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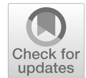

RESEARCH IN PROGRESS

Seeking Professional Help for Mental Illness: A Mixed-Methods Study of Black Family Members in the UK and Nigeria

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Abstract Seeking professional help for mental illness is a limited practice among Black family members in low and middle socioeconomic groups in the United Kingdom (UK) and Nigeria. Guided by the theory of planned behavior, we explored some factors restricting professional help-seeking practices among the target groups. This mixed-methods study recruited a heterogeneous sample of 105 (ranging from 19–64 years) UK and Nigerian Black family members in low or middle socioeconomic groups. Data were collected using a standardized questionnaire and open-ended questions. Collected data were analyzed using IBM SPSS statistics (version 22.0) and thematic analysis. There was no statistically significant difference in professional help-seeking behavior among the UK and Nigerian Black family members in low and middle socioeconomic groups [F (3, 83) = 1.13; $p > .05$]. The qualitative data analysis revealed that respondents were limited from professional help-seeking due to high consultation fees to see a mental health professional, perceived accessibility to mental health services within their various locations, stigmatization and socio-cultural factors (such as, "The perception that a man should be strong" or "Mental health isn't as important as physical health"), concerns about the safety of information shared during professional help-seeking or therapy sessions, poor knowledge about mental health services, long waiting time to see a professional in face-to-face therapy, and risk of contracting the infectious disease in the hospital setting. Implications of findings for theory and practice and direction for future research are thus discussed.

Keywords Professional help-seeking · Mental illness · Black families · Mixed-methods study · The UK · Nigeria

Abbreviations

The UK	The United Kingdom
SES	Socioeconomic status
APA	American Psychological Association
ANOVA	Analysis of variance
SPSS	Statistical package for the social sciences
COVID-19	Coronavirus disease 2019

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Introduction

To seek professional help for mental illness means that formal sources rather than informal sources are the point of contact for persons living with mental illness. The source preference (i.e., formal or informal source) from which Black family members seek mental health help remains one of the major psychosocial factors explaining their mental health (Ampadu, 2015; Broman, 2012; Campbell, 2017; Chebbet, 2012; Chineme et al., 2016; Cooper, 2016; Cooper-Patrick et al., 1999; Hackett, 2014; Issack, 2015;

Labys et al., 2016; Masuda et al., 2012; McCann et al., 2016; Neighbors, 1984; Ogueji & Constantine-Simms, 2019; Ogueji et al., 2020; Rosenblatt & Mayer, 1972; Taylor, 2018; Taylor & Kuo, 2019; Ward et al., 2013).

The United Kingdom (UK) and Nigeria have been established to report poor professional help-seeking behaviors for mental illness among Black family members, despite the fact that the prevalence of mental illness among the Black family members in these countries is on the high side (Adam & Aigbokhaode, 2018; Adamson et al., 2003; Erinosho & Ayonrinde, 1981; Lasebikan et al., 2012; Latunji & Akinyemi, 2018; Memon et al., 2016; MHFA England, 2019; The Sainsbury Center for Mental Health, 2002). This persistent problem among the UK and Nigerian Black family members could be a result of the fact that the impact of socioeconomic status (SES) and other psychosocial barriers on professional help-seeking behavior involving a comparison of Black family members in the UK and Nigeria have not been a point of study for many mental health researchers (e.g., Adam & Aigbokhaode, 2018; Latunji & Akinyemi, 2018; MHFA England, 2019). We are interested to compare the UK and Nigerian Black family members due to the potential impact of environmental and cultural differences on their behaviors, as well as the potential partnered interventions that could be informed between their respective governments through a comparative study (Afolabi et al., 2020; Furnham & Igboaka, 2007). For instance, Nigerian family members have been found to attribute supernatural and sociological factors (e.g., spirit possession) as causes of mental illness than the UK family members (Furnham & Igboaka, 2007). Also, significant differences have been reported in the perception of depression and social support among Nigerian and British mothers (Afolabi et al., 2020). These findings in the literature have been used to suggest partnered mental health interventions between the UK and Nigerian governments (Afolabi et al., 2020; Furnham & Igboaka, 2007). However, professional help-seeking for mental illness remains a problem. Comparing the UK and Nigerian Black family members could strengthen the importance of including culturally appropriate mental health interventions in mental health care for Black people, and this has been emphasized for further studies in the literature (Banks, 2020).

Although there are arguments in the literature that socioeconomic status and other psychosocial factors (e.g., perceived seriousness of the mental illness, stigmatization, socio-cultural factors, issues of confidentiality, etc.) have the potential to influence professional help-seeking (e.g., Ikuwka et al., 2016; Memon et al., 2016), it, however, remains unclear if this is true from a comparative study involving Black family members in the UK and Nigeria where many unknown barriers limit these target groups from seeking professional help.

To address this problem, the current study investigated the professional help-seeking behaviors of the low and middle socioeconomic group of Black family members in the UK and Nigeria. This study also aimed to identify other psychosocial barriers that limit the professional help-seeking behaviors of the target groups. A psychosocial barrier was defined in the current study as any psychological or social barrier that respondents perceived as limiting their professional help-seeking behaviors.

The choice for selecting the low and middle socioeconomic Black groups as a target group is that related studies have strongly suggested that in comparison with the high socioeconomic Black group, the low and middle socioeconomic groups are often the most disadvantaged when professional help-seeking for mental illness is concerned (Arday, 2018; Erinosho & Ayonrinde, 1981; Ikwuka et al., 2016; Islam et al., 2015; Lasebikan et al., 2012; Memon et al., 2016; Menberu et al., 2018; Rudell et al., 2008). Also, globally, Black family members make up a greater proportion of the population of individuals in low and middle socioeconomic groups, than in a high socioeconomic group, and these Black family members often face social challenges that limit their access to health care services, including mental health services (although the social challenges may be less for Black family members in middle socioeconomic groups in developed countries) (Mental Health Foundation, 2019). Additionally, many a time, socio-political forces (e.g., history of racism, membership to the low socioeconomic group, etc.) contribute to inequalities in the healthcare system among Black family members, and this has associations with poor professional help-seeking behaviors (Cénat, 2020; Cloos & Bilsen, 2021), and poor health outcomes for Black family members (Blom et al., 2016; Ogueji & Okoloba, 2022), unlike White people and Black people in higher socioeconomic groups who may experience less of this (Levine et al., 2016).

Socioeconomic status is often complicated to measure (Fadnes et al., 2008). This is given the fact that socioeconomic status is not determined by a person's income alone. In our study, we thus defined socioeconomic status based on a consensus in the educational attainment, yearly income, and occupational prestige of respondents as informed by recommendations from literature (American Psychological Association, 2015; Bofah & Hannula, 2017; Lorant et al., 2007). Our definition was imperative given that our study included a focus on the impact of low/middle socioeconomic status on professional help-seeking behaviors (APA, 2015).

The current study employed the theory of planned behavior (Ajzen, 1985) to explain how socioeconomic status or other psychosocial barriers may impact

professional help-seeking behaviors. According to the theory, the perception of the extent of favorability of behavior, the subjective norms about behavior or a related behavior, and the perceived behavioral control (internal control or external control) of the behavior performer are salient factors that may impact the professional help-seeking behavior of individuals.

Applying this theory is suggestive that the target group of the current study may have their professional help-seeking behaviors impacted by the extent to which they perceive external factors such as socioeconomic status as having control over their professional help-seeking behaviors. Additionally, the target group may have their professional help-seeking behaviors impacted by other psychosocial barriers such as subjective norms about professional help-seeking. Therefore, exploring the potential impact of socioeconomic status and other psychosocial barriers on professional help-seeking behavior is imperative to mitigate some barriers to professional help-seeking behavior.

In this regard, the following research questions were explored: (a) Will low or middle socioeconomic status significantly influence the professional help-seeking behaviors of UK and Nigerian Black family members? To gain insights into the other psychosocial factors limiting professional help-seeking behaviors, we asked: (b) What other psychosocial barriers limit Black family members in low and middle socioeconomic groups in the UK and Nigeria from seeking professional help for mental illness? Finally, (c) What is/are the implication(s) when results from the first and second research questions are mixed?

Based on the review of the literature (e.g., (Arday, 2018; Blom et al., 2016; Cénat, 2020; Cloos & Bilsen, 2021; Erinosho & Ayonrinde, 1981; Ikwuka et al., 2016; Islam et al., 2015; Lasebikan et al., 2012; Levine et al., 2016; Memon et al., 2016; Menberu et al., 2018; Mental Health Foundation, 2019; Rudell et al., 2008), we hypothesized that:

The UK Black family members in the middle socioeconomic group will have a significantly higher professional help-seeking behavior than the UK Black family members in the low socioeconomic group, and Nigerian Black family members in the low or middle socioeconomic group.

Methods

Design

This mixed-methods study collected data via social media (Facebook), targeting UK and Nigerian Black family members in low and middle socioeconomic groups. A mixed-methods design was worthy of consideration as it was the most suitable research design given the aim of our study and our research questions (Wisdom & Creswell, 2013). Further, a mixed-methods study has strongly been advocated by scholars interested in understanding professional help-seeking behaviors (Mmari et al., 2016; Ogan et al., 2015), and it has often yielded high-quality results in other studies that adopted it (e.g., Turnbull et al., 2019). The design employed in our study enabled the qualitative strand to elaborate on the results of the quantitative strand. Our mixed-methods design complied with the APA style of journal article reporting standards for mixed-methods study (APA, 2018).

The current study was divided into two; the first strand relied on quantitative data to establish the impact of low or middle socioeconomic status on professional help-seeking behaviors among respondents; whereas, the second strand obtained qualitative data to identify the other psychosocial barriers limiting the professional help-seeking behaviors of respondents. In the quantitative strand, the independent variable was socioeconomic status (low or middle), whereas the dependent variable was professional help-seeking behavior for mental illness. Respondents were recruited using the snowball technique in both strands (a statement politely requesting recruited respondents to roll out the survey link to prospective respondents was included in the survey). We also employed mental health stakeholders (e.g., mental health practitioners) in the UK and Nigeria to support rolling out the survey link. To participate in our study, we required that willing respondents were adult (18 years or above) members of the UK or Nigerian Black families who belonged to either low or middle socioeconomic groups. It was also required that respondents had access to a digital device, internet, and could communicate (written & verbal) using the English language.

Instruments

An online data collection form (survey monkey) was utilized throughout the study. Before conducting the main study, we pre-tested with 25 Black family members (UK = 15; Nigeria = 10) who were not part of our main study. We also subjected to content validation with five mental health professionals (two psychiatrists and three clinical psychologists). We pre-tested and subjected to content validation all research instruments in order to establish their feasibility (Krippendorff, 2013; Saunders et al., 2009). The pre-testing and content validation revealed very high feasibility and consistency from all our research instruments. The respondents in the pre-testing and content validation phase were randomly recruited from Twitter. They were informed that they would not be part of

the main study to avoid information contamination, and they all consented to be excluded from the main study. We also maintained contact with them throughout the main study.

The American Psychological Association (APA, 2015) has recommended that researchers interested in the influence of socioeconomic status on mental health concerns should consider factors such as occupational prestige, yearly income, or highest education attained when measuring socioeconomic status. Scholars have further recommended that, during measurements of socioeconomic status, errors may be minimized by requesting respondents to match an appropriate socioeconomic group with their occupational prestige, current income, or highest education attained, and researchers should crosscheck for correlations in what was matched by respondents (Bofah & Hannula, 2017; Lorant et al., 2007). The same scholars and the APA recently cited submitted that this technique reduces the overestimation of socioeconomic status from respondents, as compared with most other forms of self-report measures for measuring socioeconomic status.

Therefore, we defined socioeconomic status (low or middle) based on insights offered by the literature, and we asked respondents to match an appropriate socioeconomic status with their educational attainment, occupational prestige, and yearly income. Also, we asked respondents to open-endedly justify their choice for selecting any socioeconomic status, and we crosschecked for consonance in what was reported by respondents. We found that most respondents (58.6%) rated their socioeconomic status as low, despite that most respondents have attained education from tertiary institutions. The major reason given by the respondents was that although they had degrees from tertiary institutions, their living conditions, yearly income, or occupational prestige did not equate to a middle socioeconomic status. For instance, we noticed that most respondents (58.6%) despite having gained degrees from tertiary institutions, submitted their yearly income as less than £ 16,000 (< 7,864,700.80 NGN). In another instance, we noticed that on a scale of 0–10 most respondents (58.6%) despite having gained degrees from tertiary institutions rated their current occupational prestige below 5. This is suggestive that during the measurement of socioeconomic status, the common survey error of overrating one's socioeconomic status based on educational attainment was minimized in our current study (Fadnes et al., 2008).

In further detail, the instruments were thus discussed as they were used in our main study. For the quantitative study, a standardized anonymous questionnaire with two sections was the instrument used in collecting data from respondents. The demographic section obtained information on the gender, age, nationality, country of residence, ethnicity, socioeconomic status, yearly income, occupational prestige, and highest education attained. To obtain the yearly income that matched low or middle socioeconomic groups in both countries, we relied on professional reports (Salary Explorer, 2020), which submitted that at the time our study was conducted (between March and April 2020), low socioeconomic groups yearly earned below £ 16,000 (< 7,864,700.80 NGN), whereas middle socioeconomic group yearly earned greater than £ 16,000 but less than £ 71,000 (< 34,899,609.80 NGN) in the UK and Nigeria.

The next section measured professional help-seeking for mental illness with the professional help-seeking behavior scale adopted from Egwuonwu et al. (2019). This standardized scale consists of 10 items that were rated using a bipolar rating format (Yes or No). Sample items on the scale include: "If I believed I was having a mental breakdown, my first inclination would be to get professional help (psychotherapy)", "A person with an emotional problem is not likely to solve it alone, he/she is likely to solve it with professional help", or "Emotional difficulties, like many things, should not be left to work out themselves". The scale has been previously found to show a valid measurement of professional help-seeking in Black samples (Egwuonwu et al., 2019). According to the scale adoption source, the minimum and the maximum possible scores were 0 and 10, respectively. Further, a score of 50% or more was considered as good professional help-seeking behavior whereas less than 50% was rated poor professional help-seeking behavior. A reliability coefficient of 0.721 was obtained in the current study as informed by Cronbach's alpha.

For the qualitative strand, we obtained demographic data as obtained in the quantitative strand and utilized open-ended questions (informed by theory, Ajzen, 1985, and literature, Lasebikan et al., 2012; Memon et al., 2016) that asked respondents: (1) "In your own words, what psychosocial factors do you consider as barriers limiting your professional help-seeking behavior" (2) "How does your culture encourage or discourage you from seeing a mental health practitioner when you have the need?" (3) "Is there anything else on the barriers to your professional help-seeking behavior that you would like to describe? If yes, please describe it extensively". We politely emphasized in the study description section that respondents should provide detailed responses due to the qualitative design of the strand. Our qualitative data were collected until data saturation was observed. Data saturation, as described in the literature, is very valuable to determine data sufficiency in qualitative research (Guest et al., 2020).

The Procedure of Data Collection and Data Analysis Process

A proposal was submitted for ethics approval to the University of Ibadan, Nigeria in December 2019. Between March and April 2020, we designed our survey to enable data collection via electronic means from prospective respondents with diverse demographics (Saunders et al., 2009). As informed by the literature on how to disseminate the research instruments in a mixed-methods study of this kind (Wisdom & Creswell, 2013), we designed our survey to collect data at a different interval to prevent information overload from prospective respondents. Therefore, our quantitative and qualitative studies were not conducted simultaneously. An online consent form was used to elicit consent in both studies. All respondents were made to understand that responding to our survey was voluntary as we stated the voluntariness for participation in the online consent form.

From Nigeria and the UK, we shared the survey links via our individual social media accounts to various Facebook groups for Black people in the UK and Nigeria, and we instructed that the survey was strictly designed for research purposes. We also instructed that the survey was structured to obtain data from Black family members in the UK or Nigeria who were in either low or middle socioeconomic groups. Our procedure acknowledged the fact that self-report bias is a common confounding factor in studies like our current study, and anonymous questionnaires are strongly recommended to control for it (Althubaiti, 2016; Rosenman et al., 2011). Therefore, to minimize this confounding factor, we ensured that no identifying information was requested from respondents throughout the data collection procedure. It was less likely for a respondent to complete our survey more than once as we structured our survey to restrict access to respondents who had previously completed the survey. Further, all respondents were instructed not to attempt filling out the survey a second time if they had previously completed it and they all reported to adhere to our instructions when submitting their completed data.

The information of respondents was kept strictly confidential. Our contacts were clearly stated on the consent form for respondents to contact us if they had any inquiries. Our ethical considerations were not limited to the aforementioned, we also encouraged professional help-seeking practices by providing information on the various mental health care facilities in the UK and Nigeria on the last page of our survey. We considered it important to share such information in our study based on the literature (Adejumo & Olorunesan, 2018), and given the aim of the current study. The procedure was the same in both strands.

In the end, we exported the data for cleaning and analysis. The IBM SPSS Statistics version 22.0 was used for quantitative data analyses and descriptive analyses and one-way analysis of variance (ANOVA) were carried out. Statistical significance was determined at $p < 0.05$. About the qualitative data, the responses of respondents were manually analyzed using thematic analysis. In conducting thematic analysis, the qualitative data were first presented verbatim to preserve the meaning of respondents' responses (Corden & Sainsbury, 2006). When we presented verbatim, we noticed that almost every respondent reported at least five barriers and this contributed to giving us rich qualitative data. Following the verbatim presentation, we embarked on identifying common themes from the responses submitted by respondents. A data-driven approach was applied to the thematic analysis. We read and re-read the responses of respondents to extract themes, and we kept in mind the qualitative research question when conducting the thematic analysis. After themes were created, appropriate quotations were placed under each theme. From here, we proceeded to read and re-read each theme and its quotation(s) to ensure appropriateness. Following this, we carefully discussed the qualitative results to refine the created themes where necessary. Our discussion was partly assisted by the lens of the literature, which are cited in the section of our qualitative findings.

Member checking was conducted with five participants to enhance trustworthiness and rigor (Birt et al., 2016). Further, four external qualitative researchers (comprising two Black and two White external qualitative researchers, respectively) were invited to validate our qualitative results, and any disagreement was resolved by reworking the themes. The invitation of White external qualitative researchers was to minimize the effect of insider status as suggested by the literature (Sidhu et al., 2020). Insider status means having a similar identity with the respondents. Both authors of this paper had similar identities with respondents (Ogueji is a Nigerian, while Okoloba is a Black British) and this may have a bias on the qualitative data interpretation.

However, the invitation of White external qualitative researchers was the potential to control for any bias. Following the quantitative and qualitative data analyses, the results from both strands were integrated. Both authors conducted the data analyses of this study and we both had expertise in conducting data analyses in health and psychological research (e.g., Ogueji, 2021; Ogueji & Okoloba, 2022; Ogueji et al., 2021a, 2021b; Okoloba et al., 2020). Our qualitative strand was in keeping with the consolidated criteria for reporting qualitative studies (COREQ; Booth et al., 2014). Finally, we sent out an appreciation post to all respondents through the social media platforms that

Table 1 Demographic profile of quantitative study respondents

Variable	*N* (%)
Gender	
Male	30 (34.5)
Female	57 (65.5)
Country	
Nigeria	55 (63.2)
UK	32 (36.8)
Socioeconomic status	
Low (Nigeria)	36 (41.4)
Middle (Nigeria)	19 (21.8)
Low (UK)	15 (17.2)
Middle (UK)	17 (19.5)
Highest education attained	
High school	5 (5.7)
Bachelors	59 (67.8)
Masters	17 (19.5)
PhD/Doctorate	6 (6.9)
Yearly income	
< £ 16,000 (< 7,864,700.80 NGN)	51 (58.6)
> £ 16,000 but < £ 71,000 (< 34,899,609.80 NGN)	36 (41.4)
Occupational prestige	
< 5	51 (58.6)
> 5	36 (41.4)

respondents were recruited from, and assured them of the link to the publication from this study.

Results

Descriptive Results

A total of 115 willing respondents were recruited for the quantitative strand; however, 87 of them had their data completed, and this generated a completion rate of 76%. The total number of respondents in the qualitative strand was 18. Respondents in both strands were inclusive of diverse ethnicities, e.g., (Igbo, Yoruba, Hausa, Ijaw, Ibibio, or other) or (African, Black British, African-Caribbean, Mixed Black, or other Black). The mean age for all respondents was 48.16 ± 8.98 years (age range = 19–64 years**)**. See Table 1 for further demographic information.

Distribution of Respondents by the Total Score on the Professional Help-Seeking Scale

Of all respondents, the mean score on the professional help-seeking scale was 7.72 (SD = 2.13). Further, the mean score of respondents from each country showed [UK low and middle socioeconomic groups = 7.33 (SD = 2.13) and 7.06 (SD = 1.85), respectively; Nigerian low and middle socioeconomic groups = 8.06 (SD = 2.23) and 8 (SD = 2.13), respectively]. Further, among all respondents, the minimum total score on the scale was 1, whereas the maximum total score was 10. Further, more than half (78) of the total respondents scored 50% or more (total score of 5 or more), and this was interpreted as good professional help-seeking behavior, according to the scale adoption source. On the other hand, 9 respondents scored below 50% (total score from 1 to 4), and this was interpreted as poor professional help-seeking behavior.

From the respondent distribution on each item in the professional help-seeking scale, the results in Table 2 revealed that most respondents in the quantitative study shared similar perceptions about professional help-seeking for mental illness.

Hypothesis Testing

The UK Black family members in the middle socioeconomic group will have a significantly higher professional help-seeking behavior than the UK Black family members in the low socioeconomic group, and Nigerian Black family members in the low or middle socioeconomic group.

Results in Table 3 revealed that there was no statistically significant difference in professional help-seeking behaviors among the UK and Nigerian Black family members in low and middle socioeconomic groups as determined by one-way ANOVA at [F (3, 83) = 1.13; $p > 0.05$]. Therefore, the stated hypothesis was rejected in this study.

Qualitative Findings

This section reported the six main themes that were created from thematic analysis. Eighteen (18) respondents (12 and six Nigerian and the UK Black family members, respectively; 13 had acquired education from tertiary institutions, while five had high school education) participated in the qualitative strand, and each response was labeled with the gender, country, and socioeconomic status of respondents.

Theme One: Accessibility

Almost all respondents had accessibility reflected in their responses. The theme of accessibility had two subthemes—financial accessibility and perceived accessibility to mental health services.

Table 2 Distribution summary table of respondents on each item in the professional help-seeking scale

S/N	Item	Yes	No
1	If I believed I was having a mental breakdown, my first inclination would be to get professional help (psychotherapy)	48 (55.2)	39 (44.8)
2	If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy	55 (63.2)	32 (36.8)
3	I would want to get psychiatric attention if I was worried or upset for a long period of time	53 (60.9)	34 (39.1)
4	At some future time, I might want to have psychological counselling	62 (71.3)	25 (28.7)
5	A person with an emotional problem is not likely to solve it alone, he/she is likely to solve it with professional help	70 (80.5)	17 (19.5)
6	The idea of talking about problems with a psychologist is a good way to get rid of emotional conflicts	80 (92.0)	7 (8.0)
7	There is something admirable in the attitude of a person who is willing to get help in dealing with his/her conflicts and fears	85 (97.7)	2 (2.3)
8	Irrespective of the time and expense involved in psychotherapy, it would have much value for a person like me	67 (77.0)	20 (23.0)
9	A person should work out his/her mental problems by getting psychological counselling not only as a last resort	74 (85.1)	13 (14.9)
10	Emotional difficulties, like many things, should not be left to work out themselves	78 (89.7)	9 (10.3)

Table 3 One-way ANOVA summary table showing the differences in professional help-seeking behaviors across socioeconomic groups

Source	SS	df	MS	*F*	*P*
Between group	15.22	3	5.07	1.13	.344
Within group	374.16	83	4.51		
Total	389.38	86			

Financial Accessibility

This was described by respondents as mental health services with high consultation fees. We argued that given this sub-theme, respondents may support help-seeking from informal sources that they consider affordable. This, therefore, could potentially impact their support for and intentions to seek professional help. Theoretically, this theme supported the argument of the theory of planned behavior that external control factors such as finances can impact professional help-seeking behaviors. An example of a response endorsing this theme was given below:

> The only thing I can think of is finances, for instance, when the consultation fee is on the high side… (Male, Nigerian, low SES).

A UK respondent endorsed this theme by stating the expensive means of seeking professional help through private health professionals. However, she mentioned that the National Health Service (NHS) has an affordable service that can work well. Given that the NHS is government-funded (Baker, 2020), we argued that this sub-theme, is indicative of the potential roles that governments can play in strengthening professional help-seeking behaviors among the general public.

> Professional help through private means is expensive. However, help through the NHS, for example, can work well… (Female, UK, low SES).

Perceived Accessibility to Mental Health Services

Respondents also narrated their perceived accessibility to mental health services based on the unavailability of mental health services in their various locations. For instance:

> Unavailability of mental health practitioners is a recurrent barrier that can restrict us... (Male, Nigerian, middle SES).

A Nigerian respondent reinforced this theme by narrowing it to a specific state in Nigeria.

> Most of the times, the barrier is that there are limited mental health services in Ibadan (the capital of Oyo State, Nigeria) and even the available ones are not made so available for students to access… (Female, Nigerian, low SES).

A UK respondent contributed to this theme as follows:

> …Even though the UK is developed, there are sometimes when you need mental health services but such services are unavailable for one to access…This obviously could be a barrier… (Female, UK, low SES).

Theme two: Stigmatization and Socio-Cultural Factors

Five respondents submitted that if they seek professional help for mental illness, people could stigmatize them. For instance, a UK respondent supporting this theme

highlighted stigmatization from health workers. We, therefore, argued that such stigmatization from people (e.g., health workers) could potentially restrict the willingness to, intentions, and the actual act of utilizing mental health services.

> …The health workers in NHS may stigmatize you because you are presenting a mental health issue to them and this can limit me from seeking professional help. (Female, UK, low SES).

Nigerian respondents also endorsed the theme of stigmatization by reporting that:

> Negative reactions from members of the society who could conclude that I am mad to ask for such help. (Female, Nigerian, low SES).
> Stigmatization from people around me is a major psychosocial barrier that can prevent me from seeking professional help (Female, Nigerian, middle SES).

Another Nigerian respondent supported this theme by stating the influence that societal perceptions about mental illness can have on help-seeking behaviors. This was expected since the literature suggested that mental illness stigma in Black societies may be based on societal views of mental illness, and this may affect professional help-seeking in Black societies (Ogueji & Constantine-Simms, 2019).

> Societal perceptions about mental illness could be a barrier to seeking professional help...You know how people look at mentally ill people in Nigeria, I don't want to be looked at that way so I may rarely seek professional help... (Female, Nigerian, middle SES).

Additionally, socio-cultural factors were highlighted as barriers limiting respondents from seeking professional help. Socio-cultural factors were mostly described by respondents as socio-cultural factors regarding mental health. Theoretically, this theme aligned with the argument of the theory of planned behavior that subjective norms can impact professional help-seeking behaviors.

A Nigerian respondent stated socio-cultural factors such as that Nigerians are not brought up knowing the roles of mental health professionals nor encouraged to seek professional help.

> ...Culture (we were not really brought up knowing the roles of mental health professionals nor encouraged to seek help from them). (Male, Nigerian, middle SES).

Another Nigerian respondent supported this theme by stating the socio-cultural impact of masculinity norms.

> …Socio-cultural factors that do not promote seeking help for mental illness such as - 'The perception that a man should be strong'… (Male, Nigerian, low SES).

A UK respondent endorsing this theme highlighted that due to socio-cultural factors, one could think that mental health is not as important as physical health.

> Socio-cultural factors surrounding the way we were brought up in the UK can make us believe that mental health isn't as important as physical health…thus limiting us from seeking professional help for mental concerns (Female, UK, middle SES).

Theme Three: Concerns about Confidentiality

Respondents were bothered about the safety of information shared during professional help-seeking or therapy sessions. This was not surprising since the literature has highlighted concerns about confidentiality as a major issue in mental health service utilization (Ogueji et al., 2021a). An example of a response endorsing this theme was given below:

> …A barrier is the kind of person to meet and talk to - (for instance, who knows if they will be trustworthy like they claim?) (Female, Nigerian, low SES).

A UK respondent added to this theme by highlighting the major concerns of Black people seeking mental health help in the UK. From a clinical perspective, this, therefore, reinforced the importance of protecting clients' information during therapy sessions.

> In the UK, I think one of the major concerns of Black people seeking mental health help is how safe the information they share with the so-called 'therapist' is… (Male, UK, middle SES).

Theme four: Poor Knowledge About Mental Health Services

Some respondents submitted that having poor knowledge about mental health services was limiting them from seeking professional help. This theme was observed to be skewed towards Nigerian respondents. The skewness might be explained by data showing that mental health is acceptable to talk about in the public setting in the Western world than in Africa (Ward et al., 2013). Illustrative endorsements for this theme are below:

> ...Lack of knowledge of the role of mental health professionals in treating mental illness could be a barrier for me. (Male, Nigerian, middle SES).

> …A barrier is that the level of mental health service awareness is very low for most people that is why some people commit suicide at instance because they don't know who to talk to… (Female, Nigerian, low SES).

This theme was reinforced by a respondent who mentioned his ignorance of the roles of psychologists and psychiatrists in mental health care. This, therefore, strengthens the importance of public psycho-education about mental health services.

> …Ignorance that psychologists and psychiatrists deal with only mad people could be a barrier for most of us. (Male, Nigerian, low SES).

Theme five: Waiting Time to See a Professional

The time taken to see a professional for mental health care was identified as another barrier. This, therefore, possibly supports the importance of e-therapy to mitigate the long waiting time that could be associated with face-to-face therapy (Ogueji et al., 2021a). A UK respondent supporting this theme reported:

> The waiting time (long waiting time) to physically see a professional can restrict me from seeing a professional for my mental health needs (Female, UK, middle SES).

Theme six: Risk of Contracting the Infectious Disease in the Hospital Setting

The likelihood that one could contract an infectious disease from other patients in the hospital setting was highlighted as the last barrier to seeking professional help for mental illness. This theme may be explained by the timing at which our current study was conducted. That is, our current study was conducted when the coronavirus disease 2019 (COVID-19) had affected the world, and most people all over the world were concerned about contracting COVID-19 if they went to the clinic or hospital for any health need.

To add to this, existing data showed that during the outbreak of infectious diseases, people may doubt the healthcare system for fear that they may contract infectious diseases (Mercy Corps, 2019). Thus, making them avoid seeking treatment for any illness, and the consequence may be further health complications. This, therefore, is indicative of the need for policies and programs that ensure that the accessibility to mental health services is not hindered by the threats of the COVID-19 pandemic, especially as the world is threatened by subsequent waves of the pandemic.

A Nigerian respondent supported this theme by reporting as follows:

> The fact that most hospitals attend to patients with infectious diseases (such as COVID-19) and I could stand the risk of contracting these infectious diseases if I go for mental health care in the hospital is enough barrier. (Male, Nigerian, middle SES).

Discussion

Our current study comprised two strands. The quantitative strand using one-way ANOVA established that there was no statistically significant difference in professional help-seeking behaviors among UK and Nigerian Black family respondents in low and middle socioeconomic groups. Further, the quantitative strand also established that more than half of the total respondents were open to professional help-seeking, as shown by the total score of respondents, and the distribution of respondents on each item of the professional help-seeking behavior scale. Therefore, the similar distribution of respondents to each item in the scale and the fact that most respondents scored above average on the scale could explain the reason for obtaining a non-statistically significant result from the one-way ANOVA. To enhance our study transparency, based on the non-statistically significant results, we have not carried out a post hoc analysis (Walliman, 2015). An implication of the finding from our hypothesis testing may suggest that Black family members may be gradually recording a paradigm shift in their openness to professional help-seeking practices. However, future longitudinal studies should confirm this.

The results from our quantitative strand may augment related studies that reported that Black people are now becoming open to help-seeking from professional sources (e.g., Chebbet, 2012; Ward et al., 2013). Additionally, the results from the quantitative strand may augment the literature where it was documented that socioeconomic status was less significant in influencing professional help-seeking behaviors (Ikwuka et al., 2016). However, our quantitative results may be argued to disagree with related studies where it was found that Black people were not open to professional help-seeking (e.g., Ampadu, 2015; Broman, 2012; Labys et al., 2016). Also, our quantitative results disagree with previous studies that argued that socioeconomic related factors may influence the professional help-seeking behaviors of Black people in the UK and Nigeria (e.g., Adam & Aigbokhaode, 2018; Arday, 2018; Latunji & Akinyemi, 2018; Memon et al., 2016). The disagreement between our quantitative findings and the literature may be attributed to the comparison feature of our study. That is, the comparison of quantitative data collected from the UK and Nigerian respondents.

Our qualitative strand revealed the major psychosocial barriers limiting the professional help-seeking behaviors of respondents. As shown from the findings of the qualitative strand, it was evident that the professional help-seeking behaviors of our respondents were majorly limited by six main themes: accessibility (which had two sub-themes—financial accessibility and perceived accessibility to mental health services), stigmatization and socio-cultural factors, concerns about confidentiality, poor knowledge about mental health services, waiting time to see a professional, and risk of contracting the infectious disease in the hospital setting, in that order. The findings from our qualitative strand agree with previous studies that argued that concerns about confidentiality, stigmatization and socio-cultural factors, and other psychosocial barriers typical of the ones reported in the current study may restrict the professional help-seeking behaviors of Black people (Campbell, 2017; McCann et al., 2016; Ogueji & Constantine-Simms, 2019). The findings agree with Banks (2020) who argued that socio-cultural factors including stigmatization and poor understanding of mental health could hinder Black people from seeking mental health services. The findings support Ogueji et al. (2021a) who argued that concerns about confidentiality and long waiting time associated with face-to-face therapy may be hindrances during mental health service utilization.

Integrating the results from both strands, an implication suggests that the majority of the UK and Nigerian Black family members in our study were open to help-seeking from professional sources as revealed by our quantitative data. However, their openness may not predict their help-seeking behaviors because of the potential impact of the identified psychosocial barriers in our qualitative data. Therefore, our integrated finding augments the literature where it was argued that Black people were open to professional help-seeking, with psychosocial barriers potentially limiting their openness from being in accordance with their behaviors (Chebbet, 2012; Ward et al., 2013). Our integrated finding is also a theoretical consensus with the theory of planned behavior (Ajzen, 1985). Further, the integrated finding may be explained by the socio-cultural context of some Black societies that tend to disregard people living with mental illness and discourage them from seeking professional help (Banks, 2020; Memon et al., 2016; Ogueji & Constantine-Simms, 2019; Taylor & Kuo, 2019). Thus, not surprising that our UK and Nigerian respondents in the qualitative strand shared similar themes.

Our study was not designed to be a pilot study. But it has offered some knowledge that could be gained from a pilot study of this kind. Our study has revealed that the mixed-methods design that we employed may be suitable for large-scale studies as well. Another lesson from this study is that although we made very active efforts to limit the chances of self-report bias, there is the need for large-scale studies of this kind to employ more rigorous methods of self-report bias limitation and a more rigorous method to measure socioeconomic status, given the importance of this research title.

The core strength of our study was that we drew data from quantitative and qualitative sources. Further, our study actively minimized the likelihood of response bias as shown in our methods section. On the other hand, our study was limited by the small sample size and this occurred because of the short timeframe we used in collecting data due to limited resources. Despite that our sample size was small, we believe that our study is the first to comparatively explore the impacts of socioeconomic status and other psychosocial barriers on professional help-seeking behaviors among Black family members in the UK and Nigeria. We hope that future studies will build on our study to extend the current knowledge of professional help-seeking behaviors among the target groups.

We excluded potential respondents who could not communicate using the English language because we lacked translation services. Additionally, the electronic means of data collection in the qualitative strand could have potentially limited us from actively probing into the other psychosocial barriers limiting respondents from professional help-seeking. Nonetheless, respondents in the qualitative strand were made to understand that their responses should be as detailed as possible because of the qualitative feature of the strand. Also, the UK respondents were under-represented in the qualitative strand, and most UK respondents in the qualitative strand were females. Further, we did not collect data on the history of seeking/receiving professional help for mental illness, as this could enable a better understanding of the actual act of professional help-seeking. This, therefore, imply that our results may mostly be interpreted within the openness to and intention of professional help-seeking.

The electronic means of data collection in both strands restricted potential respondents who lack internet access. This, therefore, could have implications for the interpretation of our findings, particularly in Nigeria where most persons in the low socioeconomic group tend to lack internet access. Nevertheless, these limitations did not hinder the current study from achieving its objectives.

Recommendations

For the fact that low/middle socioeconomic status was not a significant determinant of professional help-seeking behavior, we recommend based on our qualitative results that there is the need for mental health care providers, as well as regulatory agencies to express sensitivity to the

major psychosocial barriers limiting the professional help-seeking behaviors of our study population. This could be realized by the UK, and Nigerian governments collaborating with social workers, clinical psychologists, psychiatrists, and other relevant health care workers (HCWs) to review health policies that regulate the availability of, affordability of, and accessibility to mental health services in their respective countries, to encourage professional help-seeking practices.

Further, we recommend the need for psycho-education programs that aim to discourage public stigmatization of people with mental illness in society. Another important focus of such psycho-education should be to educate the general public about the roles of the various professionals (multidisciplinary team; e.g., social workers, clinical psychologists, psychiatrists, etc.) involved in mental health care. There is also the need for psycho-education programs that are tailored towards mitigating the socio-cultural factors associated with professional help-seeking (e.g., masculinity norm as reported by a Nigerian respondent who mentioned "The perception that a man should be strong", or socio-cultural thoughts about the importance of physical health over mental health as reported by a UK respondent). Lastly, we recommend that during therapy sessions, clients/patients should be assured/re-assured of the safety of information shared, and e-therapy may be considered as an intervention for mitigating the long waiting time that could be associated with face-to-face therapy. However, e-therapy may be challenging to carry out in Nigeria where many required infrastructures are lacking (Ogueji et al., 2021a). Governments and relevant stakeholders thus need to pay attention to the unmet needs associated with carrying out e-therapy.

Conclusion

In the quantitative strand, there was no statistically significant difference in professional help-seeking behavior as most respondents from both countries were open to seeking help from professional sources. In the qualitative strand, the barriers to professional help-seeking were: accessibility (which had two sub-themes—financial accessibility and perceived accessibility to mental health services), stigmatization and socio-cultural factors, concerns about confidentiality, poor knowledge about mental health services, waiting time to see a professional, and risk of contracting the infectious disease in the hospital setting.

Based on our mixed-methods design, we concluded that our respondents who were UK and Nigerian Black family members in low or middle socioeconomic groups were open to seeking help from professional sources; however, their openness may not predict their help-seeking behaviors because of the potential impact that the identified barriers may have on them. Future studies should build on our study to extend what is currently known about professional help-seeking behaviors in the study population.

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Author Contributions MMO conceived the study and discussed it with IAO. MMO generously funded the study through the provision of the funds required for utilizing the data collection tool and developed the first version of the online data collection form. Both authors finalized the online data collection form, designed the study, collected and analyzed data, wrote the article, edited, proofread, and approved the final version. Therefore, both authors contributed significantly and are the first authors of this paper.

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Data Availability The data associated with this study are available from the authors upon request.

Declarations

Conflict of interest We have no conflict of interest to declare.

Consent to Participate An online consent form was utilized to obtain consent from every respondent.

Consent for Publication All respondents consented that findings from their data should be published in this paper. Both authors consented to the publication of this paper in the Psychological Studies.

Ethical Approval Our study was in accordance with the ethical standards of the institutional and/or national research and ethics committee, the 1964 Helsinki ethical declaration, its later amendment, or a comparable standard.

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