specific per capita figure for A-NZ is not available, the 2024 budget allocated approximately \$2.6 billion for mental health services, indicating an

increase from previous years (Beehive, 2024). According to the Vote Health report, A-NZ allocates around \$2 billion towards mental health, which represents about 8-9% of the government's health expenditure (He Ara Oranga, 2018). In contrast, many Sub-Saharan African countries reportedly allocate less than 5% of their health expenditure (Nicholas et al., 2022). Furthermore, A-NZ has been reported to invest in community care initiatives to address mental health through services such as crisis and emergency teams, supported accommodation, short-term funded psychotherapy, or government-funded psychoeducation workshops (Brunton, 2011).

6.2.1.1 Mental Health Conceptualisation and External versus Internal Factors

As stated, African perspectives tend to conceptualise mental health based on external factors (Egbe et al., 2014). Participants who spent more time in Africa seemed to view mental health in this manner. A person's mental health well-being depended on factors like safety, financial stability, and opportunities, which were associated with "good" mental health. Conversely, the lack of these factors indicated "ill" mental health. One participant mentioned that stress is a "rich man's problem," suggesting that stress is seen as a symbol of affluence. This participant had experienced life in Africa, where resources were limited, and in A-NZ, where his resources increased. This perspective indicates that higher expectations may lead to greater regret. This aligns with Barry Schwartz's (2004) Paradox of Choice, which underscores how increased opportunities and resources can result in greater dissatisfaction and stress driven by external factors. This illustrates how, from this viewpoint, mental health is reliant on external circumstances.

Participants who lived in A-NZ during their teenage years tended to conceptualise mental health primarily through internal factors. Specifically, mental health was associated with the ability to understand one's own emotions and internal experiences. This perspective aligns more with a Western understanding of mental health (Humphrey & Bliuc, 2021). Western societies

typically emphasise individualism, which prioritises the self. Consequently, mental health beliefs focus on the individual and their capacity to understand internal processes, including cognitions, emotions, and behaviours (Humphrey & Bliuc, 2021; Smith et al., 2012). In contrast, African societies generally hold communal and relational perspectives, emphasising influences beyond the self (Owusu-Ansah & Mji, 2013). The cultural nuances that normalise a focus on external and internal factors in Africa and A-NZ, respectively, impact identity narratives, which ultimately influence thought processes and behaviours such as the use of mental health services (McAdams, 2021).

6.3 Identity and Mental Health Strategies

Identity was also associated with how participants managed their mental health. Identity promotes a sense of belonging. Some participants in this study reported making efforts to connect with their identity when they were experiencing mental distress, mainly ethnic (i.e., African) and religious identities. The following section will discuss how a sense of belonging influences mental health and how this relates to connecting to African or religious identities.

6.3.1 Identity and Belonging

A sense of belonging is the subjective feeling of deep affiliation to social groups, places, and singular and shared experiences (Allen et al., 2021). It promotes acceptance and inclusion to an individual's physical, spiritual, and social environment (Hagerty et al., 1992). Belonging is an essential human need that people attempt to satisfy (Baumeister & Leary, 1995). It promotes a sense of purpose and meaning in a person's life and increases life satisfaction, happiness, and mental and physical well-being (Allen et al., 2021). Identity and belonging are interrelated concepts, with one influencing the other. Identity can shape a person's sense of belonging through shared cultures, values, and beliefs. In turn, communities, places, and situations that increase the subjective sense of belonging can influence people's narratives about who they are (Anthias, 2018).

6.3.1.1 Connecting to African Identity

Participants in this study noted various strategies they used to connect to their African identity. These included listening to related music and connecting with people in Africa. These methods have been found to help decrease mental distress symptoms (Holt-Lunstad et al., 2017; Ruud, 2013).

6.3.1.1.1 Managing through Music

Music has been found to be a helpful method for managing mental health (Ruud, 2013). From a neurobiological perspective, it activates various regions of the brain, including the amygdala, limbic system, hippocampus, and cerebellum (Toader et al., 2023). These regions are responsible for pleasure, memory, pleasure, reward, and emotion regulation (Berridge & Kringelbach, 2015). According to a recent study by Tervaniemi et al. (2021), listening to calming music can help mitigate stress responses by reducing stress-promoting hormones such as cortisol. Music has also been found to help with mental health treatments. A systematic review by Golden et al. (2021) found that listening to music can help mitigate symptoms related to schizophrenia, bipolar disorder, generalised anxiety disorder, and post-traumatic stress disorder. The combination of the dopamine release, reduction of cortisol and the increased feeling of belonging associated with listening to, in this case, African music indicates a key strategy for managing mental health distress symptoms.

Music not only has positive neurobiological effects, but also serves as a point of cultural connection. As Crooke et al., (2024) assert: "Music is a source of cultural understanding and a site for cultural exchange" (p. 19). Music is deeply embedded in cultural traditions and attitudes; it allows individuals to connect with the culture it represents (DeNora, 2000). In addition to conveying cultural information, music fosters social bonding among its audience (Wilks, 2011). This, in turn, promotes social cohesion and a shared sense of belonging (Crooke

et al., 2024). Music offers migrants a vital connection to their cultural roots (Baily & and Collyer, 2006). It has the power to evoke emotions and memories tied to their experiences with that culture, which creates a sense of familiarity and connection (Baily & Collyer, 2006). Music can emulate the feeling of home, especially for those physically separated from their homeland. Due to the effect music has on a sense of belonging, it can improve people's mental wellbeing (Crooke et al., 2024),

6.3.1.1.2 Managing Through Social Connection

Another strategy participants highlighted was contacting family members in Africa. Analogous to how music fosters connection, contacting people in a person's home country has the same effect (Klingenberg et al., 2021). Given that many Africans use social connections to manage their mental well-being (Bletscher & Spiers, 2023), the loss of social support can be detrimental to people's health (Doma et al., 2022). Rebuilding social connections can be difficult for Black Africans in A-NZ (Song et al., 2024). However, in this digital age, people have different options for reconnecting with those in their countries of origin, such as email, video calls, texts, etc (Park & and Waldinger, 2017). This has many benefits, such as increasing social and emotional support and maintaining opportunities for cultural connections.

Connecting with people is beneficial and integral to managing mental health (Holt-Lunstard et al., 2017). It can provide psychological resources that help individuals navigate life stressors. These include benefits such as stress reduction, reduced loneliness and isolation, higher self-esteem, and increased life satisfaction (Holt-Lunstard et al., 2017; Song et al., 2024). Connecting with other people facilitates a sense of belonging and community (Song et al., 2024). Furthermore, when people feel supported, their perception of their ability to handle stress increases, which can reduce stress levels (Acoba, 2024).

Social connections are integral for migrants to maintain ties to their culture (Klingenberg et al., 2021). Language is a fundamental component of cultural identity and functions as a form of cultural expression that reinforces belonging (Altun, 2023). Similar to how music evokes a sense of familiarity, the ability to communicate in one's native language can elicit comparable emotional connection (Altun, 2023). Furthermore, speaking with members of the same cultural background, allows migrants to connect with a shared identity, which includes common customs, values, and beliefs (Cunningham & King, 2018). This shared framework of understanding promotes familiar and meaningful connections, thereby managing mental health through increasing a sense of belonging and cultural integration (Cunningham & King, 2018).

6.3.1.2 Connecting with Religious Identity

Participants highlighted using religious practices such as worship, reading religious texts (e.g., the Bible), and attending church to manage their mental health. Literature has shown that religion and spirituality can positively impact mental health (Fidrmuc & Tunali, 2015; Lucchetti et al., 2021). Religion fosters a sense of connection, belonging, and purpose. Religious practices often include coping strategies such as prayer that improve mental well-being.

6.3.1.2.1 Religion and Social Connection

Similar to how ethnic identity provides a shared identity, religion offers shared beliefs and values that foster connectedness. Studies have found that regular participation in a religious community has been associated with higher reported levels of happiness and community engagement (Fidrmuc & Tunali, 2015). Religious activities such as attending church services create opportunities for building support networks and socialising, leading to relational connections (Brown et al., 2022). Religious persons are also prone to be involved in philanthropic exploits such as volunteering in community groups due to such behaviour

aligning with the religion's values (von Essen et al., 2015). This creates opportunities for social interaction, promotes shared identity through engagement with similar values, and increases feelings of belonging. All of these factors positively influence mental health (Lusk et al., 2021).

6.3.1.2.2 Religion and Purpose

Another benefit of religion that aids in the management of mental health is the sense of purpose it provides. A sense of purpose provides people with long-term goals that add meaning to one's life (Kim et al., 2022). It connects individuals to something greater than themselves that can make an impactful difference (e.g., helping others) (Klein, 2017). People who actively engage in religion report higher levels of a sense of purpose than non-religious individuals (Krok, 2015). Purpose incurs mental health benefits such as lower stress levels, higher reported levels of happiness, reduced loneliness, and increased optimism (Kim et al., 2022b; Stavrova et al., 2013). Kim et al.'s (2022) study also found that people with a sense of purpose had a reduced risk of developing mental health disorders such as depression. It is hypothesised that the mechanisms operating when a person feels purposeful include an enhanced ability to recover emotionally from life stressors, enhanced self-efficacy, and increased ability to manage daily stress (Hill et al., 2022; Kim et al., 2022; Rush et al., 2021; Schaefer et al., 2013).

6.3.1.2.3 Religious Practices and Mental Health

Religion often involves practices that act as a mitigating factor in mental health management (Schille-Hudson et al., 2024). One of the most common is prayer. This typically involves communicating to the particular religion's God (Gallup & Poloma, 1991). There are different forms with the most common being intercessory and petition prayer (Janssen et al., 2000). Intercessory prayer occurs when the person praying is not the subject of the prayer (e.g., praying for someone else). Petition prayer involves asking for help for oneself (Janssen et al., 2000). Many religious traditions believe in the use of prayer for healing both physical and mental difficulties (Andrade & Radhakrishnan, 2009). Some participants in this study noted

using prayer as a strategy to manage their mental health. This is consistent with the literature as prayer has been found to be positively correlated with mental health outcomes (Simão et al., 2016). Other benefits of prayer include using it as a problem-solving strategy and the sense of relaxation such behaviour evokes (Schille-Hudson et al., 2024).

6.4 Fluidity of Identity

Identity is a complex phenomenon that affects how people view and manage mental health (Barnett et al., 2021). It indicates the social groups that an individual identifies with (Crocetti et al., 2021). Consistent with narrative theories of identity, depending on the new information and experiences available, people can reconstruct the story about themselves and renavigate their identity (Upadhyay, 2021). In this way, identity is fluid and dynamic, evolving with new experiences and challenges that a person experiences (Barnett et al., 2021). Changes in identity also means changing how people view the world and conceptualise various phenomena, such as mental health (McAdams & McLean, 2013). Participants in this study exemplified this by the identity changes they underwent following migration and exposure to cultures in A-NZ. In particular, some participants transitioned from overlooking mental health to prioritising it. Identity narratives are, therefore, continuously adjusting and developing due to a range of factors such as cultural integration and life experiences.

6.4.1 Cultural Integration

Acculturation showcases how migratory experiences can change identity (Côté, 2006; S. Schwartz et al., 2006). Acculturation is the process of navigating the changes that occur when migrants move to a new environment (Berry, 1997). People can respond differently to migration (Berry, 1997). Migration allows exposure to different social groups that may resonate better with a person's convictions and values, which causes them to adopt an identity that is more consistent with the identity narrative they wish to form (Côté, 2006; Schwartz et al., 2006). The options involve some adoption of the host culture's norms and values, therefore

resulting in identity shifts (Schwartz et al., 2006). For some participants in this study, migrating to A-NZ exposed them to how other cultures navigate life.

6.4.2 Life Experiences

Life experiences can result in people renegotiating their identity and how they conceptualise the world (Eriksson & and Frisé, 2024). When a significant life event happens, the meanings people form from this shape identity (Eriksson & and Frisé, 2024). Overcoming difficulties and traumas can lead to improved resilience. The changes people adopt in efforts to overcome trauma challenge previously-held identity narratives, increasing the chance of new identities forming (Eriksson & Frisé, 2024). Normative life changes such as engaging in an occupation, transitioning into new roles (e.g., parenthood), and changes in financial circumstances can result in identity shifts to accommodate to the new roles (Upadhyay, 2021). The combination of migration and normative life experiences results in factors that are constantly influencing the identity of Black Africans. Through reviewing and renegotiating the meaning associated with these experiences, they can embrace the identities that best suits them at the time. In this way, identity for Black Africans is constantly evolving and is fluid.

6.5 Differences in Perspectives

Participants highlighted gender and intergenerational differences regarding mental health perspectives. Among families, participants described older persons as avoidant of mental health topics, while younger individuals were proactive in overtly addressing it. In addition, participants noted gender differences in mental health discourse, with African men being typically more avoidant of the topic than African women. The following section will discuss these differences further.

6.5.1 Intergenerational Differences

Generational differences can lead to conflicts within a migrant family household. First-generation migrant children often have distinct values and perspectives compared to their parents, which may cause misunderstandings and disagreements (Renzaho et al., 2017). First-generation migrants' parents are often tasked with migrating their families from their home country to the new country. For Black Africans, this is often due to societal stressors in the home country pushing people to leave (Adelowo et al., 2016). As such, people tend to be concerned with financial stability and educational success to ensure their children do not experience the same stressors they had to (Adewolo et al., 2016; Winbush, 2015). As highlighted previously, in social contexts where issues such as safety and financial strain are salient, mental health discourse can become a lower priority. Similarly, Black African parents tend to avoid mental health topics as it is not deemed as significant as other factors. However, this can create tension if their children have adopted the views of their host country, A-NZ, which prioritises mental health to a greater extent (Abdi, 2018; Renzaho et al., 2017). Studies have shown that some first-generation migrant children experiencing mental health distress are usually invalidated by their parents, which can worsen mental health outcomes (Abdi, 2018).

From an identity perspective, adults tend to have less drastic identity changes than young adolescents (Becht et al., 2021). As teenagers explore their identity with more exposure to Western societal norms, they may adopt different values and attitudes from their migrant parents who spent key formative years in Africa (Renzaho et al., 2017). As such, these parents typically hold values and attitudes that are more consistent with their home country (Renzaho et al., 2017). These identity differences can lead to conflicting values, beliefs, and attitudes. Discrepancies in expectations can result in family conflict, difficulty understanding and empathising with one another, and tension in a household (Abdi, 2018). This results in the intergenerational differences seen by participants.

6.5.2 Gender Differences

In addition to intergenerational differences, one participant described gender differences among Black Africans. In particular, it was highlighted that African men were less likely to address their mental health. Furthermore, it is noted that the majority of participants for this study, which aimed to discuss mental health, were women with minimal engagement from African men. Reasons for lack of engagement with mental health discourse are likely unrelated to men not experiencing distress. For example, men are more than twice as likely to die by suicide than women (Mental Health Foundation, 2024). Furthermore, the Ministry of Health's (2023) report stated that 10.2% of men experienced high or very high levels of psychological distress. Despite this, in the literature, it indicates that men are less likely to engage with mental health services (Gallagher et al., 2022; Sagar-Ouriaghli et al., 2019). As such, there may be other reasons contributing to the avoidance of addressing mental health among men, such as social expectations.

Social and cultural expectations often impose constraints that discourage behaviours that address mental health. For example, in many Black African communities, there is a prevalent expectation for men to avoid emotional expression (Ezeugwu & Ojedokun, 2020). This tendency is associated with broader masculinity narratives, which encourage men, in general, to restrict emotionality and suppress vulnerability (Gross & Levenson, 1997). These narratives are rooted in socially constructed beliefs about men's roles, behaviours, and thought patterns (Ezeugwu & Ojedokun, 2020). These expectations manifest in daily interactions and choices which shapes how men navigate challenges. African men are often expected to demonstrate strength and stoicism in the face of adversity, where expressing mental distress may be perceived as a sign of weakness which reinforces emotional restrictiveness (Ezeugwu & Ojedokun, 2020). As such, men may feel the need to conform to these norms which hinders their willingness to address any mental health difficulties (Abdikadir et al., 2024). In this way,

this particular masculine identity plays a role in how African men engage in mental health discourse. The narratives associated with identifying as an "African man" lead to the attribution of beliefs and values that view engaging in mental health discourse and services as a sign of weakness. These different societal roles imposed on and adopted by African men can result in a discrepancy in mental health engagement between men and women.

6.6 Conclusion

In summary, this study emphasises identity's central role in conceptualising and managing mental health for Black Africans. From a narrative perspective, identity enables individuals to construct meaning around phenomena such as mental health, shaped by their personal experiences. Furthermore, consistent with the social identity theory, cultural norms from Africa and A-NZ, influence these identity narratives, which shape people's behaviours. Importantly, identity is dynamic rather than static; Black African migrants hold evolving beliefs and values that reflect their lived experiences. Furthermore, identity fosters a sense of belonging, a fundamental aspect of the human experience. For many, connecting with their identity reinforces this sense of belonging, which, in turn, supports mental health. While there are shared elements of identity and mental health perspectives among Black Africans, intragroup differences, such as those based on gender and generation, contribute to the varying levels of engagement with mental health discourse and services.

7. Findings

Focus Groups

The following chapter outlines the findings from the focus groups that examined the perspectives on mental health services among Black Africans in A-NZ. All participants were assigned pseudonyms, and any identifying information was omitted. Data was analysed using Reflexive Thematic Analysis. Two groups were conducted, each consisting of Black African women migrants and refugees aged between 20 and 35 years. Since the demographic characteristics of participants were similar across the groups, the results were summarised based on key themes from both groups. Two major themes were highlighted: barriers to accessing care and preferences for mental health services. Table 5. summarises the main themes and sub-themes that emerged.

Table 5

List of major themes and sub-themes.

Major Theme	Sub-theme
1. Barriers to accessing and engaging with mental health services	1. Clinician-specific barriers 2. Personal barriers 3. Systemic barriers
2. Preferences regarding mental health services	1. Clinician characteristics 2. Knowledge

7.1 Theme One: Barriers to Accessing and Engaging with Mental Health Services

Members of the focus groups recognised barriers that limit their engagement with and access to mental health services. They identified clinician, systemic, and personal barriers. These are summarised in this section.

7.1.1 Subtheme One: Clinician Barriers

For this study, the term "clinician" referred to any individual mental health care provider (e.g., counsellor, psychologist, or psychiatrist), as participants varied in the type of clinician they referenced when detailing their experiences. Clinician barriers included negative interactions that deterred engagement in care. These barriers can be classified into two groups. The first related to negative experiences directly linked to participants' identities as African or Black women. The second subtheme pertained to general negative experiences that were not overtly connected to participants' racial or ethnic identity.

7.1.1.1 Culturally Related Negative Experiences

Culturally related issues pertained to points participants raised directly associated with their Black African identity. Firstly, they noted that excessive time spent educating clinicians on cultural factors was a barrier. They highlighted how this diverts their interactions from the reasons they sought help. Participants, like Betty, described this as a distraction rather than a benefit to the therapeutic process.

When I finally found a therapist, um, I don't know if it's just me but, um, maybe I just felt this way with the therapist that I had, but I felt like I had to educate them on certain cultural things and I just found that like very distracting. (Betty)

Underlying assumptions were also identified as factors that discouraged people from feeling supported. The first set comprised the assumptions participants had about clinicians, while the second set pertained to those held by clinicians regarding participants. The first was marked by distrust in a clinician's ability to understand and relate to the Black African experience. For instance, Jane discussed the questions she considers when looking for a clinician.

Whenever I'm looking at who I can speak with regarding therapy or counselling, it's always a question like, are they going to understand what I'm talking about?... Are they going to understand, you know, that this is something that I've gone through from the beginning as a black woman, you know? (Jane)

Assumptions were not only based on experiences with non-Black clinicians but also applied to Black clinicians. One concern participants expressed was whether Black clinicians would enforce cultural norms from African communities that were irrelevant to them. For instance, some clinicians might have specific behavioural or religious expectations that do not resonate with participants. Another concern was the belief that Black clinicians might impose hierarchical cultural norms based on age, which could make participants feel uncomfortable. Betty emphasised this by illustrating how such assumptions could limit her engagement with a clinician.

I don't know how to explain it, but there's this thing in our communities where it can sometimes be difficult to talk to someone older than you, especially about things that you know aren't culturally appropriate to speak about. Say, for example, if I was to go to an older African therapist, um, and speak to them about my sex life, for example, it's not something that culturally we would speak about with our older generation. (Betty)

Similarly, others raised concerns about the capacity of Black African clinicians to uphold confidentiality due to the significant likelihood that, considering the small size of the local African community, they might be acquainted with someone they know. For instance, Diane pointed out her assumptions related to this.

I know that we have similar cultural experiences. You're from this place; I'm from this place. We can bond with that. I'm probably more likely to open up to you. Whereas sometimes, it might be like I know you or you know a bit too much about me, so I might

not be comfortable sharing too much about myself with you, or you know people that I know, like my family. (Diane)

Furthermore, some group members identified preconceived notions about themselves that may be held by clinicians and would act as a deterrent to engagement. This included assumptions about the tenacity of Black women; in other words, "Black women are strong". Other assumptions included service providers assuming a person has strong community support and is religious based on Black African stereotypes. Isla summarised some of these concerns below:

Yeah, I think off the bat of those stereotypes. I remember the last time I was in therapy, [the clinician] had this idea that Black women were really, really strong, and we came from really strong communities. I remember just looking at her, and I was like, "One, we are far away from home and two, I don't go to church, so cancel that out. I'm not going to have that strong communal, strong familial support as you would assume that we do given that we're quote on quote out collectivist people". (Isla)

One group member, Isla, spoke about the invalidation of racist experiences as another barrier to accessing care, a point that other participants agreed with. She detailed how she and others she knew faced negative life circumstances due to their race, which they wished to address in therapy but were ultimately dismissed by clinicians. This led to an avoidance of engaging with mental health services.

People have gone to a therapist and expressed something about racism, and the therapist has said, "Oh, but why are you making it about race? Are you sure it's about colour?" and completely did not want to discuss those things and unfortunately, that is like a common... it's a common thing. (Isla)

7.1.1.2 Other Negative Experiences

This subtheme outlines additional negative experiences not explicitly tied to participants' cultural identity. This encompassed a clinician's approach and power dynamics. Several group members expressed their dislike of a clinician's approach, particularly regarding how the clinician interacted with them. Specifically, some participants preferred a problem-focused approach rather than a solutions-focused one (and vice versa). The differing opinions among participants highlighted variations in personal preference. As highlighted by Holly:

Overall, depending on the individual's personal preferences, negative experiences with a therapist can be related to the therapist's ability to match with their preference.
(Holly)

Participants differed in their preference for either a solutions-focused or problem-focused approach. Some individuals preferred to explore practical solutions to resolve the issue promptly. Consequently, they felt disheartened by clinicians who did not adopt this approach.

Yeah, it was just not the right fit. I needed tools like practical tools. I don't want to come into a session and keep talking about everything, and you keep asking me questions. Yeah, I don't know. It was [laughs]. Yeah, I just... I just need practical tools. Like, help me get out of this slump. (Kelly)

Others were not fond of an approach that quickly focused on solutions without dedicating enough time to discussing the problem and grasping the underlying causes of their challenges. This was true for participants like Holly, who shared her perspective on the practical tools the clinician offered her.

And I'm like, I don't feel like I have resolved anything because all you have given me is just a piece of paper, and I still have all these issues that I need to deal with. However,

you're not... as my counsellor, you're not digging deep to figure out what is causing this, why this is happening, and how to figure something out to not get into this situation again. (Holly)

Group members discussed issues concerning power dynamics that led to negative experiences with clinicians. The difficulty in navigating client-clinician roles caused some individuals to feel a lack of autonomy in their treatment decisions. Some participants mentioned a lack of full understanding regarding what they consented to in treatment. Expectations and perceptions of the clinician as the expert resulted in forced compliance.

They are not giving us the freedom to make our own decisions... You know, you have the repeats of medication and stuff like that. I need to be able to know why you are giving me this medication. I need to be able to know if I can say no... It can be intimidating being at a doctor's office because they have 15 minutes to look at you and sort you out. And within that time, most of the time, they don't really give you a chance to say anything else. (Holly)

Group members spoke about the difficulty of discussing instances when they did not find therapy beneficial due to power dynamics. Consequently, they described experiences of confusion regarding the rights participants felt they had concerning negative experiences with clinicians.

I felt like saying to her, "hey, do you want me to come back another time?". Um, and I should have, but I felt like I couldn't do that. Um, and there have been times when I felt like, uh, I didn't get much from the session, and it's costing me this much. I guess this is a question. Can you say to a therapist that I didn't get anything from this session? Can we do it again? I can't afford paying that much, and I feel like I'm not getting that much out of it. (Betty)

In summary, subtheme one outlines the barriers identified by participants that emerge from clinicians. While some barriers were unrelated to racial or ethnic culture, others were directly connected to participants' identities as Black Africans. In terms of these culturally related negative experiences, participants noted that educating clinicians about cultural factors, assumptions, and stereotypes, as well as the risks of cultural imposition by Black clinicians, were significant barriers to engaging with clinicians. Additional barriers included a mismatch with a clinician's approach and issues surrounding autonomy that arise due to client-clinician power dynamics. These findings overlapped with those identified in the individual interviews, particularly in *5.3 Theme Three: Limitations to Mental Health Services in A-NZ*. Similar sentiments were expressed across both datasets, where participants described feeling unheard by their clinicians, whether due to clinicians being described as overly solutions-focused or participants feeling pressured to adopt a biomedical approach without acknowledgement of alternative understandings of mental health. However, it is important to highlight that some participants who were in the individual interviews were in the focus groups, which explains the overlapping findings.

7.1.2 Subtheme Two: Personal Barriers

Group members acknowledged how internal (i.e., personal) barriers have played a role in preventing them from engaging with mental health services. This included having limited knowledge of mental health and underlying shame and stigma.

7.1.2.1 Lack of Knowledge/Awareness

Some group members detailed how one of the barriers was their lack of knowledge about mental health. Without understanding what mental health issues were, they did not consider using service providers for support.

It's like, for me, it's like recognising within myself that something is wrong and I need help and I can go somewhere and get help, and this type of help exists for mental health. Yeah, um, I think the biggest barrier was realising that focus is a mental health issue. (Ella)

7.1.2.2 Shame and Stigma

Another personal barrier highlighted was shame and stigma. Some participants, like Betty, spoke of how they did not associate Africans as having any mental health issues. As such, shame and stigma were associated with avoidance of seeking help.

You know, when you are going through something like anxiety or depression, I had this stigma that it's not something that Africans go through. So, you know, the cost and that stigma and also, feeling sort of ashamed to look or seek for help. (Betty)

It literally puts you off [seeking support] because you are already feeling ashamed for having the mental illness, that feeling of stress, anxiety, and depression. (Holly)

They also acknowledged that the context they grew up in and how mental health discourse was framed influenced their underlying stigma. In particular, there was a negative connotation when considering mental health, which then influenced how some group members avoided seeking support.

When growing up, you don't... you don't talk about mental health. Mental health is taboo. Like, you don't, you don't. If you're depressed or have that anything mental thing, you know, you're... you're an outcast of some kind. So, it's like... because that's sort of been, like, engrained. (Holly)

Overall, this section outlines the findings related to personal barriers that prevented participants from engaging with clinicians. This included a lack of knowledge about mental health topics,

which hindered a general understanding of relevant support services. Additionally, the shame and stigma associated with mental health discouraged participants from seeking support due to the negative connotations both individually and within the African community.

7.1.3 Subtheme Three: Systemic Barriers

Group members discussed barriers that reflected systemic issues. These barriers decreased participants' ability to access mental health services. This included issues of availability of services and costs.

7.1.3.1 Availability of Services

Members from each focus group acknowledged that a key barrier was the availability of services. They noted that long waitlists restricted them from having support when they required it the most.

I remember asking to see a counsellor, and sometimes, it would be weeks of wait time to see them. (Ella)

My biggest put-off so far is, um, just finding someone, um, and in the times when you know you really, really need to talk to someone, and it's like, oh no sorry, they are fully booked until three months. (Kelly)

They also expressed that by the time they received support, the need or desire was not as prevalent as when they first reached out.

For me, I would say that um, the longest I have had to wait was like three months and by then, I didn't really need them anymore. And, even when I get the appointment after the long wait, um, there is really like nothing to talk about, and most of the time, um, I felt like if I did not want to express myself. (Holly)

The availability of services was also related to the lack of options in clinicians' cultural backgrounds (i.e., no Black therapists). Some group members disclosed their desire to find a therapist who was not only available but was also from a similar background. However, limited services are available.

Um, so I think, in terms of access, finding a therapist is extremely hard here. Especially trying to find a Black therapist, a Black female therapist. (Jane)

Group members also brainstormed an intervention they would like to see to address this issue. This included having more community-based groups specific to A-NZ African communities. For example, Ella agreed with another group member about the usefulness of community support groups for mental health.

I was just going to say as well, there are so few Africans, just to add to your point about community groups. It would be great to do it together because you don't get to know as many people. And opening up that much might be intimidating but if you had that sort of setting might make it feel normal. (Ella)

7.1.3.2 Costs

Members of the focus groups emphasised that service costs posed a significant barrier to accessing care. One participant characterised it as a service reserved for those with adequate financial resources. Consequently, despite their desire to engage with healthcare providers, they were constrained by their financial situations.

A lot of services are more available because some people are richer, and you know, if you have a good job, you can afford it, but if you don't have the means, it's hard to get to it. (Holly)

I think for me, what I found the most challenging was the cost. Um, the time when I really needed therapy was when I was in Uni and, um, it... yeah, the cost was just too high. (Betty)

Participants acknowledged that the time-limited free services available were insufficient for providing long-term support. Although they wished to continue working with service providers, they could not do so without access to funds.

It goes back to a previous question. Um, about like barriers. I was thinking about the cost. Um, the cost has been a barrier in the past, actually at the moment as well, to seeing a counsellor. Like, my sessions have run out. I need someone who is cheap and accessible. (Ella)

One of the solutions suggested by members of both focus groups was to increase funding for mental health services. For example, one participant suggested a koha-based initial session based on her experience.

One of the therapists that I saw was... she did say to me in the first session that it's a koha donation for this first session, and then we can see how this goes and if this is the right fit for you. (Jane)

In conclusion, subtheme three highlights the findings related to the systemic barriers that limited participants' access to mental health services. The availability of services emerged as a significant barrier, with long waitlists and a lack of diversity among clinicians' cultural backgrounds. Additionally, service costs hindered participants from accessing care, as they perceived services to be too expensive. While participants acknowledged the existence of free services, they pointed out their limitations in providing long-term support.

7.2 Theme Two: Preferences Regarding Mental Health Services

Members of the focus groups shared their desires when engaging with mental health service providers. Sub-themes included the attributes of a clinician and the knowledge they expect providers to have.

7.2.1 Subtheme One: Clinician Characteristics

Participants discussed the expectations they have regarding the characteristics that clinicians they work with should possess. They expressed a desire for clinicians who demonstrate strong interpersonal skills. In other words, clinicians who are relatable and understanding. For instance, Isla explains how she seeks validation and someone who acknowledges her perspective on the world around her. This feeling was common among most participants in the focus groups.

It minimises your everyday lived experience because not only are you seeking help from someone, you're also seeking validation for someone to see you and hear you, and because a lot of therapist don't have an awareness of other ways of being, um, outside of the Western framework, it can be hard to really hear what your client is going through because you can't actually see them for who they fully are. (Isla)

Another characteristic discussed by participants was whether a clinician was culturally aligned with them or if being culturally neutral was preferable. Some group members expressed a desire for someone from a similar cultural background. This preference was not limited to those with an African background but also included individuals who had experience as migrants or refugees or shared the same religious background.

I feel like you covered so many of my specific things there. Um, one of my main, main ones would be definitely someone who is a migrant or someone who has experience. Even if they are like from somewhere, like, Canada because that's experience of moving

to another country. Especially someone, if they are like first or second generation because at least that way, they kind of can draw from that experience and say, "I can completely understand" or they can share snippets from their experiences. Um, because I like talking a lot and I find me sharing with some people, even if it's a small thing, even if it's not me being like, "oh my gosh. This is what I went through. This what I needed to do". Even if it's just something small, oh yeah, I can relate to that. That's helpful. It helps me connect with you more. I will probably be more likely to tell you a bit more. (Diane)

I think for me, as Gemma and Holly were saying, I think the fit and relatability. Fitting in with where I am at and my values. Um, for example, my counsellor that I had, the last one, she's not a Christian, so that was a barrier sometimes when we would get talking. She would start talking about evolution, and then I would just shut down and then it gets awkward. Um, yeah, so, like, having the same values as me. So, like a Christian. (Ella)

For some participants, this desire was also associated with external physical traits, such as the clinician being Black. For instance, Gemma explained how having a Black clinician can create a safer environment for discussing racial experiences.

Having someone who looks like me, who understands situations when I talk about racism at work, um, cause sometimes you feel like... you're calling... let's say the person is white, you're calling them racist. Like, you just feel uncomfortable to open up. (Gemma)

However, not everyone shared the same views as Gemma. Some individuals expressed concerns that having a therapist with a similar cultural background could obstruct their therapeutic process due to the perceived biases or expectations that clinicians might possess.

Kelly summarised these thoughts by pointing out the internal tension that might emerge when working with someone familiar with the anticipated norms within her cultural context. Consequently, those who diverge from the cultural norms of that group may find it challenging to collaborate with someone from that culture.

I don't know if this is controversial or what, but sometimes, I feel like what actually makes me feel safe with a therapist is if they are like more neutral. And what I mean by... I'm not necessarily looking for someone who really understands what it's like to be Black or the Black culture or a Zimbabwean. [...] I almost feel safer because if I went to somebody who's, let's say, um, got a Christian background. As great as it is, and they might understand the Christian side of things, but I also have my own conflicts as much as I'm, like, I have a Christian faith, but I'm still battling with that. And then, if I go to a super Christian person, then all they are going to do is probably nail me down with that. [...] There is a lot of pressure, as well, of us always having to be on to it about being Black. And, sometimes, I just want to be Kelly in that space. And, um, so I think, um, you know, the less pressures that are taken out. (Kelly)

Overall, this subtheme outlines participants' views about the preferred characteristics of clinicians, including the clinician's approach and cultural background. It was evident that participants differed in their preferences, indicating personal preferences.

7.2.2 Subtheme Two: Knowledge

The second subtheme participants discussed was the type of knowledge they desired mental health service providers to have. Group members recognised the expectation that clinicians should have some understanding of the negative stigma that permeates mental health discourse in African communities. For example, Holly highlighted that one of her desires was for service providers to know that African communities do not discuss mental health.

I think just to have some sort of understanding of, um, our culture in terms of like how in our communities, I'll use my Zambian culture as an example, um, like when growing up, you don't kind of like, you don't talk about mental health. Mental health is almost like a taboo. Like, you don't, you don't. If you're depressed or have that anything mental thing, you know, you're... you're an outcast of some kind. (Holly)

A few participants also stated that they wanted mental health services to be understanding of the family dynamics that occur in African communities. However, they did not expand on what they wished clinicians to understand about family dynamics.

I think I wanted to tie in the family aspect of, um, Africans because I feel like family is a very strong part of African culture. There's lots of family dynamics going on. So, maybe they could include asking about family or asking around, like family and how that fits into whoever the person it is that they are seeing into their life. (Ella)

Some group members also discussed how they desired service providers to understand how some African migrants and refugees might communicate differently to other populations. They spoke of how they tended to communicate indirectly and hoped clinicians would acknowledge and adapt to this different communication style.

Yeah, I know kind of like how I know Africans tend to be indirect with how they communicate, whereas Kiwis are more direct and to the point. Sometimes, it takes a little bit of working around to figure out what we are actually meaning. (Ella)

Our communication styles is just... it's always going around like this. The counsellor needs to understand that we are trying to get there, but we just don't know how to literally get to that point. (Holly)

Overall, this subtheme elucidated the key areas in which participants sought increased awareness from clinicians. Of note, these points were related to their Black African identity.

7.3 Summary

Chapter seven presents findings from the focus groups, analysed through Reflexive Thematic Analysis. Two primary themes emerged: barriers to accessing and engaging with mental health services and preferences related to these services. While some themes did not relate to the participants' cultural experiences, others were tied to their Black African identity. Access barriers included clinician-related issues (such as assumptions and stereotypes, the necessity for clinician education, fears of cultural imposition, and power dynamics), personal factors (including limited mental health knowledge, shame, and stigma), and systemic challenges (including cost and a lack of diversity among service providers). In addition to these barriers, participants shared their preferences, primarily influenced by individual differences, such as a clinician's therapeutic approach and the extent of cultural alignment. Notably, preferences for clinician knowledge were especially linked to their Black African identity, reflecting a desire for clinicians to understand aspects of shame, stigma, family dynamics, and communication styles within Black African communities. These findings highlight significant considerations for clinicians working with Black African populations.

8. Discussion

Focus Groups

The second part of the present study explored the experiences and perspectives on mental health services among Black African migrants. A qualitative methodology was employed and focus groups were adopted for data collection. The data was analysed using reflexive thematic analysis. Results showed two main themes: barriers to accessing mental health services and client preferences. The following chapter will discuss these findings, including the relevant sub-themes, with reference to existing literature.

8.1 Barriers to Accessing Mental Health Services

8.1.1 Clinician Barriers

Results from this study showed that clinician-related barriers can deter Black Africans from engaging with mental health services. This included factors such as educating clinicians, stereotypes, and power dynamics. The following section will explore how these factors affect the therapeutic process. Potential strategies to mitigate these barriers will also be discussed. While a clinician's therapeutic approach was identified as a barrier to accessing services, this study focuses on experiences unique to Black Africans. As such, themes that are not specific to being Black African and instead reflect more general issues will not be explored in-depth. It is recognised that a clinician's approach may be more related to individual preferences than factors directly associated with being Black African.

8.1.1.1 Educating Clinicians

This study found that participants viewed educating clinicians on cultural issues to be a barrier. They noted that explaining aspects of their culture derailed their interaction away from their purpose of engagement. This indicates a misalignment between what clinicians and clients consider as important. Over the years, there has been a growing emphasis on cultural awareness

among mental health clinicians to provide better care for people, particularly minority populations (Durie, 2001). While there might be an awareness, the dilemma arises with how cultural knowledge is obtained and the different expectations between clinicians and clients. This speaks to the issue of cultural taxation and the cultural competence of a clinician.

8.1.1.1 Cultural Taxation

The term cultural taxation was first coined by Padilla (1994). It was defined as the “obligation to show good citizenship toward the institution by serving its needs for ethnic representation on committees, or to demonstrate knowledge, and commitment to a cultural group” (p.26). In other words, it is the burden placed on minority populations to engage in additional responsibilities that majority populations do not have to. This concept was originally used to detail the roles ethnic scholars in academia and organisations engage in because of their race/ethnicity (Padilla, 1994). For example, being required to provide education on cultural processes to the majority group (Padilla, 1994). While cultural taxation was used to conceptualise the experience of minority scholars, it can be inferred to understand the tension that can exist between mental health clinicians and Black African clients in A-NZ. Cultural taxation can manifest as the expectation for Black Africans to educate clinicians on cultural experiences. The onus is placed on the client to satisfy the knowledge gap for a clinician. While there can be benefits to this, as it allows clinicians to understand the nuances of the individual’s experience, acquiring knowledge at the expense of meeting a client’s needs can result in service disengagement (Asnaani & Hofmann, 2012; Smith et al., 2013).

Cultural taxation reflects similar sentiments to the risk of exploitation when researching minority populations. Recommendations for researchers working with minorities typically urge caution to ensure that the pursuit of knowledge does not become unintentionally exploitative (Rogers & Lange, 2013). Exploitation occurs when knowledge only functions to benefit the researcher and not the participants (Burnette & Sanders, 2014). The same can be considered

with clinicians in the mental health sector. While it remains imperative for clinicians to understand their clients, asking cultural questions must either benefit the client's therapeutic goals or have a sound clinical rationale (Higgs et al., 2008). An equilibrium must, therefore, be maintained where clinicians understand a client's cultural context while avoiding cultural taxation and unintentional exploitation.

8.1.1.1.2 Cultural Competence

Knowing how to manage factors such as cultural taxation reflects the underlying issue of cultural competence. Cultural competence can be defined as a set of behaviours and attitudes that enable professionals to work cross-culturally (Kodjo, 2009). It encompasses cultural sensitivity, which speaks to a clinician's awareness, empathy, and respect towards the cultural factors when interacting with members of a different cultural group (Trimble, 2003). Sue and Torino (2005) assert that cultural competence involves a person's ability to engage and create conditions that maximise the development of a client within their world systems. This involves supporting people in ways that acknowledge their culture as central to their wellbeing (Westerman, 2010). The New Zealand Psychology Board defines it as "having the awareness, knowledge, and skills necessary to perform a myriad of psychological tasks when recognising the diverse world views and practices of oneself and of clients from different ethnic/cultural backgrounds" (New Zealand Psychologists Board, n.d.). Similarly, the literature also suggests that the main components of cultural competence are awareness, knowledge, and skill (Arnold, 2022; Pernell-Arnold et al., 2012; Sue & Torino, 2005; Sue et al., 2009). Awareness refers to a clinician's ability to acknowledge that culture can influence the therapeutic process. Knowledge refers to understanding the worldview of culturally diverse clients. Lastly, skills refer to the practical ability to utilise and implement appropriate strategies when working with culturally diverse people (Sue et al., 2009).

While the pursuit of awareness, knowledge, and skill provides an easy-to-understand framework for developing cultural competence, the workability of this is nuanced. The experiences spoken by participants in this study when a clinician seeks cultural information speak to an issue with the knowledge component of cultural competence (Sue et al., 2009). Clinicians querying about a person's cultural experiences can facilitate dialogue that promotes an understanding of a person's cultural milieu, allowing clinicians to mitigate biases and understand the client's culture from their perspective (Alarcón, 2009; Huang & Zane, 2016). However, this knowledge must serve a clinical purpose that enhances the client to avoid cultural taxation and exploitation. A clinician needs to remain attuned to a client's needs and comfort during the interaction. As highlighted by Deardhoff (2006), cultural competence requires not only curiosity about a person's culture but also openness, flexibility, and respect for the client. These characteristics can help balance the desire for knowledge with the needs/wants of the client.

Another useful strategy is cultural supervision. This entails obtaining guidance and insight on cultural issues from an individual with a differing cultural background. It is a collaborative process to ensure that clinicians practice in ways that are culturally safe for both themselves and their clients (Eketone, 2012). Estrada et al. (n.d., p. 332) states, "Cross-cultural supervision refers to the analysis of contents, processes, and outcomes in supervision in which racial, ethnic, and/or cultural differences exist between at least two members of the client-counsellor-supervisor triad". A search of the literature identified little literature regarding cultural supervision when working with Black African clients; however, several pieces of literature focusing on working with Māori clients have been published (Eketone, 2012; Morice & Fay, 2013). The considerations in this literature are geographically relevant and can be applied to clinicians working with Black Africans living in A-NZ.

Cultural supervision can facilitate discussions that enhance a clinician's practice. For example, it assists in a clinician's self-awareness and recognition of underlying biases, understanding cultural nuances that impact the therapeutic alliance or a client's healthcare preferences, and comprehending how culture influences a client's identity (Morice & Fay, 2013). Furthermore, Lee and Kealy (2018) propose four components to cultural supervision.

1. Clarifying goals and expectations. This can help establish what will be the purpose of cultural supervision.
2. A supervisor must be an active listener who is sensitive to issues such as social injustice, power imbalances, and oppression during supervision.
3. Facilitating self-reflexivity. A supervisee must feel safe to disclose personal stories and biases they carry. Furthermore, a supervisor creates a safe environment for self-disclosure and models cultural humility.
4. Modelling relational reflexivity. This involves enhancing a supervisee's procedural competence and addressing clinical tasks in supervision. A supervisor offers specific feedback that focuses on a supervisee's skills and client work.

One of the main characteristics of a cultural supervisor is a strong knowledge base of cultural norms. According to Eketone (2012), while it is helpful for a cultural supervisor to have knowledge of the clinician's clinical expertise, cultural knowledge is deemed more important. While it would be ideal to consult with an African to obtain cultural supervision, due to the small population of Black Africans, it might be difficult to source a supervisor (Stats NZ, 2024). However, where it is difficult to consult with a Black African, seeking support from a Māori advisor would provide benefits. The social and historical context for Māori in A-NZ is characterised by minority experiences, racism/discrimination, and holistic views of wellbeing. Having an advisor who understands these nuances can provide helpful considerations for working with other ethnic minorities, such as Black Africans.

8.1.1.2 Stereotypes

Participants were dissuaded from engaging in mental health services by the assumptions they perceived clinicians to hold. This included assumptions such as the tenacity of Black women, belonging to a strong community, and having strong religious beliefs. These assumptions suggest the use of stereotypes by mental health care providers within a therapeutic context. The following section will discuss stereotypes and stereotype threats and how this can impact the therapeutic process. It will also include how clinicians might mitigate such issues.

A stereotype involves generalising attributes associated with members of a particular group to an individual (Puddifoot, 2019). Stereotypes serve as a function of organising and simplifying complex or uncertain situations. This helps people develop greater confidence in understanding and responding effectively to people who may be different (Tritt, 2009; Weary et al., 2001). In this way, racial stereotypes among healthcare providers unconsciously serve to help the perceiver feel more at ease or confident in their ability to understand the person they are working with, thus, reinforcing their use (Puddifoot, 2019). While there may be a function to stereotypes, they can lead to detrimental health interactions between clinicians and their clients (Aronson et al., 2013; Marcelin et al., 2019; Puddifoot, 2019). Both implicit and explicit stereotypes influence how a person relates interpersonally and the lens through which they view information provided to them (Marcelin et al., 2019). Implicit stereotypes occur when a clinician's unconscious beliefs influence thoughts and behaviours. In contrast, explicit stereotypes involve conscious beliefs about a population and the open expression of them (Nesdale & Durkin, 1998). This can lead to clinicians to view their clients through a biased lens resulting in potentially unhelpful practices (Marcelin et al., 2019).

8.1.1.2.1 Stereotype Threat

Stereotype threat is an internal process where the fear of being judged according to identity-based stereotypes leads to impaired performance (Aronson et al., 2013). This phenomenon was coined by Steel and Aronson's (1995) study which showed that African Americans who associated their racial identity with their academic performance earned lower grades than African Americans who did not. In other words, when participants were reminded of popular racial stereotypes, it negatively impacted their performance.

While stereotype threat was originally coined within an academic context, it provides a framework for understanding why clients might disengage from mental health services. Stereotype threat has also been observed in healthcare settings (Abdou et al., 2016; Cooper et al., 2012). Studies have shown that when clients perceived their clinicians as holding negative stereotypes against them, it resulted in psychological and physiological consequences leading to negative health outcomes (Cooper et al., 2012). It has also been associated with increased clinician distrust and dissatisfaction with healthcare services (Abdou et al., 2016). This ultimately increases the risk of client disengagement. This relates to the fears participants in this study highlighted regarding the assumptions they presumed clinicians as holding, particularly regarding stereotypes such as the perceived tenacity or religiosity of Black African women.

8.1.1.2.2 Stereotypes and Black African.

Stereotypes such as assuming the tenacity of Black individuals have been documented in literature which can result in stereotype threat (Abdou & Fingerhut, 2014; Godbolt et al., 2022). In their 2023 systematic review, Kunstman et al. (2023) found that both laypersons and clinicians believed that psychopathology would be less distressing to Black people than White people due to the assumed tenacity. This conceptualisation negatively impacted the healthcare and social support provided for Black people (Kunstman et al., 2023). In this study, participants

listed stereotypes from clinicians such as a rich communal support network and religiosity which have been associated with protective factors for mental health (Kleiman & Liu, 2014; Li et al., 2023). The risk of such stereotypes is that they can lead to unintentional biases, potentially influencing the recommendations, professional support, and intervention plans a clinician offers (Meidert et al., 2023). Furthermore, the threat of being exposed to racial stereotypes can lead to dissatisfaction with the service and subsequent rapport rupture (Abdou & Fingerhut, 2014). As therapeutic success is dependent on the clinical relationship, rupture can result in poorer treatment outcomes and drop-outs ('Rapport', 2024; Yager et al., 2021). This highlights the importance of clinicians needing to be aware of underlying stereotypes influencing their interaction with Black Africans.

8.1.1.2.3 Managing Stereotypes

Given that stereotypes can result in service deterrence for clients, it is important to consider how clinicians might mitigate against them. Some literature has suggested strategies to address this issue. This includes strategies such as education about biases, self-reflection, supervision, and feedback. This section will elaborate on these further.

Education:

To address underlying stereotypes, education sets the foundation for clinicians to develop insight and awareness. This can include discussions about stereotypes and their implications (Vela et al., 2022). Yager et al. (2021) recommend that this education be offered early in clinicians' professional training while they are forming their professional identity as clinicians. Early learning can prompt detection of when stereotypes influence clinical decisions (Yager et al., 2021). In Vela et al.'s (2022) article, a systematic review examined how awareness of biases can be achieved. All the studies they reviewed used didactic instruction, discussions, workshops, and reflection-based strategies. While these methods showed successful promotion

of awareness of underlying biases for clinicians, on their own they are insufficient in achieving long-term reduction of biases for clinicians and those in training. This suggests that while education increases awareness, education alone may be inadequate in sustaining the reduction of biases. As highlighted by Gopal et al. (2021), while recommendations at an individual level may be useful in raising awareness, there are wider socio-economic, political, and structural barriers that reinforce stereotypes in healthcare.

Self-Reflection:

Yager et al. (2021) argue that self-reflection can help raise awareness of stereotypes. This involves clinicians accepting the responsibility of identifying and understanding the stereotypes they may hold (Vela et al., 2022). Stereotypes arise from one's social context and the type of exposure experienced with other social groups (Puddingfoot, 2019). As such, self-reflection should not only examine stereotypes toward social groups, but also consider how one's own identity may influence the perception of others (Yager et al., 2021). Strategies such as reviewing case notes, journaling, recording client sessions, and reading can provide material for self-reflection (McGillivray et al., 2015; Yager et al., 2021).

Supervision and Feedback:

Supervision can help identify underlying stereotypes that impact a clinician's therapeutic relationships (Yager et al., 2021). It involves an intentional review of a clinician's practical competence when working with clients (Alfonsson et al., 2018). As such, a different perspective can help identify and address issues related to stereotypes (Yager et al., 2021). Feedback also relates to supervision as it is associated with receiving constructive feedback on a clinician's work (Alfonsson et al., 2018). Supervision and feedback can provide appropriate modelling and idiosyncratic instruction to help with managing stereotypes (Alfonsson et al., 2018; Yager et al., 2021). Furthermore, seeking supervision from a cultural supervisor can

promote cultural humility, self-reflection, and procedural competence towards addressing any underlying stereotypes (Morice & Fay, 2013).

Stereotypes may offer a cognitive shortcut to ease clinicians working with minority populations. However, they can result in detrimental effects such as stereotype threat that may lead to therapeutic rupture and client disengagement. Strategies such as education on stereotypes and their impact, self-reflection, supervision, and feedback can help mitigate this issue.

8.1.1.3 Power Dynamics

Apparent in the analysis was the influence of power dynamics between clinicians and clients. This was associated with clients' perceived inferiority, lack of understanding of suggested interventions, and difficulty articulating their desires and needs to clinicians. These findings illustrated the tension that exists regarding power distribution in mental healthcare, particularly when working with minority groups such as Black Africans.

Power is considered a dynamic relational construct that occurs when there is a potential for someone or something to exert influence (Looman et al., 2022). It is neutral until its consequences display either a positive or negative effect (Goodyear-Smith & Buetow, 2001; Looman et al., 2022; Raven, 1993). Power dynamics refers to the relationship between two or more people and how authority and influence are distributed (Goodyear-Smith & Buetow, 2001). Toffler (2022) states that power can derive from three key sources: knowledge (e.g., information and expertise), material resources (e.g., wealth), and force (e.g., violence). These factors can be used to create a hierarchy between people, which can then be used to impact social engagement. Raven (1993) expands on these factors by defining power as a form of interpersonal influence through resources such as a person's expertise, position, or ability to coerce or provide rewards. Power dynamics can exist in any relationship, including those in

healthcare. It can influence the sense of independence and agency a client experiences when engaging with services (Looman et al., 2022; McDonald et al., 2012). The following section will discuss how power imbalances relate to the social identities relevant to participants in this study (i.e., client, Black African, and women). This includes considering the intersectionality and the complexity of factors influencing the experience of power within healthcare interactions.

8.1.1.3.1 History of Power Imbalance in Healthcare

It is important first to consider the socio-historical context of power in healthcare. Historically, within a Western context, medical professionals were viewed as paternalistic authority figures (Louis-Courvoisier & Mauron, 2002). They existed within a structure that emulated a patriarchal system whereby clinicians were typically men with higher socio-economic status (Goodyear-Smith & Buetow, 2001). They also were regarded as having access to exclusive knowledge as health professionals, imbuing them with higher social status, and thus increasing their social dominancy (Goodyear-Smith & Buetow, 2001). As such, health decisions were often made for clients with little collaboration, leaving minimal room for client autonomy (Louis-Courvoisier & Mauron, 2002). While modern healthcare attempts to address this issue by shifting to an egalitarian approach, the ramifications of this historical context has meant a power difference endures between clinicians and clients (Goodyear-Smith & Buetow, 2001). It is, therefore, a primary goal for clinicians to actively promote shared power to ensure shared decision-making with clients (Nimmon & Stenfors-Hayes, 2016). If decisions are solely based on the perspective of the service provider, it diminishes the quality of care leading to negative health outcomes (Nimmon & Stenfors-Hayes, 2016; Goodyear-Smith & Buetow, 2001).

8.1.1.3.2 Contemporary Power Imbalance

Due to the historical context described above, power is inherently imbalanced with clinicians socially positioned to hold greater power than clients (Boyd, 1996; Togioka et al., 2025; Zur,

2014). This can negatively affect clients (Nimmon & Stenfors-Hayes, 2016). Depending on the use or misuse, power can result in a loss of autonomy, agency, and independence (Goodyear-Smith & Buetow, 2001). Clients may consequently feel dissatisfied with the service and, in some cases, be confused about their treatment. This impacts ethical principles such as informed consent and accurately meeting the client's needs (Cleary, 2003). For example, one participant in this study indicated uncertainty about the treatment she received for her mental distress. However, she did not vocalise her uncertainty with the clinician. Te Whatu Ora defines informed consent as “the process of exchanging information so that a patient/consumer can make an informed decision about their healthcare options, including the option of refusing the treatment, procedure, or intervention” (Te Whatu Ora, n.d.). In this definition, for informed consent to occur, clients must understand what they are agreeing to. However, if a client feels inhibited or feels unsafe to ask questions, it compromises their consent. In this way, power imbalances can negatively influence the security a client feels, leading to service disengagement (Cleary, 2003).

8.1.1.3 Intersectionality

In addition to the inherent power differences, power imbalance can be exacerbated by a client's minority identity (Ray, 2019). Intersectionality is a theoretical framework for understanding the impact of a person's multiple intersecting identities. It reflects the impact of power dynamics on minority populations. Furthermore, it highlights how the socio-historical context results in systems of oppression (Rehman et al., 2023). It is rooted in the Black feminist theory and is a component of the Critical Race Theory (CRT). CRT is a framework that examines how systematic racism is embedded within society and amplifies inequalities (Rehman et al., 2023). It shows how people's identities influence their experiences of power imbalances (Ford & Airhihenbuwa, 2010). Black African migrants, particularly women, hold multiple minority identities leading to a socially constructed diminished power. The minority identities

exacerbate the power imbalance beyond a client-clinician relationship where the client associates with dominant social groups (Brooks & Hopkins, 2017). The intersection of minority identities – such as being Black, an African migrant, and a woman – highlights the multifaceted nature of power imbalance. While this section will explore how these identities influence power dynamics, it is important to recognise that Black African migrants are not limited to these identities but can also identify with other social groups.

Minority populations, particularly those with a colonial history, are impacted by the social implications that arise from racial discrimination and marginalisation (Graham & Masters-Awatere, 2020). This can result in an internalised sense of inferiority, which affects how they engage with perceived authority figures (Senoussi, 2022). Individuals may feel silenced and subjected to diminished autonomy (Wepa & Wilson, 2019). This is consistent with participants' reports of difficulty vocalising their perspectives or opinions with their clinician. As such, within a therapeutic relationship, the power imbalance may be expressed in the form of clients withholding concerns from the clinician.

For Black Africans, the historical context of colonisation and racial discrimination led to a persistent power imbalance, as they were often viewed as inferior to their non-Black counterparts (S. Cooper & Nicholas, 2012). Within a healthcare context, this meant decisions related to the health of Black persons were made for them rather than in collaboration with them (Jackson, 1999; Swartz, 1995). While this social norm has decreased with the rise of equality and equity narratives, inclusive policies, alternative practices, these ideologies can unconsciously permeate the client-clinician relationship (Amster, 2022). Such historical events can influence the power distribution for modern-day Black Africans, resulting in less social power (Amster, 2022).

In addition to being Black, gender plays a role in the experience of power for this study's participants. Gender inequalities in power exist between men and women due to socially constructed gender roles and practices (Bacigalupe et al., 2022). Women were historically confined to child-rearing and homemaking roles (Zhu & Chang, 2019). This includes African women, particularly post-colonisation with the influence of Western patriarchal customs (Bawa, 2012). They were considered less socially significant than men (Day, 1992). This led to discrimination across social, institutional, and household levels, where women's perspectives were frequently silenced and marginalised (Day, 1992). Women have since experienced the ramifications of this historical context. In general, they are more susceptible to facing barriers to accessing healthcare, experiencing discrimination, and lacking access to decision-making power (Hutchens et al., 2023). This can result in detrimental effects on the quality of care provided to them. For example, within a mental health context, women are more likely to be diagnosed with mental distress and be prescribed psychotropic drugs (Bacigalupe & Martín, 2021). Two possible explanations for this postulated in the literature include (a) higher adverse life conditions for women leading to mental distress and (b) over-medicalisation of issues (Bacigalupe & Martín, 2021; Cherepanov et al., 2010; Conrad & Slodden, 2013).

8.1.1.3.4 Strategies to Mitigate Power Imbalances

As shown, Black African migrants, especially women, hold multiple identities that skew the power imbalance in favour of the clinician, especially when the clinician is white and/or male. These exist inherently based on the historical and social contexts that constructed this power imbalance. As stated in Billups et al.'s (2022) article, "embodying two disadvantaged social categories renders Black women invisible as they represent the prototypical example of neither race (i.e., Black men) nor gender (i.e., white women)" (p.2). Clients may feel unsafe to disclose their dissatisfaction or confusion with the treatment provided by a clinician, leading to their unmet needs and diminished rapport (Cleary, 2003). Given the negative implications that power

imbalances can bring, it is prudent to consider strategies to help mitigate them. If clients hold the perception of shared power, it can facilitate open and collaborative interactions (Nimmon & Stenfors-Hayes, 2016). The following section will provide a couple of suggestions for ways clinicians can address power issues. This includes developing knowledge and awareness and adopting a person-centred approach.

Knowledge and awareness are some of the building blocks for action towards minimising power imbalances (Nimmon & Stenfors-Hayes, 2016). Without these two factors, clinicians may remain ignorant of the impact of power on the client-clinician relationship (Elias, 2024). As such, the first recommendation is for clinicians to acknowledge that a power imbalance exists. Acknowledgement, particularly for minority populations, helps with becoming aware of differences, promotes decolonisation practices, and encourages reflexivity in clinical practice (Curtis et al., 2019). As stated by Curtis et al. (2019), this facilitates cultural safety and enhances the quality of care. In addition, it is helpful for clinicians to consider the impact of their cultural context on the therapeutic relationship. This includes reviewing any underlying biases, assumptions, and prejudices that might influence clinical interactions (Curtis, 2019). Adding to this, clinicians would benefit from educating themselves on a client's various identities, as intersectionality highlights how these overlapping identities affect power dynamics, thus enriching clinical understanding (Rehman et al., 2023). It is a clinician's responsibility to learn the socio-historical history of power imbalances and exercise self-reflection in their clinical practice.

Utilising a person-centred approach offers a practical way to facilitate shared power with clients (Coulter & Oldham, 2016). This approach had its beginnings in Rogerian Therapy. It recognises clients as equal agents in their healing journey, aims to work collaboratively, and draws on clients' knowledge, skills, and self-confidence (Coulter & Oldham, 2016). It involves empowering clients to participate actively in decisions concerning their health. This can include

notifying them of their right to refuse or consent to treatment, seek a secondary opinion, or ask questions (Coulter & Oldham, 2016). A person-centred approach also welcomes open communication and client feedback to facilitate shared decision-making (Honavar, 2018). Given that power imbalances can affect the ethics of informed consent, it can be helpful for clinicians to be intentional in checking a client's understanding and willingness to engage in a particular form of intervention. This might include providing sufficient time for clients to process information, communicating clinical terms in an accessible manner, and verifying their understanding of treatment options (Coulter & Oldham, 2016; Honavar, 2018). While these strategies can facilitate increased shared power, it is important to note that the literature regarding the efficacy of these interventions in increasing shared decision-making is limited and further research would be beneficial.

Power imbalances exist inherently due to the socio-historical context of healthcare. These are exacerbated in the context of minority groups. When considering intersectionality, Black Africans, particularly women, have multiple minority identities that influence their experience of power in a client-clinician relationship. As such, utilising strategies such as increasing knowledge and awareness of power dynamics and adopting a person-centred approach may assist in establishing shared power.

8.1.2 Client Specific Barriers

The second subtheme identified was personal barriers that deterred participants from accessing mental health services. These included shame, stigma, and limited knowledge about mental health. The following section will explore these themes further and will conclude with relevant strategies to address these issues at both a clinical and societal level.

8.1.2.1 Shame and Stigma

The American Psychological Association (APA) Dictionary of Psychology defines stigma as:

The negative social attitude attached to a characteristic of an individual that may be regarded as a mental, physical, or social deficiency. A stigma implies social disapproval and can lead unfairly to discrimination and exclusion of the individual (American Psychological Association, 2018).

Link and Phelan (2001) noted similar defining themes in their seminal article; they provided a comprehensive definition that included six components. The first two involve characteristics of the victim of stigma: having labelled differences and undesirable stereotypes. An example of a labelled difference may be that a Black African client comes from a family of religious people. An undesirable stereotype might be the assumption that the individual is also religious or shares the same level or involvement in religious activities. The following three components involve the consequences: social separation (i.e., us vs them), status loss, and discrimination. Extending from the aforementioned example, the implications of assuming a person's religiosity can result in inappropriate interventions or misassumptions of a person's protective factors, thus limiting resources provided to them. The last component involves what precipitates and perpetuates stigma: power imbalances. Link and Phelan (2001) assert that stigma depends on social, economic, and political power to create discriminatory consequences. In essence, the definition of stigma can be summarised using the two key elements listed in Arboleda-Florez's (2002) article: the recognition of differentiating factors between the majority and minority and the subsequent devaluation of a person.

Stigma can occur as both self and public stigma. Self-stigma is associated with shame, which sociologist Graham Scambler coined as "felt stigma" (Scambler, 2004). It is the negative self-conscious emotion and the experienced or internalised aspects of stigma. This is associated with a person's negative beliefs and perceptions about themselves (Tracy et al., 2007). In contrast, public stigma involves negative societal beliefs that marginalise a particular group (Corrigan et al., 2012). In addition to the general population, public stigma can occur at a

structural level. This can be via institutional attitudes and beliefs that create and perpetuate discrimination and prejudice, such as restrictive policies and laws (Hatzenbuehler, 2016). These public attitudes can then become internalised, resulting in self-stigma (P. W. Corrigan & Rao, 2012).

8.1.2.1.1 Mental Health Shame and Stigma

Mental health stigma occurs when people with mental distress are viewed negatively or treated differently in a way that leads to marginalisation or ostracisation (Sickel et al., 2014). This stigma is associated with negative stereotypes perpetuating harmful narratives; for example, being as "crazy", "scary", or "incompetent" (Rose et al., 2007). These stereotypes often stem from a lack of understanding or misinterpretations about mental health, which relates to historic structural policies and approaches to mental health that set the foundation for a negative perspective on mental health (Rössler, 2016). For example, historically, in some Southern African countries, individuals with mental distress were treated poorly and subjected to experiences such as imprisonment, torture, or murder (Jackson, 1999). This was exacerbated toward Black Africans due to the racial discrimination brought forth by colonisation (Akyeampong, 2015).

Furthermore, some African communities often traffic in discourses that attribute mental distress to demon possession and witchcraft, which also added to the negative narratives surrounding people with mental distress (Koenig, 2009). One of the consequences of such narratives is that they become a barrier to accessing care. These experiences and narratives create the framework by which individuals conceptualise phenomena such as mental health.

For Black Africans experiencing mental distress, public stigma can lead to internalised feelings of shame (Rössler, 2016). Alemu et al. (2023) systematically reviewed the prevalence of internalised stigma among Africans with mental distress. They found that 29% of their sample

population exhibited elevated scores of internalised stigma, suggesting that this was a common experience for some people with mental distress in Africa. Alemu et al. (2023) acknowledged that internalised stigma is related to suppressive negative but accepted societal beliefs. An example of this in terms of mental health can be the aetiological belief that mental distress is the result of one's own sins or a punishment. These perpetuate negative views on addressing mental health. When considering African migrants and refugees, growing up within this social context, particularly during formative developmental years such as adolescence, can influence the stigma some hold about mental health (Gowers, 2005). This was exemplified in the narratives of a participant, Betty, who recognised that while she acknowledged that she experienced mental distress, the shame and stigma associated with it became a strong barrier to her seeking help. In addition, participants like Holly disclosed narratives of family members avoiding issues related to mental health. This can lead to delayed initial contact with health providers, treatment-avoidance behaviours, and reduced quality of life (Ahad et al., 2023).

8.1.2.2 Limited Knowledge

Another barrier to accessing care is having limited mental health literacy. This includes a lack of knowledge about the recognition, prevention, and possible treatments for mental distress (Rüsch et al., 2013). Some participants in this study noted that this was an issue for them. Immigrants, particularly refugees, are often exposed to highly traumatic events that influence their well-being (Desjarlais, 1995). In environments where basic needs are threatened, the priority shifts towards securing essential resources for survival, often leaving mental health issues unaddressed (Desjarlais, 1995). As such, while some individuals might experience mental distress following their migration, they may not have the knowledge of what they are experiencing. In other cases, they may draw on different forms of discourse to articulate their

experience that is foreign to an A-NZ context. These factors can prevent individuals from approaching relevant support services when needed (Rüsch et al., 2013).

8.1.2.3 Strategies

It is useful to consider what interventions may be beneficial at a clinical and societal level. At a clinical level, clinicians should consider the social context that might be influencing Black Africans in therapy. This includes recognising the historical influences of colonisation and the discourses in an African context regarding the origins of mental health. Exploring how a client makes sense of their experiences and how they feel about them can be a helpful way to ascertain possible shame narratives.

A systematic review by Norder et al. (2023) found that the most successful approaches to addressing internalised shame included psychoeducation, experiential exercises, and increasing social support. Education involves providing information on shame and stigma and exploring the impact it has on an individual's thoughts and behaviours (Coons, 1998). This might include exploring socio-cultural expectations, triggers, and responses to shame (Brown, 2006). Experiential exercises can support the individual in addressing the consequences of shame and stigma, such as possible withdrawal (Norder et al., 2023). Lastly, increasing social support can help target shame. However, it is essential to identify safe and positive support, as stigma can often result in negative responses from others (Moses, 2010). Social support can help a person develop positive self-awareness and reduce negative emotions associated with shame (Li et al., 2023).

At a societal level, increasing opportunities for mental health knowledge would help address the barrier of limited understanding. Apers et al. (2023) reported that directly targeting minority populations instead of general outreach promoted mental health discussions more successfully. One of the strategies they noted involved community involvement and participatory strategies.

This involved actively including members of the minority group, including community leaders, to participate in campaigns for mental health awareness. This elicited better engagement from members of the minority population (Apers et al., 2023). As such, creating campaigns among African social groups within A-NZ would increase knowledge of mental health. This can involve attending key social areas for Black Africans in A-NZ and involving the community in mental health discourse.

Shame, stigma, and having limited knowledge can influence Black Africans in A-NZ's likelihood to access support. These factors can lead to delayed engagement with service providers, treatment avoidance, and general deterrence for mental health services. Historical influences such as colonisation and discourses that construct mental health concerns negatively provide the foundation for mental health stigma. However, interventions at both a clinical and societal level can help mitigate these barriers.

8.1.3 Systemic Barriers

The final subtheme related to barriers to accessing care was systemic barriers. This referred to procedures or policies that negatively affected Black Africans, including the availability of services and costs. It is important to recognise that these are not limited to Black Africans but affect other populations in A-NZ (He Ara Oranga, 2018). However, given this was a prominent barrier for participants, it will be explored in this section.

8.1.3.1 Systemic Racism

While earlier in this chapter racial issues such as stereotypes and power imbalances were discussed within the client-clinician relationship, it is important to recognise that racism also operates at a systemic level. Systemic racism refers to the ways racial bias is embedded in societal structures, policies, and institutional practices that consistently disadvantage individuals based on race (Came et al., 2018). A-NZ's colonial history has entrenched systemic

inequities that disproportionately affect minority groups, particularly Māori. As noted by the Waitangi Tribunal, early healthcare systems were shaped by colonisation, often prioritising the needs of European settlers while neglecting the health of Māori (Ahuriri-Driscoll et al., 2022). These colonial histories continue to influence healthcare outcomes for marginalised populations today.

Contemporary examples of systemic racism in A-NZ can be seen in inequitable government funding allocations and disparities in access to healthcare providers for non-European populations (Came et al., 2018). For example, funding provided to marginalised groups, such as Māori initiatives, is often found to have a shorter duration, which leads to issues such as recruitment and staff retainment (Ahuriri-Driscoll et al., 2022). While some efforts have been made to incorporate Indigenous worldviews into healthcare, biomedical and Western models of health are still often privileged over Indigenous perspectives, reinforcing institutional biases (Ahuriri-Driscoll et al., 2022; Came et al., 2018). Although clinicians can take individual action to address racism in their practice, broader structural transformation is required at the policy and government level to dismantle the systemic roots of health inequities.

8.1.3.2 Access to Services

The Government Inquiry into Mental Health and Addiction was introduced in 2018 to examine the concerns regarding mental health services in A-NZ. The inquiry explored experiences shared by members of the community, people with lived experience, and service providers. Results from their report showed that, among people living in A-NZ, one in five experience mental distress each year. Furthermore, they estimated that 50-80% of the population would experience mental distress at least once in their lifetime. According to the Health Status Report (2023), psychological distress in A-NZ has been consistently increasing since 2011/12, and this

has been exacerbated during the COVID-19 pandemic. While there is an increase in demand for mental health support, the resources available are unable to meet the demand.

The Government Inquiry into Mental Health and Addictions (2018) showed that people across the country were experiencing access issues. They noted long wait times, not meeting the required admission criteria, clinician unavailability, and limited therapy options. These were significant barriers for clients trying to access care. Te Pou's (2022) report on wait times for mental health and addiction services in A-NZ found that 80% of clients are seen within three weeks, leaving the remaining 20% waiting longer than three weeks to be seen. Long waitlists have been associated with adverse health outcomes, increased anxiety, reduced motivation to engage with services, and reduced satisfaction with service providers (Punton et al., 2022; Te Pou, 2022).

8.1.3.3 Cost

Another systemic barrier is the cost of accessing care. Te Tāhū Hauora (2020) found that 17% of people reported not seeing a health provider due to the cost. While free public mental health services are available to A-NZ residents and citizens, prolonged wait-times and specific criteria compromise access (Te Pou, 2022). The average cost of therapy sessions in A-NZ is between \$70 and \$200 per session, depending on a clinician's training, expertise, and experience (Tough Talk, 2020). This is likely unaffordable for some people.

8.1.3. Strategies

The issues of access and cost as barriers suggest a systemic issue with the current mental health system. This includes evaluating solutions to increase the workforce for mental health service providers, increasing funding available to services, and broadening the criteria required to allow more people to access support (He Ara Oranga, 2018; Kulshrestha & Shahid, 2022). Such

changes need to be considered in relation to other issues within the country, particularly regarding where and how money is distributed within the country.

8.2 Clinician Preferences

The second major theme identified was clinician preferences. This is related to the important factors participants considered when engaging with mental health service providers. Clinician characteristics and knowledge were the two sub-themes identified. Regarding clinician characteristics, findings showed that participants reflected on interpersonal skills and cultural alignment as important factors. For knowledge, findings suggested that understanding stigma among Black African communities, family dynamics, and communication styles were areas participants wanted clinicians to be aware of. These themes and sub-themes are explored further below.

8.2.1 Clinician Characteristics

8.2.1.1 Interpersonal Skills

During the focus groups, participants indicated that clinicians being interpersonally skilled was important. Skills facilitate effective communication and engagement with others, establishing rapport with the client (Hayes, 2002). Rapport refers to the relationship between a client and a clinician that promotes connection, trust, and safety (English et al., 2022). Establishing and maintaining strong rapport is associated with client satisfaction, treatment adherence, and reduction of client complaints and clinician errors (English et al., 2022; Lang, 2012; ‘Rapport’, 2024). Hayes (2002) states that rapport allows clinicians to comprehend a client's holistic personhood (i.e., their physical, emotional, spiritual, and cognitive domains), and this deeper understanding ensures better cultural sensitivity and client safety (Brooks et al., 2019). Interpersonal skills are, therefore, vital to the clinical process for mental health services (Kawamichi et al., 2015).

8.2.1.1 Validation and Active Listening

Participants in both the focus groups and individual interviews described feeling unheard and invalidated by their clinicians. As such, they desired clinicians to promote a therapeutic space characterised by validation and active listening. Validation, in the context of therapy, involves recognising and accepting a person's emotions, experiences, and thoughts as understandable (McMillen et al., 2023). Listening involves active engagement in a client's narrative (Rogers, 1951). Kawamichi et al. (2015) succinctly summarise Rogers' (1959) definition of active listening as "empathic understanding, unconditional positive regards, and congruence behaviour" (p. 1). Both validation and active listening can facilitate positive interpersonal interactions, which improves client engagement and satisfaction (Kawamichi et al., 2015).

Clients can feel invalidated and unheard when they perceive their experiences or feelings as diminished or rejected (McMillan et al., 2022). It can communicate the clinician's lack of understanding and acceptability, leading to distrust within the client-clinician relationship (Vybiral et al., 2024). Perceived invalidation has been associated with exacerbated mental distress and poorer health outcomes (Nock, 2009). Linehan (1993) and Fruzzetti (2010) provided seven invalidation levels, summarised below. These behaviours may lead to clients' discomfort and decreased quality of care.

1. Inattention – being distracted or lack of interest in the client's story
2. Missed opportunities – failure to respond to a client's vulnerability.
3. Insisting – persisting on a particular feeling or thought.
4. Negative valence – perpetuating a client's self-invalidating narratives.
5. Pathologising – treating reasonable client responses as strange or erroneous.
6. Fragilising – treating a client as incapable or too fragile to manage negative emotions.
7. Indifference to vulnerability – when a clinician is non-responsive to a client's struggles.

It is helpful to consider the social context of Black African women and the particular importance of validation and active listening for this population. In many Black African communities, mental health discourse often carries stigma, and related topics are frequently minimised or dismissed (Alemu et al., 2023). This stigma can impact how mental health issues are addressed within nuclear families, resulting in avoidance, invalidation, and minimisation of mental distress among Black African migrants (Alemu et al., 2023; Rössler, 2016). Therefore, validation and active listening provides therapeutic support that may not be available in these client's everyday context.

Social structures linked to gender and age hierarchies likely influence these cultural dynamics (Mbele, 2006; Stoeltje, 2015). Historically, power distribution between men and women was varied across Southern African societies. While some communities practised egalitarianism, others operated on hierarchies based on gender (Stoeltje, 2015). Following colonisation, Eurocentric norms became prevalent, exacerbating power imbalances and granting men greater authority (Stoeltje, 2015). Additionally, age seniority is significant in power distribution within African relationships, where older individuals hold higher decision-making power and influence than their younger counterparts (Mbele, 2006).

While these gender and age-based hierarchies and power distributions occur at a societal level, they can also impact the nuclear family. Participants in the focus groups were mainly aged 20 to 30 years old and still considered their parents as part of their nuclear family. Since participants' parents were born and raised in Southern Africa, their views on mental health were likely shaped by the stigma present in those environments (Bamgbose Pederson et al., 2022). As a result, avoidance and denial of mental health issues can permeate the nuclear family dynamics. When considering participants' positions as Black African women, they often rank lower within socially constructed gender and age hierarchies (Mbele, 2006; Stoeltje, 2015). This is significant as people with less social power often have their difficulties minimised and

feel silenced (Billups et al., 2022). Consequently, Black African women may experience invalidation and feel unheard (Bassey & Zaka, 2024; Yasui et al., 2017), leading to a greater need for validation and active listening in therapeutic settings.

8.2.1.2 Strategies for Interpersonal Skills

As shown, interpersonal skills are critical to developing strong client-clinician rapport and maintaining treatment engagement (Hayes, 2002). As such, it is beneficial for clinicians to continually review their clinical practice and reflect on areas of development. This can be initiated through direct observation, role-play exercises, and feedback from other clinicians (Butt, 2021). Such strategies can identify weaknesses and facilitate constructive feedback from peers. These approaches can increase a clinician's awareness of tendencies of invalidation and help them take appropriate measures to address these (e.g., seeking supervision or engaging in role-play exercises) (Butt, 2021; Rønning & Bjørkly, 2019).

8.2.1.2 Cultural Alignment

Participants expressed varied opinions on whether they wanted their clinician to have the same cultural background. While some preferred mutual cultural understanding, others favoured cultural heterogeneity, appreciating the clinician's lack of prior knowledge regarding the client's cultural background. The following section explores the benefits and limitations of each scenario.

8.2.1.2.1 Shared Cultural Background

Cultural background is not limited to ethnic identity but includes other social identities, such as race, gender, or religion (Heyes, 2020). Literature suggests clinicians with similar cultures to their clients have better treatment outcomes (Saha et al., 2008; Street et al., 2008) (Roter et al., 2002; Saha et al., 2000; Street et al., 2008). The benefits discussed in this section include

comfort and communication, while the limitations include overidentification and possible biases.

Comfort:

Shared cultural identity can help clinicians understand social nuances. This is particularly helpful when the presenting issue is associated with a client's culture (Roter et al., 2002). Studies have shown that Black clients are more likely to report feeling understood when their clinician shares the same racial background (Moore et al., 2022). When a clinician shares the same cultural context, it allows clients to have a sense of familiarity (Cooper-Patrick et al., 1999; Street et al., 2008). This can help foster an environment of comfort, which improves client outcomes. For example, a study by Street et al. (2008) found that shared identity led to higher client satisfaction, trust, and treatment adherence reports. It is likely that sharing the same identity results in similar cultural beliefs, values, and experiences, which allows clients to feel safer communicating their experiences (Cooper-Patrick et al., 1999).

Communication:

From a linguistic perspective, shared identity can help mitigate potential language barriers (Verkerk et al., 2021). For many migrants and refugees, English is not their first language, and they often encounter communication difficulties (Kanengoni-Nyatara et al., 2024). Language-concordant healthcare has been shown to enhance trust between clients and clinicians, optimising healthcare outcomes (Molina & Kasper, 2019). Furthermore, speaking a similar language results in less confusion and better quality of care (González et al., 2010). Linguistic nuances are not limited to language. Every social group will have linguistic structures, accents, slang, and sociolects that make their communication unique (Gumperz & Tannen, 1979). Despite sharing the same language, words might communicate a different meaning. In sharing

the same social identity, clinicians minimise the risk of misunderstanding stemming from linguistic nuances.

Overidentification:

One of the limitations that can arise from having a shared culture is that the clinician may over-identify with their clients. According to Watkins (1985) identification occurs when a clinician can relate to a client's experience. While this is not inherently negative, over-identification can arise when a client's experiences are related to a clinician's unmanaged issues – this speaks to the problem of countertransference (Alfonso, 2023; Watkins, 1985). Over-identification can result in ambiguous client-clinician boundaries (Schames, 1981) and can affect client outcomes, through clinician withdrawal and a failure to empathise, thus jeopardising the therapeutic alliance (Alfonso, 2023).

Potential Biases:

Another possible limitation is the risk of biases. Prior knowledge of a particular culture will include awareness of its norms (Puddifoot, 2019). This can lead to intentional and unintentional assumptions about the client. As discussed earlier in this chapter, assumptions and stereotypes can result in inaccurate conclusions and subsequent poorer health outcomes for clients (Aronson et al., 2013; Marcelin et al., 2019; Puddifoot., 2019). Furthermore, participants in this study highlighted possible discomfort in discussing issues that deviate from the expected norms of the cultural group. For example, if religion was the shared identity, the client may be uncomfortable discussing matters contrary to the customs of that religion. Mistrust within a clinician-client relationship can negatively impact treatment outcomes (Adekunle et al., 2023)

8.2.1.2.2 Different Cultural Backgrounds

Some participants preferred clinicians with a different cultural background. Literature suggests that, in general, clients prefer engaging with someone from the same cultural context (Street et

al., 2008). However, heterogeneity may offer some benefits, such as diverse perspectives and comfort for clients discussing issues contrary to their cultural norms. This section will discuss these and some limitations, including the risk of misunderstandings, stereotypes, and language barriers.

Diverse Perspectives:

Working with clinicians from different cultural backgrounds can provide a new viewpoint separate from one's beliefs (de Oliveira & Nisbett, 2017). This might facilitate novel ways to address issues that clients may not have considered. A clinician may make observations and ask questions that allow the client to consider their situation differently, which can lead to therapeutic breakthroughs (de Oliveira & Nisbett, 2017). It is crucial to note that clinicians should maintain cultural safety in ensuring their values and beliefs are not imposed on the client (Asnaani & Hofmann, 2012; de Oliveira & Nisbett, 2017).

Comfort:

The second benefit is a client's comfort during interactions. When a client's difficulty carries stigma within their social context, working with a clinician outside that context may be beneficial. For example, one participant highlighted how talking to someone culturally different removed the fear of being judged by someone from the same culture. One reason for fear is negative prior experiences with members of the same community. For many migrants and refugees, migrating to a new cultural context can lead to re-evaluating one's culture and values (Berry., 1997; Merz et al., 2009). Such circumstances may result in tension between themselves and other members of their original culture due to conflicting lifestyles or values. These dynamics are prevalent among nuclear families, where parents and children may develop incongruent cultural identities (Edelblute et al., 2024; Merz et al., 2009).

Consequently, such divergence can lead to negative experiences such as ostracisation, stigma, and isolation, which may foster distrust (Egbe et al., 2014). Perceived safety and comfort are critical to developing and maintaining a strong therapeutic alliance (Street et al., 2008). For example, a study by Greenhalgh et al., (2006) found that migrants listed trustworthiness as the defining quality of a good clinician. As such, having a clinician who is not associated with negative experiences might increase the feeling of trust.

Misunderstandings:

One limitation of having different cultural backgrounds is the misunderstandings that occur. Firstly, language barriers are a risk. For many migrants and refugees, English is their second language, which means that while they may be proficient, there may be some linguistic challenges (Pandey et al., 2021). This can result in communication difficulties with their clinician (Krystallidou et al., 2024; Pandey et al., 2021). The other challenge is that what is normative in one culture might be considered abnormal in another culture. If cultural sensitivity is not exercised, a clinician runs the risk of interpreting normative behaviours and experiences as pathological (Jimenez et al., 2022).

Stereotypes:

Another risk is the issue of stereotypes. Stereotypes act as cognitive shortcuts to help people draw conclusions about others (Puddifoot, 2019). However, these are often harmful and inappropriate (Puddifoot, 2019). For example, Isla, a participant in this study, highlights how assumptions made about Black Africans from clinicians can lead to inaccurate conclusions about who the person is. As highlighted earlier in this chapter (i.e., stereotypes), this can lead to poorer health outcomes for clients (Aronson et al., 2013; Marcelin et al., 2019; Puddifoot., 2019). It can make people feel invalidated and subjected to unhelpful generalisations (Marcelin

et al., 2019). In particular, for Black African migrants and refugees, stereotypes may retrigger negative experiences of discrimination and marginalisation (Abdou & Fingerhut, 2014).

One of the preferences participants discussed was for particular clinician characteristics. Interpersonal skills were identified as of particular importance, with participants highlighting active listening and validation. Considering the social context where participants' mental health experiences were likely dismissed, listening and validation become important strategies for service providers. Another clinician preference discussed was the cultural alignment of a clinician. Participants had variable preferences, some preferring a person with the same cultural identity, while others preferred someone wholly removed. Both scenarios have their benefits and limitations.

8.2.2 Knowledge

The second sub-theme identified was clinician knowledge. This referred to topics that participants wished clinicians were more knowledgeable about. The areas identified were mental health stigma, family dynamics, and communication styles. This section will discuss these further.

8.2.2.1 Stigma among Black Africans

Participants desired clinicians to be aware of the stigma among Black Africans. The implications, significance, and potential strategies regarding mental health stigma among Black Africans are discussed in more detail under the sub-theme *8.1.2.1 Shame and Stigma*. Mental health stigma can influence recovery attitudes, impacting treatment adherence and engagement (Chan et al., 2022). It can also lead to diminished self-esteem, self-efficacy, and demoralisation (Rüsch & Xu, 2017). Furthermore, stigma influences how community members may treat/respond to clients with difficulties (Pederson et al., 2021). The combination of internalised self-stigma and externalised public stigma adds to the pressure of engaging with mental health

services (Ahad et al., 2023). Understanding these underlying processes can help clinicians develop greater empathy for Black Africans seeking mental health support, enhancing clinician-client rapport (Riess, 2017).

8.2.2.2 Family Dynamics

The second area participants wanted clinicians to have a good understanding of was family dynamics. Although they did not specify which family dynamics they were referring to, it is still beneficial to understand the common challenges that arise within migrant and refugee families. The first issue relates to changes in cultural values. Children of first-generation migrants often struggle to navigate and negotiate differences between their country of origin and their new country (Mwanri et al., 2022; Waite et al., 2009). Parents usually adhere to their homeland's value systems, while children explore and adopt new cultural values (Waite, 2009). This discrepancy can often result in tension within families resulting in fractured relationships (Mwanri et al., 2022).

Another helpful dynamic to consider is the power distribution among Black African families. Age and gender hierarchies often influence family relationships and can exist in both the nuclear and extended family (Charema & Shizha, 2008; Mbele, 2006; Stoeltje, 2015). Hierarchies speak to how much say and autonomy someone has within their family and provides insight into their expected responsibilities (Ekane, 2013; Mabandla et al., 2023). For example, in some African families, adult children are expected to provide financial support to their parents (Okeke-Ihejirika et al., 2022). These responsibilities and expectations may differ from a clinician's worldview, potentially leading to emotional disconnect and invalidation from a clinician (Vybiral, et al., 2024). However, it is prudent to acknowledge and respect the cultural norms that exist for a client. Neglecting family dynamics may omit a vital attribute of a client's personhood (Mabandla et al., 2023). Knowledge of the family system results in a more

appropriate and comprehensive view of the client (Mabandla et al., 2023). This can help tailor interventions that are considerate of a client's context.

8.2.2.3 Communication

Lastly, participants desired clinicians to be sensitive to their different communication styles. They stated that being direct can be challenging and found comfort in speaking in a circumlocutory manner. While participants did not expand on why this is important, the literature offers valuable insights, which will be discussed in this section.

Communication styles refer to the components of a person's speech used to relay information and connect with others (De Mooij, 2019). Factors such as culture, personal experiences, and individual personality can influence how a person communicates (Azmi et al., 2023). Concerning culture, different social groups' values, beliefs, and norms affect the unique ways people communicate (Balakrishnan, 2022) . Participants in this study indicated that they preferred an elaborative communication style. According to De Mooij (2019), this is where people use rich, expressive language to articulate an idea. In contrast, an understated communication style tends to be direct and to the point (De Mooij, 2019). Black Africans tend to communicate in a circumlocuting manner, which is reflected in their historical modes of communication, such as songs, dances, folklore, riddles, and proverbs (Darkwa, 1987; Liu, 2016). As such, Black African migrants may be inclined to communicate this way. This communication mode differs from the standard medical approach, which tends to be more directive and understated (Liu, 2016; Taylan & Weber, 2023). Cooper et al. (2012) argued that ethnic-cultural differences in communication can perpetuate racial disparities in mental healthcare, highlighting the importance of clinicians becoming attuned to communication differences. Schouten and Meeuwesen (2006) offered five predictors of culture-related communication issues.

1. Cultural differences in health perceptions.
2. Differences in cultural values
3. Differences in desired doctor-patient relationships
4. Racism and prejudice
5. Language barriers

These five issues can lead to communication discordance, leading to unhelpful client/clinician interactions (Schouten & Meeuwesen, 2006). Disregarding communication styles can result in inappropriate assumptions and misinterpretations, which leads to mental health misdiagnosis and poorer health outcomes (Paternotte et al., 2015; Taylan & Weber, 2023). Understanding that, although a clinician and client may speak the same language, different communication styles exist can facilitate compassion and mindfulness for minority clients (Paternotte et al., 2015). As Tayla and Weber (2023) asserted, “Respect does not mean agreeing with a foreign culture in everything but allowing others the right to express their values and culture” (p. 646). This means allowing people to articulate their experiences in ways that are familiar to them.

One of the preferences participants discussed was what they desired clinicians to know. This included the mental health stigma among Black Africans, family dynamics, and communication style. These areas allow clinicians to better understand clients and enhance client-clinician rapport. Understanding the mental health stigma that occurs contextually can allow clinicians to understand the difficulty associated with engaging with mental health services for Black Africans. Family dynamics help elucidate clients' cultural norms, behaviours, and expectations. Lastly, communication styles inform clinicians of how clients relay information and are attuned to communication differences. All these factors help clinicians develop a richer and more comprehensive understanding of Black African migrants.

It is important to note that, while this chapter reflects participants' stated desires, it is not always feasible to satisfy all demands, and clinicians may embody some, but not all, of the desired characteristics, particularly as individual differences shape these preferences. Clinically, this highlights the importance of holding the internal tension that not all client preferences can be fulfilled. As such, engaging in ongoing collaboration and open discussion to clarify and prioritise clients' needs allows clinicians to uphold a person-centred approach, even when all desires cannot be met.

8.3 Conclusion

Chapter 8 discusses key themes from Focus Group interviews related to literature, focusing on barriers to mental health services and clinician preferences. Barriers include clinician-related factors such as cultural taxation and stereotype threat, client-related issues such as shame and stigma, and systemic challenges like costs and clinician availability. This chapter proposes strategies to address these barriers. Individual differences influence Black Africans' therapy preferences, with a common desire for strong interpersonal skills, validation, and active listening. Preferences can vary between seeking clinicians from the same or different cultural backgrounds, each with its own advantages, yet client preference remains paramount. Understanding issues unique to Black Africans, such as community stigma and family dynamics, can improve rapport and therapeutic engagement.

9. Conclusion

The purpose of this study was to explore the mental health conceptualisations among Black Sub-Saharan African migrants and refugees in A-NZ. Three key objectives were identified:

- to explore mental health conceptualisations
- to identify mental health management strategies
- to explore perspectives on mental health services in A-NZ.

Two data collection methods were employed: individual interviews for the first two objectives and focus groups to explore mental health service perspectives. Data analysis was completed using IPA for the individual interviews and RTA for the focus group. The following chapter aims to summarise the key findings, discuss the implications and contributions of this study, acknowledge limitations, and provide recommendations for future research.

9.1 Summary of Key Findings

9.1.1 Identity and Mental Health

According to Kleinman's theory of explanatory models, understanding how people conceptualise health helps reveal their perspectives and management of health (Kleinman, 1978). In line with this, one key finding from this study was the role of identity in understanding and managing mental health. Identity is how individuals define and understand themselves. Based on their identity, they adopt values, beliefs, and norms that align with it. It is not limited to ethnic background but can include other factors such as religion, geographical location, or occupation. These social groups incur cultural norms that influence how people view the world around them, including mental health. Findings from this study highlighted how depending on which identity is prominent to a person, they will adopt mental health perspectives and management styles consistent with that identity. As such, rather than it being about being a

Black African, it is more about who people identify as. Results also indicated that intergenerational and gender differences occur among Black Africans.

9.1.1 Mental Health Services Perspectives

It was also deemed important to ascertain how Black Africans perceive mental health services in A-NZ. Barriers to engaging and accessing services were identified. These included clinical, personal, and systemic barriers. Some clinical barriers were related to participants' identity as Black Africans. Experiences with cultural taxation, stereotype threat, and stigma deterred people away from services. Other factors, such as power imbalances, also discouraged engagement. Secondly, personal barriers, such as shame and stigma were also discouraged contacting services. Lastly, systemic issues such as high costs and limited clinician availability made access difficult.

While barriers deter people, preferences attract. Characteristics such as a clinician who is validating, an active listener, and possesses strong interpersonal skills allow for rapport to be established and encourage client engagement. Some preferences appeared to be specific to Black Africans, which related to the knowledge they wished clinicians to be familiar with. This included family dynamics and different communication styles as typical of Black African cultures. Individual differences existed regarding whether Black Africans preferred someone with the same cultural background or someone who was different. Both positions demonstrate benefits and limitations. Thus, whether a Black African prefers to see someone similar or different to them is dependent on their own preference.

9.2 Contributions and Implications

This study is the first to specifically explore the mental health experiences of Black Africans in A-NZ. The findings provide insight into how Black Africans make sense of their mental

health, which contributes to developing a more appropriate ethos of engagement for clinicians working with this population.

9.2.1 Importance of Identity

Given the results, clinicians need to identify the most salient identity in a person's life. This facilitates rapport and a better understanding of an individual's mental health explanatory models. Additionally, acknowledging factors such as family dynamics, communication styles, and intergenerational or gender difficulties enables clinicians to demonstrate empathy and understanding towards the cultural norms and expectations of Black African clients.

9.2.2 Clinical Implications

The findings of this study hold significant clinical implications. Central to these is the role of identity, which influences how individuals understand mental health and engage with management strategies. For clinicians, creating a space that acknowledges the variability and diversity of identity is crucial. Specifically, recognising that the identities of Black Africans go beyond ethnic and racial dimensions can strengthen the therapeutic alliance, foster trust, and lead to more accurate interpretations of clients' explanatory models. As Kleinman (1978) states, such recognition enhances understanding of clients' lived experiences.

Equally vital is the role of culture in clinical practice. The findings underline the need for cultural competence, not merely as an ethical duty but also as a way to improve treatment outcomes. To reduce risks like cultural taxation, clinicians should commit to continuous development of awareness, knowledge, and skills that support culturally responsive care. This includes respecting individual differences, actively encouraging clients to share their needs and preferences, and collaborating to shape the therapeutic process. Such practices help minimise power imbalances in healthcare relationships while promoting cultural safety for both clinician and client.

Several practical strategies can support this approach. Regular supervision, including cultural supervision, offers a structured space for reflection and professional growth. Self-reflective practice enables clinicians to examine their biases and assumptions, while a person-centred approach ensures interventions stay aligned with each client's context and priorities. Additionally, understanding the socio-historical experiences of Black Africans is clinically important. Issues like shame and stigma can impede engagement, but targeted approaches such as psychoeducation and experiential exercises can help address these barriers and foster healing.

While these recommendations can be applied by individual clinicians, lasting change also requires community-level initiatives. Expanding learning opportunities within communities, promoting relevant psychoeducation, and involving community members in participatory decision-making can amplify these efforts. These strategies not only improve individual outcomes but also strengthen broader systems of support for mental health within Black African communities.

9.3 Limitations

As with most studies, this research had limitations, which are summarised in this section.

These included the demographic pool, access to an external cultural advisor, and the researcher's insider role.

The demographic pool for participants in this study was limited, consisting predominantly of Black African women migrants aged between 20 and 40 years. Consequently, the findings reflect this demographic. In some ways, this focus was also advantageous, as IPA recommends that the sample should aim to be as homogeneous as possible (Smith, 2004). With the exception of the one male participant, the perspectives of Black males within the focus groups and older Africans were absent from the sample.

Several factors may have contributed to the lack of participants from those cohorts. Firstly, recruitment occurred during COVID-19 restrictions, which led to the halting of many social group events, and I was unable to actively attend various community gatherings for recruitment. As a result, all recruitment took place online, excluding those not engaged with online community pages. Attempts were made to recruit from men's social groups; however, no responses were received.

Recruitment challenges meant only one male and one refugee participated, limiting the diversity of perspectives from these groups. Nonetheless, a notable advantage of employing Interpretative Phenomenological Analysis is its capacity to generate comprehensive insights from relatively small samples. Despite the small number of participants, the study generated valuable insights. Regarding the development of the literature, future research could usefully narrow participant criteria to focus specifically on either Black refugees or Black African men. While this study aimed to broadly explore Black Africans in general, one of its objectives was to serve as a foundational step for future research.

The limited engagement from men and older Africans aligns with both existing literature and participant narratives. Studies indicate that among Black Africans, discourse around mental health is often restricted, resulting in many not accessing mental health services (Memon et al., 2016). Furthermore, prevailing narratives about masculinity, emphasising stoicism, self-reliance, and emotional restraint, pervade society and contribute to the reluctance to seek mental health services (Gough & Novikova, 2020). Additionally, participants expressed similar feelings by emphasising the negative stigma and sparse mental health discussions among men and older Africans.

A limitation of this study is that only participants who were fluent in English were recruited. This approach was selected for several reasons. Firstly, Sub-Saharan Africa encompasses over

2000 languages, making it challenging to find interpreters for all of them, particularly given the small Black African population in A-NZ (Harvard University, n.d.). Furthermore, a search of the New Zealand Society of Translators and Interpreters database revealed that interpreters were unavailable for many languages commonly spoken by Black Africans (New Zealand Society of Translators & Interpreters, n.d.). For instance, although Swahili, the most widely spoken language in Sub-Saharan Africa, was listed, no interpreters were available. The combination of extensive linguistic diversity and the scarcity of accessible interpreters informed the decision to recruit only English-fluent participants. It is also noteworthy that English is the most widely spoken foreign language across Africa, with over 20 countries recognising it as an official language (Harvard University, n.d.). Given these factors, the inclusion of English-fluent participants was considered the most feasible and appropriate approach. Nevertheless, this decision introduces limitations, particularly the exclusion of individuals who do not speak English. Their perspectives, which may differ from those of English speakers, are thus absent from the study, restricting the range of experiences shown. From a clinical perspective, it is difficult to determine if the needs of non-English speaking Black Africans would differ from those of English speakers.

A further limitation is the absence of data on participants' geographical locations. Recruitment was open to any Black Africans residing in A-NZ, and the use of Zoom for interviews enabled participation from across the country. However, to protect confidentiality due to the small population of Black Africans, regional location data was not collected. This omission limits the ability to explore potential regional differences, especially since perspectives on mental health can be influenced by variations in the availability and accessibility of local services. Future research could address this by gathering geographical information to examine possible links between region and perceptions of mental health services.

While it would have been beneficial to have an external cultural advisor, the composition of the supervisory team provided diversity and relevant experiences to support the cultural component. Firstly, the primary supervisor, Associate Professor Clifford van Ommen, is South African and lived in South Africa for the majority of his life. His lived experiences as a clinician, researcher, and African inform his understanding of African norms. Furthermore, the other supervisor, Associate Professor Natasha Tassell-Matamua, has extensive experience in Indigenous psychology research. Her sensitivity to minority perspectives and themes prominent in Indigenous studies (e.g., colonisation, discrimination, minimisation, etc.) was beneficial in providing relevant advice. Additionally, my identity as a Black African migrant meant my lived experience and understanding of typical cultural norms could assist in reviewing the cultural elements of this study. Throughout the research process, regular supervision meetings were held during which the supervisory team engaged in discussions, provided advice, and facilitated decision-making.

Having an emic perspective allowed me to build rapport with participants and quickly understand their experiences. However, there are some limitations that come with an emic approach. Firstly, I recognised that I would carry biases and assumptions based on my personal experiences. To address this, I maintained a diary that detailed my emotions and perspectives throughout each stage of the research process. When factors emerged that highlighted my biases, these were openly discussed during supervision to ensure that the supervisory team was aware of any biases that could have impeded the research process.

A few assumptions and biases were documented that are worth highlighting. Firstly, during the early stages of the literature review, I needed to examine the history of mental health in Africa, which evoked strong emotional responses in me. Gaining insight into the marginalisation, colonisation, and discrimination faced by Black Africans led to feelings of frustration and hurt.

Recording these emotions and discussing them with my supervisors was my way of addressing these responses to ensure they did not hinder or negatively impact the writing process.

Another assumption I held was related to my religiosity and ethnic identity. I grew up in an African household with strong social connections and a deep religious background that I identify with. One reflection I noted during the individual interviews was the unconscious assumption that participants would have similar backgrounds to mine. I expected most participants to be Christian or have strong family ties. However, this was often not the case. Keeping a research diary and documenting these assumptions helped me remain aware of potential biases and avoid its influence on analysis and data collection. Additionally, I reviewed one of the initial interviews I completed with my supervisory team. This was to enable individuals from different backgrounds to assess and identify areas for development or determine if my biases were affecting the data collection process, especially since I used a semi-structured approach.

Overall, while these limitations inevitably shaped the study, they also created opportunities for reflexivity and provided a foundation for future, more targeted research.

9.4 Future Recommendations

This study aimed to provide a broad overview of the factors that impact mental health conceptualisations, management, and service experiences for Black Africans. As such, there is an opportunity for research to explore each key theme in greater detail (e.g., cultural taxation, stigma/shame, or stereotypes). This can facilitate a comprehensive understanding of the nuances of these major themes.

Additionally, considering the sample included fewer males and older Africans, a study targeting these demographics would be advantageous. However, alternative recruitment strategies may facilitate participant involvement. Engaging with community members and participating in

social events can assist future researchers in building connections and trust within the African community, which may increase the likelihood of participation due to these established relationships. Another option could involve ethnographic research, which entails immersive observation and engagement with a specific group (Ploder & Hamann, 2021). This approach fosters participant involvement by enhancing the chances of building trust and rapport.

9.5 Final Statement

Overall, this thesis highlights the nuanced understanding of the mental health experiences of Black Africans in Aotearoa New Zealand, a population that is often underrepresented in research. By exploring both conceptual understandings of mental health and perspectives of mental health services, the study showcases how identity is central to meaning making of mental health and also identifies culturally specific barriers to care. These insights have important implications for clinical practice, policy development, and developing culturally responsive mental health services. Furthermore, the findings contribute to the broader literature on mental health of Black Africans, offering a foundation for future research and supporting the development of interventions to meet the needs of Black Sub-Saharan African migrants and refugees in A-NZ.

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Appendix

A) Advertisement Poster



MASSEY UNIVERSITY
TE KUNENGA KI PŪREHUOA
UNIVERSITY OF NEW ZEALAND

RESEARCH PARTICIPANTS WANTED

Are you a Black African migrant or refugee?
Would you be interested in discussing what mental health means to you or your perception of mental health services in New Zealand?

WHAT IS INVOLVED

- You will be invited to take part in a 45-min interview and/or one 1-2 hour focus group
- Interviews can be in-person or via Zoom
- You will be provided with a \$20 Pak'n'Save voucher to compensate for your time

PARTICIPANTS MUST:

- Be Black Sub-Saharan African migrant or refugee
- Have lived in New Zealand for at least one year
- Be 18 years of age or over
- Be fluent in English

*This study is interested in all perspectives.
You do not need to have a history of mental health difficulties to participate.*

If you're interested or wish to find out more information, please contact:
michellemusakwa21@gmail.com

B) Information Sheet – Individual Interviews



Conceptualisation of Mental Health among Black Sub-Saharan African Migrants and Refugees

Interview Information Sheet

Mental wellbeing is a growing research topic around the world. How people understand what this involves differs across social groups. Depending on cultural, social, and personal experiences, ways of viewing wellbeing will vary. It is important to understand this as people's views can have an impact on how they respond to mental health services. As it stands, there is a scarcity of research that specifically focuses on the experiences of Black Sub-Saharan Africans in New Zealand. With minimal understanding in this area, many mental health professionals may have limited cultural competency when working with such clients. As such, the present study aims to address this gap.

The coordinating researcher for this study is myself, Michelle Musakwa. I am a Black Sub-Saharan African migrant. I completed my Honours which examined the acculturation experiences of African migrant women. This study aims to extend from this research and specifically consider mental health experiences. I am conducting this research as part of the requirement of the Doctorate in Clinical Psychology programme as well as to add to the body of literature in this area. The supervisory team for this project is Associate Professor Natasha Tassell-Matamua and Dr Clifford van Ommen.

What is the Aim of the Study?

This study aims to explore how Black Sub-Saharan Africans in New Zealand understand mental wellbeing and manage mental distress. It also aims to understand the attitudes and perceptions held towards mental health services in New Zealand.

What Type of Participants are being sought?

I am inviting Black Sub-Saharan African migrants and refugees over the age of 18 to participate in this study. Participants are required to be fluent in English and have resided in New Zealand for at least one year.

What is Sub-Saharan Africa?

Sub-Saharan Africa constitutes of African countries that lie south of the Sahara. This includes the countries listed in the table below.

Angola	Côte d'Ivoire	Madagascar	Seychelles
Benin	Djibouti	Malawi	Sierra Leone
Botswana	Equatorial Guinea	Mali	Somalia
Burkina Faso	Eritrea	Mauritania	South Africa
Burundi	Ethiopia	Mauritius	Sudan
Cameroon	Gabon	Mozambique	Swaziland
Cape Verde	The Gambia	Namibia	Tanzania
Central African Republic	Ghana	Niger	Togo
Chad	Guinea	Nigeria	Uganda
Comoros	Guinea-Bissau	Réunion	Western Sahara
Congo (Brazzaville)	Kenya	Rwanda	Zambia
Congo (Democratic Republic)	Lesotho	Sao Tome and Principe	Zimbabwe
	Liberia	Senegal	

What will Participants be Asked to Do?

If you are interested in taking part in this study, you will be invited to take part in one interview. In short, I will be asking you some questions regarding your experiences and opinions around mental wellbeing. This is more of a conversation and, as such, there are no right or wrong answers. You can share anything you are comfortable sharing.

The interviews will involve a meeting with myself to explore how you understand mental wellbeing as well as how you manage your own mental wellbeing. You do not need to have a history of mental health issues to participate. This study is interested in the perspective of *all* Black Sub-Saharan African migrants and refugees.

Interviews will take place in-person and are expected to take approximately one hour. However, this time can vary from participant to participant. The interviews will be conducted via Zoom. You will be compensated with a \$40 Prezy card for your time.

In the event that the interview provokes discomfort, you can stop at any point. In addition, a list of useful psychological resources has been provided for you at the end of this information sheet. You are free to withdraw from the study at any time and can withdraw your interview material within 3 weeks after the interview.

What Data or Information will be Collected and What Use will be Made of it?

The interviews will require you to talk about your personal experiences and opinions regarding mental health. The interviews will be audio recorded and/or video recorded via Zoom. These recordings will be transcribed by myself. A pseudonym will be given to each participant to avoid personal identification. No personally identifying information will not be added to the final reports of the study. Data will be stored securely in such a way that only myself and the supervisory team will be able to access it. If you wish, a summary of the project findings can be emailed to you.

All resources and documentation will be kept for three years and then destroyed.

What are my Rights as a Participant?

You are under no obligation to accept this invitation. If you decide to participate you have the right to:

- Decline to answer any particular question.
- Withdraw from the study (within 3 weeks after the interview).
- Ask any questions about the study at any time during participation.
- Provide information on the understanding that your name will not be used unless you give permission to the researcher.
- Be given access to a summary of the project findings when it is concluded.
- Ask for the recorder to be turned off at any time during the interview.

Project Contacts

If you have any questions about the study, please feel free to contact me using the following details:

Michelle Musakwa

Michellemusakwa21@gmail.com

Supervisory team

Dr Natasha Tassell-Matamua

N.A.Tassell-Matamua@massey.ac.nz

06 951 8080

Dr Clifford van Ommen

C.VanOmmen@massey.ac.nz

Useful Support Resources

New Zealand Red Cross

NZRC are the primary provider of community refugee settlement programmes in New Zealand. They assist new Kiwis in adjusting to life in New Zealand.

Phone: 0800 RED CROSS (0800 733 2767)

Website: www.redcross.org.nz

Lifeline Helpline

Lifeline is a free helpline to provide support for you or if you are concerned for someone's wellbeing. They offer phone calls or texting services to listen to any issues you may have.

Phone: 0800 LIFELINE (0800 543 354)

Mental Health Crisis Team

If you feel you or someone else is at risk or you're worried about safety. Please contact the Mental Health Crisis Team.

Healthline: 0800 611 116

Please note if this is an emergency, please call 111

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 21/06. If you have any concerns about the conduct of this research, please contact Dr Gerald Harrison, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83570, email humanethicsouthb@massey.ac.nz

C) Consent Form- Individual Interview



Conceptualisation of Mental Health among Black Sub-Saharan African Migrants and Refugees

INTERVIEW PARTICIPANT CONSENT FORM

I have read, or have had read to me, the Information Sheet attached as Appendix I and understand its contents. I have had the details of the study explained to me, any questions I had have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I agree/do not agree to the interview being sound recorded
2. I agree/do not agree to the interview being image recorded. (if via Zoom)
3. I wish/do not wish to have my recordings returned to me.
4. I wish/do not wish to have the transcribes sent to me.
5. I agree to participate in this study under the conditions set out in the Information Sheet

Declaration by participant

I _____ hereby consent to take part in this study.

Signature: _____ **Date** _____

D) Information Sheet – Focus Group

Conceptualisation of Mental Health among Black Sub-Saharan African Migrants and Refugees

Focus Group Information Sheet

Mental wellbeing is a growing research topic around the world. How people understand what this involves differs across social groups. Depending on cultural, social, and personal experiences, ways of viewing wellbeing will vary. It is important to understand this as people's views can have an impact on how they respond to mental health services. As it stands, there is a scarcity of research that specifically focuses on the experiences of Black Sub-Saharan Africans in New Zealand. With minimal understanding in this area, many mental health professionals may have limited cultural competency when working with such clients. As such, the present study aims to address this gap.

The coordinating researcher for this study is myself, Michelle Musakwa. I am a Black Sub-Saharan African migrant. I completed my Honours which examined the acculturation experiences of African migrant women. This study aims to extend from this research and specifically consider mental health experiences. I am conducting this research as part of the requirement of the Doctorate in Clinical Psychology programme as well as to add to the body of literature in this area. The supervisory team for this project is Associate Professor Natasha Tassell-Matamua and Dr Clifford van Ommen.

What is the Aim of the Study?

This study aims to explore how Black Sub-Saharan Africans in New Zealand understand mental wellbeing and manage mental distress. It also aims to understand the attitudes and perceptions held towards mental health services in New Zealand.

What Type of Participants are being sought?

I am inviting Black Sub-Saharan African migrants and refugees over the age of 18 to participate in this study. Participants are required to be fluent in English and have resided in New Zealand for at least one year.

What is Sub-Saharan Africa?

Sub-Saharan Africa constitutes of African countries that lie south of the Sahara. This includes the countries listed in the table below.

Angola	Côte d'Ivoire	Madagascar	Seychelles
Benin	Djibouti	Malawi	Sierra Leone
Botswana	Equatorial Guinea	Mali	Somalia
Burkina Faso	Eritrea	Mauritania	South Africa
Burundi	Ethiopia	Mauritius	Sudan
Cameroon	Gabon	Mozambique	Swaziland
Cape Verde	The Gambia	Namibia	Tanzania
Central African Republic	Ghana	Niger	Togo
Chad	Guinea	Nigeria	Uganda
Comoros	Guinea-Bissau	Réunion	Western Sahara
Congo (Brazzaville)	Kenya	Rwanda	Zambia
Congo (Democratic Republic)	Lesotho	Sao Tome and Principe	Zimbabwe
	Liberia	Senegal	

What will Participants be Asked to Do?

If you are interested in taking part in this study, you will be invited to take part in one focus group conducted via Zoom. Focus groups involve a small number of participants that will discuss the given topic. In this study, discussions will be focused on your opinions of mental health services in New Zealand. Please note that you **do not** have to have engaged in mental health services to participate in this study.

Two focus groups will be held: one for women and another for men. These will take approximately 1-2 hours. However, this can vary depending on the discussions. Short breaks will be offered throughout the discussions. All focus groups will be facilitated by myself. You will be compensated with a \$40 Prezzy card for your time.

In the event that the focus group provokes discomfort, you are welcome to withdraw from the discussions. Furthermore, a list of useful psychological resources has been provided for you at the end of this information sheet. Please note, you are also free to withdraw from the study at any point prior to the focus group.

What Data or Information will be Collected and What Use will be Made of it?

The focus group discussions will be video and audio recorded. The recordings will be transcribed by myself. A pseudonym will be given to each participant to avoid personal identification. All personally identifying information will not be added to the final reports of the study. Data will be stored securely in such a way that only myself and the supervisory team will be able to access it. If you wish, a summary of the project findings can be emailed to you.

All resources and documentation will be kept for three years and then destroyed.

What are my Rights as a Participant?

You are under no obligation to accept this invitation. If you decide to participate you have the right to:

- Decline to answer any particular question.
- Withdraw from the focus group while it is taking part however it will not be possible to withdraw the information you have provided up to that point.
- Ask any questions about the study at any time during participation.
- Provide information on the understanding that your name will not be used unless you give permission to the researcher.
- Be given access to a summary of the project findings when it is concluded.
- Ask for the recorder to be turned off at any time during the interview.

Project Contacts

If you have any questions about the study, please feel free to contact me using the following details:

Michelle Musakwa

Michellemusakwa21@gmail.com

Supervisory team

Dr Natasha Tassell-Matamua

N.A.Tassell-Matamua@massey.ac.nz

06 951 8080

Dr Clifford van Ommen

C.VanOmmen@massey.ac.nz

Useful Support Resources

New Zealand Red Cross

NZRC are the primary provider of community refugee settlement programmes in New Zealand. They assist new Kiwis in adjusting to life in New Zealand.

Phone: 0800 RED CROSS (0800 733 2767)

Website: www.redcross.org.nz

Lifeline Helpline

Lifeline is a free helpline to provide support for you or if you are concerned for someone's wellbeing. They offer phone calls or texting services to listen to any issues you may have.

Phone: 0800 LIFELINE (0800 543 354)

Mental Health Crisis Team

If you feel you or someone else is at risk or you're worried about safety. Please contact the Mental Health Crisis Team.

Healthline: 0800 611 116

Please note if this is an emergency, please call 111

This project has been reviewed and approved by the Massey University Human Ethics Committee: Southern B, Application SOB 21/06. If you have any concerns about the conduct of this research, please contact Dr Gerald Harrison, Chair, Massey University Human Ethics Committee: Southern B, telephone 06 356 9099 x 83570, email

humanethicsouthb@massey.ac.nz

E) Consent Form – Focus Groups



Conceptualisation of Mental Health among Black Sub-Saharan African Migrants and Refugees

FOCUS GROUP PARTICIPANT CONSENT FORM

I have read, or have had read to me, the Information Sheet (Appendix 1) and I understand its contents. I have had the details of the study explained to me, my questions have been answered to my satisfaction, and I understand that I may ask further questions at any time. I have been given sufficient time to consider whether to participate in this study and I understand participation is voluntary and that I may withdraw from the study at any time.

1. I understand that I have an obligation to respect the privacy of the other members of the group by not disclosing any personal information that they share during our discussion.
2. I agree/do not agree to the focus group being sound and image recorded
3. I understand that all the information I provide will be kept confidential to the extent permitted by law, and the names of all people in the study will be kept confidential by the researcher.

Note: There are limits on confidentiality as there are no formal sanctions on other group participants from disclosing your involvement, identity or what you say to others in the focus group. There are risks in taking part in focus group research and taking part assumes that you are willing to assume those risks.

4. I agree to participate in the focus group under the conditions set out in the Information Sheet attached as Appendix I.

Declaration by participant

I _____ hereby consent to take part in this study.

Signature: _____ **Date** _____

F) Confidentiality Agreement – Focus Group

Conceptualisation of Mental Health among Black Sub-Saharan African Migrants and Refugees

CONFIDENTIALITY AGREEMENT

I (Full Name - printed)

agree to keep confidential all information concerning the project “Conceptualisation of mental health among Black Sub-Saharan African migrants and refugees in New Zealand”.

I will not retain or copy any information involving the project.

Signature:

.....

Date:

.....

G) Interview Schedules

Semi-structured interviews:

The purpose of the semi-structured interviews is to explore the first two aims of the study: how Black Sub-Saharan Africans conceptualise mental health and how they manage mental distress. It is important to note that the terms ‘mental disorder’ and ‘mental distress’ are likely to be associated with Western models of what mental health is. As such, it is likely that these terms might be associated with a Western understanding of mental health. As such, to promote more authentic responses, the interviews will be initiated with a question that is broad and emphasises breadth to allow for participants to be free to lead the conversation to areas that they consider to be important.

The following the question that will be asked to initiate the discussion:

- *What is wellness to you? What does it mean to be ‘okay’?*

After this is asked, I will be guided by the participants’ responses and explore further. If a participant uses a particular term to refer to mental health, I will explore their definition and use that phrase to refer to mental health. Following this, if the conversation does not naturally proceed, I will refer to some guided areas. Below are some of the key areas I intend to ask in each interview. The exact phrasing each question is not documented as this will vary depending on the flow of the conversation.

- What the term ‘mental health’ means to participants?
 - How they came to that understanding of mental health
- What their personal experiences with mental distress was like
 - Pre-migration
 - During migration
 - Current experiences

- How they manage their mental health/distress
 - Strategies employed to manage mental distress
 - Explore the preferred vs less preferred strategies
 - Reasons for strategies
 - Differences between the migration stages.
- What good mental health looks like vs ill mental health
- What does ‘mental distress’ or ‘psychological distress’ mean to participants
 - *This question will be asked at the end of the interview as a way to see if there is a difference in the way someone responds when asked directly*

Focus Group Interview Plan

Welcome

The focus groups will commence with a welcome from myself. This will involve a brief description about who I am (e.g. name, where I am from, what I am studying etc). Followed by a brief round of introduction to facilitate a warm environment.

Participants will be encouraged to make their space as comfortable as they wish which may involve making a cup of tea or another beverage. I will check if anyone wishes to do that at this point.

Overview of the topic

This will involve reviewing the information sheet which will include the following:

- The focus groups will involve questions regarding perspectives and opinions around mental health services in New Zealand.
- A review of participants’ rights as detailed in the information sheet.
- Invitation for any questions

- Reminded that there will be breaks during the interview.
- Emphasise that participants do not have to share or answer questions they are uncomfortable answering.

Ground Rules

This will involve a discussion around the general rules of interaction between people in the focus groups.

- General etiquette will be explained
 - o Speak one at a time
 - o Respect of other people's opinions and differing perspectives
 - o Encourage participants to talk together as opposed to talking to me. For example, encouraging clients to add on to a point that another participant has stated.

Focus Group Questions

Accessing Mental Health Services

1. When considering mental health services, what services are you aware of that are available to you.
2. What are your thoughts, feelings, or experiences on accessing mental health services in New Zealand?
 - a. What are some reasons that currently deter you from accessing mental health services?
 - b. Contrastingly, what are some of the reasons that currently appeal to you when thinking of mental health services in New Zealand?
3. What are some of the barriers that you have experienced or anticipate would occur when trying to access or accessing mental health services in New Zealand?

- a. What have been the difficulties that you experienced regarding being African and accessing mental health services.
4. What would have helped you or would help others in the future in seeking and finding help for mental health problems.

Expectations of Mental Health Services and Practitioners

5. What kind of support do you expect to receive from mental health services or professionals?
6. What aspects of African culture or African social norms do you think would be important for mental health clinicians working with Africans to know?
7. What are some of the difficulties have you experienced, or do you anticipate might happen when a Black African works with mental health practitioner?

Concluding Questions

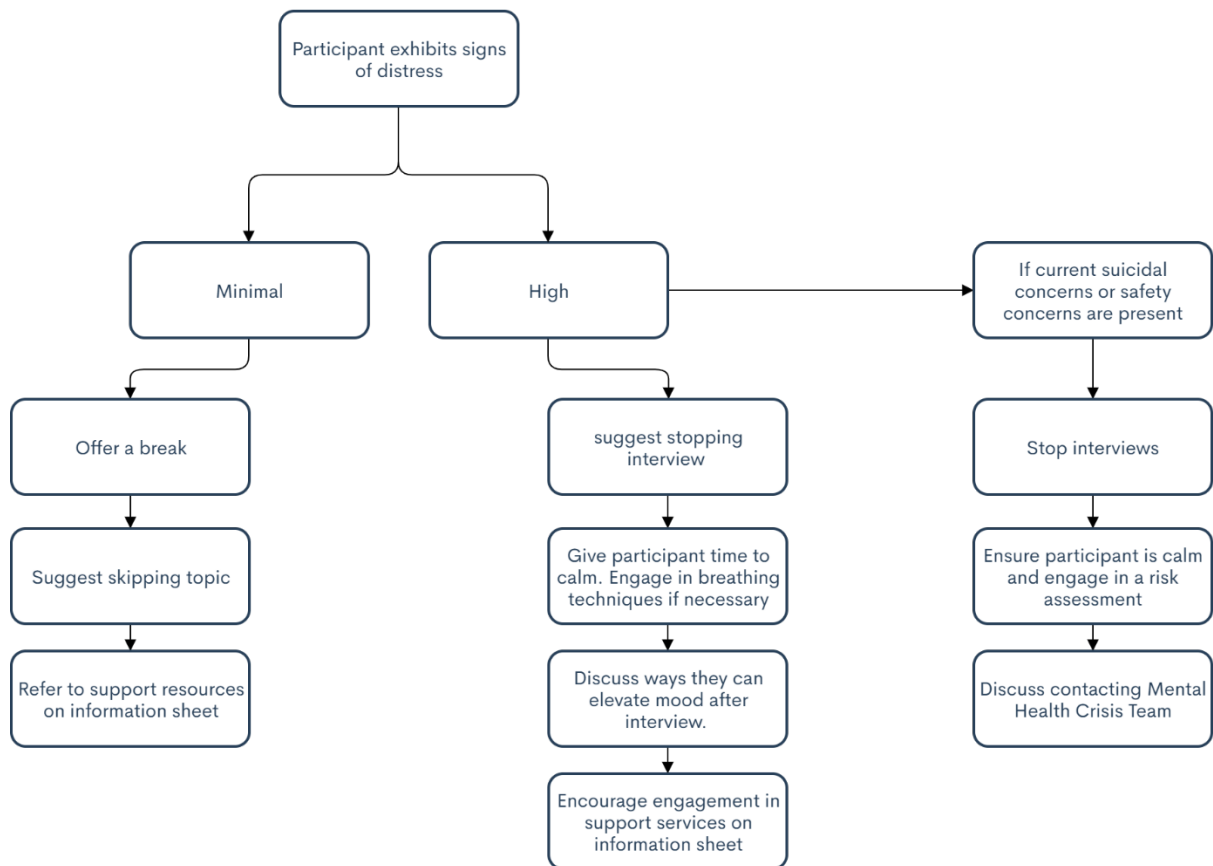
8. What is something we have not yet discussed that you would like to discuss?
9. What was the most important issue that we have talked about today?

Closing Format

I will thank the participants for their participation and explain the process of the compensation. I will also engage in generic conversation to ensure that I leave participants with a lighter note.

H) Risk Management Flow Chart

Participants' Safety:



Researcher's Safety:

Researcher will debrief with supervisory team after all interviews to ensure adequate support.

I) Research Case Study

Massey University

Clinical Psychology

Application of Doctoral Research Reflections on Clinical Practise

In accordance with the Code of Ethics for Psychologists Working in Aotearoa/New Zealand the privacy of any clients is maintained using pseudonyms and adapting identifying information.

Candidate: Michelle Idah Musakwa

Student ID

Setting: Ara Poutama, Department of Corrections

Supervisor: Dr Melanie Simons and Dr Chelsea Dowling

Word Count: 4468

Candidate:

Michelle Idah Musakwa
Intern Psychologist
Ara Poutama Aotearoa, Palmerston
North

Supervisor

Dr Clifford van Ommen
Senior Lecture
Massey University, Auckland

Abstract

My doctoral thesis explores the mental health experiences of Black Sub-Saharan Africans in New Zealand. A key theme in the study is the importance of culture and the impact it has on wellbeing. To be an effective clinician, it is important to consider the cultural context of clients. This involves the continuous development of cultural competence. Cultural competence is comprised of three key mechanisms: awareness, knowledge, and skill (Sue & Torino, 2005). Hays (2016) also adds four key characteristics therapists should have as a foundation for cultural competence. These include humility, compassion, critical thinking, and courage. The present case study will summarise my doctoral thesis to date, discuss cultural competence, and reflect on my clinical practice while working in Ara Poutama.

Doctoral Research Overview

Introduction

The number of Black Sub-Saharan African migrants and refugees in New Zealand continues to increase (Stats NZ, 2018). However, there is still limited understanding regarding the mental health experiences of people from this population. Black African migrants and refugees have a complex culture that is entrenched and shaped by factors such as African traditions, a history of colonisation, racial discrimination, and acculturation experiences (Jackson, 1999; Johnson, 1994; Nkulu-N’Sengha, 2005; Nunn, 2012; Viriri & Mungwini, 2010). All these experiences affect the epistemological and phenomenological views they hold about the world and their experiences within the world. According to Kleinman (1980), how an individual conceptualises illness will affect how they respond to treatment. As such, it is difficult for health professionals to provide culturally informed services without adequate knowledge of how individuals understand mental illness. Therefore, the present research aimed to understand how Black Sub-Saharan Africans conceptualise mental health experiences. Increasing the body of literature in this area will promote an appropriate ethos of engagement for clinicians working with Black Africans in New Zealand.

Personal Inspirations for the Study

My initial interest in the study began during my work as a receptionist at Anxiety New Zealand Trust. I had the privilege of seeing different clients engage in the service; however, I never saw any Black Africans. This experience sparked my curiosity, and I wondered whether there were barriers to seeking support. For this reason, I engaged in informal discussions with my Black African friends to hear their views. They advised that although they believed there would be benefits in engaging with psychological services, they had general reservations towards engaging with mental health services in New Zealand. The combination of personal experiences and the scarcity of literature in this area created the foundation for this study.

Brief Literature Review

Psychological Distress Experienced by African Migrants and Refugees

As it relates to Black Sub-Saharan Africans, exposure to war-torn countries and other traumatic events places them in a vulnerable position to developing symptoms associated with a trauma response. A recent study by Idemudia and Boehnke (2020) examined the impact of pre- and post-migration stressors on mental health and post-traumatic stress disorder (PTSD). This study

employed a mixed methodology and found that the stressors experienced during the pre-migration stage can predict PTSD. However, variability across different countries was noted, indicating that the post-migration environment impacts mental health. Literature suggests that the presence of PTSD is more likely among individuals who are refugees than migrants due to the forced nature of their migration (Onyut et al., 2009).

Another Paris-based study by Pannetier et al. (2017) found that gender differences can occur between African migrants. Specifically, depressive and anxiety symptoms were associated with pre-migration factors in women. In contrast, among men, the same symptoms were associated with factors that threatened their migration experience, such as visa difficulties. In addition to migration-related disorders, a review article by Wilson (2001) noted that Black women in Britain were more likely to be diagnosed with schizophrenia. Similar sentiments were noted by Sutherland (2016) regarding both men and women. As highlighted by Sutherland (2016), the disproportionate findings bring into focus the racial disadvantages experienced by Black people. With little understanding of Black mental health experiences, it becomes difficult to ascertain whether the resources used to assess migrants held adequate cultural competency and acknowledged the cultural nuances of the individuals.

Although these studies provided useful information and insight into some of the mental health disorders among Black Africans, they do not delve into how people understand these experiences. However, one study by Whittaker et al. (2005), which utilised a qualitative approach, investigated how Black Somalian refugees and asylum-seekers in the UK understand their experiences with mental health. Results from this study indicated the importance of religious beliefs and spirituality in explaining the aetiology and maintenance of mental distress. Religion and spirituality are often core aspects of African cultures and influence their views about different phenomena, such as mental health (Egbe et al., 2014; Koenig, 2009). Historically, the relationship between religion and mental health was often considered controversial (Moreira-Almeida et al., 2006). However, as highlighted in Whittaker et al.'s (2005) study, aspects such as these affect how people approach mental health. For example, the level of religiosity a person holds can impact their use of mental health services (Harris et al., 2006). Without further research exploring such conceptualisation, there remains a gap in understanding people's experiences.

There have been a few studies that examine the mental health of Africans in New Zealand. However, most literature does not focus specifically on Black Sub-Saharan Africans. Most

studies look at the acculturation experience of Africans and focus on how people adjust to life in New Zealand (e.g. Bennett et al., 1997; Philipp & Ho, 2010; Udahemuka & Pernice, 2010; Winbush & Selby, 2015). Although this provides valuable information, it does not consider the nuanced cultural factors that influence the experience of mental distress. The proportion of literature that either focuses on or includes Black Sub-Saharan African participants is relatively small. Since they comprise a small percentage of the population in New Zealand (Stats, 2018), they are often neglected in the literature or clustered with other cultural groups. This issue makes it difficult to extrapolate information on their experiences.

Support for Psychological Distress.

It is essential to consider how Black Sub-Saharan Africans receive New Zealand mental health support services. As such, this section will examine some protective factors and help-seeking barriers that tend to exist for immigrants. Some migrants seek support from other sources other than mental health services. This is particularly true for cultural groups with a holistic health perspective. A study by Burns and Tomita (2015) found that Africans in Southern Africa tend to seek support from traditional and faith healers. The World Health Organisation (2019) defines traditional healers as individuals who utilise practices based on a community's beliefs and Indigenous theories. There are many variations of traditional healers among various African tribes (Patel, 2011). However, the main healers include herbalists and witch doctors (Okello & Musisi, 2015). Depending on the type of healer, they will engage in practices to help the individual. Herbalists will utilise natural herbs, while witchdoctors tend to use traditional practices to contact ancestral spirits to help the individual with the distress they may be experiencing (Freeman & Motsei, 1992; Okello & Musisi, 2015).

In addition to traditional healers, others seek the support of faith healers. A faith healer can be defined as a religious leader who provides advice, prayer, or exorcisms to support individuals with illnesses (Koenig, 2009). As Koenig (2009) and Mayeya et al. (2004) highlight, many Africans tend to prefer faith healers to mental health services. The primary reason participants indicated was the religious beliefs they held. Furthermore, in Whittaker et al.'s (2005) study, Black Somali refugee and asylum seeker women presented themes of resilience during adversity and having strong social support as factors that help manage mental distress. In both these studies, their conceptualisation of mental health likely guided participants to seek support in these areas compared to healthcare professionals.

Although these pre-existing protective factors impact whether Africans access mental health services, some barriers may discourage seeking help. The barriers noted in the literature include stigma, lack of mental health literacy, absence of culturally competent resources, and a financial burden (McCann et al., 2016). Many African cultures tend to view mental health with a negative stigma. Beliefs such as demon possession and ancestral curses have impacted how people view mental health (Adewuya & Makanjuola, 2008). As such, mental distress is often stigmatised. Some Africans with mental distress symptoms have a negative self-perception in addition to the stigma in society that affects their desire to seek support (Makanjuola et al., 2016). Whittaker et al.'s (2005) study found themes that suggested a paradox where people wish to seek support but also value the concealment of their psychological distress. Thus, it makes it difficult for people to engage in the services offered. Furthermore, most Africans come from societies where mental health is considered secondary to other aspects of health (Richards et al., 2012). Despite experiencing significant distress, they do not seek support due to minimising the experience (Whittaker et al., 2005). Understanding these barriers is, therefore, essential as they affect how an individual is likely to respond to therapy.

In New Zealand, there are no studies that examine the attitudes and perceptions that Black Sub-Saharan Africans have toward mental health services. Corrigan (2004) argues that individuals with a negative perception of mental health services are less likely to experience the benefits of therapy sessions. Given that the literature above indicates that Black Africans may have cultural barriers that influence their relationship with mental health services, it is important that an understanding of some preconceived ideas is established. Although not every African will share the same viewpoints due to individual differences, having a general foundation of some common perceptions would be helpful. It can allow mental health professionals to increase their awareness and be sensitive to perceptions that might hinder the therapeutic process. Overall, research into this area will promote ethics of engagement with the African community in New Zealand.

Research Questions

The main question for my doctoral study was, "what is the lived experience of mental health among Black Sub-Saharan African migrants and refugees in New Zealand?". To explore this, secondary objectives were established. This included exploring their conceptualisation of mental health and mental distress, management of mental distress, and the attitudes and perceptions held toward mental health services in New Zealand.

1. *Conceptualisation and Management of Mental Health Experiences*

Based on Kleinman's (1980) Explanatory Model of Health Framework, how clients create meaning of their mental health experiences has implications on their reception to treatment. As such, this study aimed to establish an understanding of mental health and associated distress from the perspective of Black Africans. Secondly, exploring how Black Africans manage mental health provides insight into the factors that they consider important to well-being.

1. *Attitudes and Perceptions toward Mental Health Services in New Zealand.*

It is important to consider how mental health service providers are viewed among Black Africans. As highlighted by Corrigan (2004), a person's perceptions towards service providers can have implications on the therapeutic process, which can either strengthen or inhibit treatment. As such, examining these attitudes and perceptions is essential for clinicians.

Methodology

This study utilised a qualitative approach to explore participants' experiences. Under the umbrella of qualitative research, the study employed an Interpretative Phenomenological Analysis (IPA). IPA is a methodology that examines how a person makes sense of a particular phenomenon (Pietkiewicz & Smith, 2014). It is grounded in phenomenology, hermeneutics, and idiography (Smith et al., 2009). IPA has its epistemological positioning in constructivism which asserts that human knowledge is constructed, and individuals attribute their own meaning to phenomena (Gray, 2014; Moon & Blackman, 2014). This theoretical framework was considered the most appropriate for the present study.

Participants

A convenience sampling method was utilised for this study which was considered ideal for research that targets a small population (Naderifar et al., 2017). Participants were recruited through online African community groups on social media platforms such as Facebook and Whatsapp. The research advertisement was shared among the African community, resulting in a snowball recruiting method. In addition, relevant organisations such as Red Cross and the Multicultural Centre in Palmerston North were approached for recruitment. All participants were Black Sub-Saharan Africans, over 18 years old, fluent in English, and had resided in New Zealand for more than one year.

Method

Potential participants were sent information sheets about one-on-one interviews and focus group interviews. They were invited to participate in either one or both of the interviews. Once they expressed their preference, they were sent relevant consent forms prior to the interviews.

Semi-Structured Interviews

A total of nine interviews were administered and ranged between one to two hours. The semi-structured interviews were utilised to explore how participants conceptualise mental health and manage associated distress. All interviews were conducted via Zoom Meetings, a video-conference call application. Although an interview schedule was prepared, the content of the interviews was participant-led and dependent on the participants' responses.

Focus Group Interviews

The focus group interviews were employed to explore the attitudes and perceptions of mental health services. As Gibbs (1997) highlighted, focus groups allow participants to reflect on each other's feelings and experiences about a particular topic. Two focus groups with Black African women were held using the Zoom application. Five participants were allocated to each group. Group allocations were based on participants' time availability. Each group was facilitated by the researcher and ran for two to three hours. Although an interview schedule was prepared, the progression and flow of the interviews were primarily participant-led. Due to recruitment difficulties, a focus group with African men is yet to be completed.

Data Analysis

Analysis of the data will commence following the internship year. The study will adopt two forms of data analysis. An Interpretative Phenomenological Analysis (IPA) will be utilised for the one-on-one interviews. This approach takes an idiographic approach and seeks to understand how an individual makes sense of a given phenomenon (Smith et al., 2009). For the focus group interviews, a thematic analysis will be utilised. This approach will examine the key themes that arose from each group discussion. The key findings will be reported based on the analysis results.

Literature Review

Cultural Competence

My doctoral thesis highlighted the importance of considering culture when working with people. Although there are numerous definitions of culture (e.g. Allan, 1998; Eagleton, 1978), Betancourt and Lopez (1993) conceptualised it as the shared behaviours, norms, beliefs, and tradition that a particular social group hold. These social groups can include but are not limited to ethnicity, racial background, or socioeconomic status (Betancourt & Lopez, 1993). A person's cultural identity can impact their values and how they experience the world around them. This includes how they understand what healthy wellbeing is and deviants from that (Mio et al., 2006). Therefore, cultural identity can influence a person's mental health experience and understanding (Mio et al., 2006). As such, psychologists should consider the cultural context of the people they work with.

Sue and Torino (2005) define cultural competence as “the ability to engage in actions or create conditions that maximise the optimal development of the client and client systems”(p. 8). It refers to a clinician’s ability to support individuals in a way that acknowledges culture and its central role in mental wellbeing (Westerman, 2010). Thus, cultural competence becomes essential for psychologists to ensure appropriate accommodation and respect for a client’s context (Frisby, 2018). As highlighted by Leong et al. (2016), cultural context should guide all aspects of clinical work, including assessment, diagnosis, and treatment (Hays, 2016). The following literature review will consider the three main components of cultural competence: awareness, knowledge, and skills (Bassey & Melliush, 2013; Frisby, 2018; Jones-Smith, 2018). Furthermore, Hays (2016) proposed key personal characteristics psychologists should have when considering cultural competence, which will be discussed.

Awareness

Johns-Smith (2018) positioned cultural awareness as the first step in developing cultural competence. Awareness refers to a clinician’s ability to acknowledge the impact of their cultural influences on the therapeutic process (Sue et al., 2019). As such, a crucial first step is for psychologists to understand their cultural context and the social influences that play a role in making meaning to phenomena (Sue & Torino, 2005). As highlighted by Collins and Arthur (2007), it is important for psychologists to be aware that their worldview is shaped by their personal, professional, cultural, and contextual factors. These factors can result in differences in communication and understanding of health between psychologists and clients (Bassey &

Melluish, 2013). Since this can impact the therapeutic alliance, psychologists are recommended to continuously question how their preconceived biases and assumptions regarding what is considered 'normal' may impact the assessment and treatment processes (Sue & Torino, 2005).

Knowledge

The second component of cultural competency is knowledge. While awareness refers to personal reflections on one's processes, knowledge refers to understanding the worldview of culturally diverse clients (Sue & Torino, 2005). Frisby et al. (2018) purport that it is a clinician's responsibility to engage in additional research to address knowledge gaps of the different cultural nuances of clients. Psychologists are advised to understand the cultural norms specific to the people they work with (Sue et al., 2019). In addition, knowledge regarding communication styles and language patterns can be useful in developing a meaningful working alliance with people (Frisby, 2018). As the cultural context is shaped by historical and social events, Sue et al. (2019) argue that it is important to be aware of the sociohistorical context in which clients' worldview develops. This can help delineate client/clinician differences and allow for the mitigation of any potential stigma or biases that might arise. In addition, understanding the sociohistorical context involves knowing the institutional barriers that might prevent clients from engaging in mental health services (Sue & Torino, 2005). Overall, developing cultural knowledge can then be useful in creating a culturally safe environment for clients.

Skills

Lastly, developing skills in cultural competence refers to the practical ability to implement appropriate interventions and strategies when working with different groups (Bassey & Melluish, 2013). According to Hays (2016), self-awareness and knowledge about a client should inform decisions that promote culturally safe practices. This involves adopting evidence-based practice relevant to the client's identity. Psychologists are encouraged to critically analyse the appropriateness of the measures and therapy modalities they utilise (Sue et al., 2019). Extending beyond accessing literature, utilising relevant support persons such as cultural supervision or referring to appropriate cultural services is part of developing skills in cultural competence (Sue & Torino, 2005). Thus, the development of awareness, knowledge, and skill creates a foundation by which cultural competence can be enhanced.

Personal Characteristics

Hays (2016) identifies four personal characteristics psychologists should hold when considering cultural responsiveness. These include humility, compassion, critical thinking, and courage. Humility is the understanding that a clinician's views are not the only perspective available. It involves acknowledging that clients may hold different perspectives and attempts to avoid imposing judgment on clients' understanding of the world. Similarly, compassion seeks to appreciate those different views that clients may hold and appreciates any challenges they may present to those differences. Hays (2016) argues that critical thinking allows psychologists to continuously question their biases and consider alternative explanations for clients' experiences. Lastly, Hays (2016) asserts that courage is an important characteristic for psychologists to be culturally responsive. This refers to a clinician's willingness to work with diverse populations and engage in meaningful work despite the difficulties that might be involved in shifting personal paradigms. Hays (2016) argued that these characteristics create a foundation for psychologists to be more culturally responsive.

Clinical Reflections

My doctoral thesis has been instrumental in my clinical practice. As I began my journey as a psychologist, I understood the importance of culture and how it impacts the people I work with. The following section will detail my reflections regarding my internship at Ara Poutama and the components of cultural competence.

Awareness

Strengths

My internship year has been a journey of self-discovery and acknowledging how this affects my practice. I identify as a Black African migrant Christian woman. These five identities have shaped how I see the world and my values. From a young age, it was evident that within a New Zealand context, I was a minority and the way I conceptualised my experiences differed from the dominant culture. As such, I was always aware of people's differences and how there can be multiple ways of understanding the same phenomena. As such, I found connecting with people from a minority background easier. The idea of colonisation, intergenerational trauma, and racism were not foreign concepts as they were themes evident in my history. Given that majority of the clients I work with are Māori and hold a similar history, there were elements of their experiences that I could relate to, which helped enhance my understanding of their context.

Areas of Development

As much as there were benefits, challenges came from my cultural identity and clinical practice. As I identify with a minority group, I always assumed that I understood the implications of culture and its complexities. However, I was naïve in my belief that my experiences as a Black woman would mean I could understand *all* experiences of minority groups. My internship has been humbling and emphasised how nuanced and unique culture truly is. I have begun recognising my biases and how they have coloured my engagement with clients. For example, in as much as whakapapa is important to Māori clients, for various reasons, some people cannot give an account of their whakapapa. Many clients have a significant trauma history that has led to insecurities around their background, and it can be daunting to be asked to account whakapapa to a psychologist who is a stranger. As such, I learned the importance of being aware of unintentionally eliciting feelings of whakama because

of unhelpful assumptions. Now, I approach these discussions with sensitivity and awareness of the importance of individual differences.

Emic and Etic Approach

When I started my thesis, I thought it would be easy to understand the perspectives of my participants, as a Black African myself. However, as I heard their stories, I realised that culture is much more than ethnic identity or the shared experiences brought forth by the colour of our skin. My participants taught me that aspects such as religion, sexual orientation, or even the city we live in could bring forth cultural differences beyond ethnicity. As such, during the research process, I learned how to adopt both an emic and etic position. I also learnt that both perspectives hold their own strengths. While holding an emic position allowed for a quick connection and a deeper understanding of a person's experiences, an etic approach allowed for the adoption of a naïve inquirer stance, which promoted further explorations into their experiences.

One of the strategies I used to connect with clients was offering to start the session in a way that is special or important to them. Ironically, while encouraging clients to do this, I was simultaneously too embarrassed to ask my clinical supervisors if I could open supervision with a Shona prayer. It was only when I became significantly stressed and was trying to find a way to make the difficult internship year a little more comfortable that I finally became brave enough to ask. It was the most validating and welcoming experience to open supervision in a way that was important to me. Through this personal experience, I realised how incredibly powerful it could be to allow a person's identity to shape the process of engagement. Further, it exposed how difficult it might be for the people I work with to tell me if they would like to do something to make the sessions more comfortable. Now, when I ask people if there is a way they would like to open the session, it is with more intentionality. This experience highlighted that when we become more aware of our own processes, we can develop a sensitivity to cultural competence.

Knowledge

Developing cultural knowledge has been incredibly challenging but rewarding. The challenge stems from realising my lack of knowledge regarding various cultural groups. I have needed to increase my knowledge about working with various clients and allow extra time to develop that knowledge. As hard as it has been, the rewards have matched the difficulty. The people I have worked with have shown genuine appreciation when I take the time to learn more about the

factors that are important to them. It highlighted the importance for psychologists do their best to bridge knowledge gaps.

Cultural Supervision

I have learnt the importance of cultural supervision when engaging with individuals from different cultural backgrounds. There were many times my cultural supervisor would provide advice regarding my clients that would surprise me because of my limited knowledge. It reinforced a sense of humility and promoted the importance of understanding a person's experiences from their perspective. Cultural supervision exposed the biases that I had about my clients' experiences. I was reminded that experiential knowledge will always be missing when working with clients who hold a different perspective from me. As such, I need to adopt a naive enquirer position to ensure that my conclusions are not based on stereotypes and biases. This has helped facilitate meaningful discussions with clients about how they lead their lives and understand their experiences from their perspective.

Skill

Awareness and knowledge are important; however, without the skill to overflow from the two, cultural competence will never develop. I have found the application of cultural skills to be the most difficult part of development. Interning at Ara Poutama has provided the opportunity to work predominantly with Māori male clients who have differing connections with Te Ao Māori. My anxiety about respecting someone's cultural identity resulted in overcompensation. This was shown as one of the mistakes I made with clients who held a strong connection with Te Ao Māori was only discussing their cultural identity while neglecting other aspects of a clinical assessment. I would walk out of an hour-long appointment without any information regarding their presenting problems or their current functioning. The combination of wanting to acknowledge every aspect of their identity while simultaneously trying to manage my anxieties resulted in an excessive discussion of ethnic identity that was not client-led. When reflecting upon this experience, I realised I did not learn anything about how their cultural experiences related to their mental wellbeing. In this way, the kaupapa of the meeting was not met. Through self-reflection and discussions with my supervisors, I learned the importance of being intentional in applying cultural discussions with clients. Cultural safe practice does not equate to random questions about a person's identity. It is about *intentionally* exploring a person's context and considering how this might impact their presentation, assessment, formulation, and

overall therapeutic engagement. As such, I have been challenging myself to be mindful of my processes and frequently reflect on my clinical rationale for my decisions.

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